NY CLS Ins § 3221

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New York

Consolidated Laws Service **>**

Insurance Law (Arts. 1 — 99) **>**

Article 32 Insurance Contracts — Life, Accident and Health, Annuities (§§ 3201 — 3245)

Notice

This section has more than one version with varying effective dates.

§ 3221. Group or blanket accident and health insurance policies; standard provisions. [Effective January 1, 2026]

(a) No policy of group or blanket accident and health insurance shall, except as provided in subsection (d) hereof, be delivered or issued for delivery in this state unless it contains in substance the following provisions or provisions which in the opinion of the superintendent are more favorable to the holders of such certificates or not less favorable to the holders of such certificates and more favorable to policyholders, provided however, that the provisions set forth in paragraphs six and thirteen of this subsection shall not be applicable to any such policy which is issued to a policyholder in accordance with subparagraph (E) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter:

(1)

(A) No statement made by the person insured shall avoid the insurance or reduce benefits thereunder unless contained in a written instrument signed by the person insured.

(B) All statements contained in any such written instrument shall be deemed representations and not warranties.

(2) That no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer.

(3) That all new employees or new members in the classes eligible for insurance must be added to such class for which they are eligible.

(4) That all premiums due under the policy shall be remitted by the employer or employers of the persons insured or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof, with such period of grace as may be specified therein.

(5) The conditions under which the insurer may decline to renew the policy.

(6) That the insurer shall issue either to the employer or person in whose name such policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage and in substance the following provisions of this subsection.

(7) The ages, to which the insurance provided therein shall be limited; and the ages, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages.

(8) That written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(9) That in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within thirty days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within one hundred twenty days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

(10) That the insurer will furnish to the person making claim or to the policyholder for delivery to such person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(11) That the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.

(12) That benefits payable under the policy other than benefits for loss of time will be payable not more than sixty days after receipt of proof, and that, subject to due proof of loss all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer

is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(13) That indemnity for loss of life of the insured is payable in accordance with subsection (e) of section four thousand two hundred thirty-five of this chapter; and that all other indemnities of the policy are payable to the insured, except as may be otherwise provided in accordance with such subsection; and that if a beneficiary is designated, the consent of the beneficiary shall not be requisite to change of beneficiary, or to any other changes in the policy or certificate, except as may be specifically provided by the policy.

(14) That no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.

(15)

Any policy and certificate, other than one issued in fulfillment of the continuing care responsibilities of an operator of a continuing care retirement community in accordance with article forty-six of the public health law, made available because of residence in a particular facility, housing development, or community shall contain the following notice in twelve point type in bold face on the first page:

"NOTICE — this policy or certificate does not meet the requirements of a continuing care retirement contract. Availability of this coverage will not qualify a residential facility as a continuing care retirement community."

(16) No policy delivered or issued for delivery in this state which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-

preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).

(17) Space shall be provided on any enrollment, renewal or initial online portal process setup forms required of an insured or applicant for insurance so that the insured or applicant for insurance shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment, renewal or initial online portal process setup forms and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

(b) No such policy shall be delivered or issued for delivery in this state unless a schedule of the premium rates pertaining to such form shall have been filed with the superintendent.

(c) Any portion of any such policy, which purports, by reason of the circumstances under which a loss is incurred, to reduce any benefits promised thereunder to an amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed, in such policy and in each certificate issued thereunder, in bold face type and with greater prominence than any other portion of the text of such policy or certificate; and all other exceptions of the policy shall be printed in the policy and in the certificate, with the same prominence as the benefits to which they apply. If any such policy contains any provision which affects the liability of the insurer, on the grounds stated in subparagraph (J) or (K) of paragraph two of subsection (d) of section three thousand two hundred sixteen of this article, then such provision shall be contained in the policy and certificate in the form set forth in such section.

(d)

(1) The superintendent may approve any form of certificate to be issued under a blanket accident and health insurance policy as defined in section four thousand two

hundred thirty-seven of this chapter, which omits or modifies any of the provisions hereinbefore required, if the superintendent deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. Certificates issued under a policy or contract of student accident and health insurance as defined in section three thousand two hundred forty of this article shall comply with such section.

(2) The superintendent may approve any form of group insurance policy providing disability benefits to be issued pursuant to article nine of the workers' compensation law which omits or modifies any of the provisions hereinbefore required, if such omission or modification is not inconsistent with the provisions of such article nine and he deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder.

(3) The superintendent may also approve any form of group insurance policy to be issued to a social services district pursuant to subdivision two of section three hundred sixty-seven-a of the social services law, which omits or modifies any of the provisions hereinbefore required, if he deems such omission or modification suitable for the character of such insurance.

(e)

(1) A group policy providing hospital, medical or surgical expense insurance for other than specific diseases or accident only, shall provide that if the insurance on an employee or member insured under the group policy ceases because of termination of (A) employment or of membership in the class or classes eligible for coverage under the policy or (B) the policy, for any reason whatsoever, unless the policyholder has replaced the group policy with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group policy shall be entitled to have issued to the insured by the insurer without evidence of insurability upon application made to the insurer within sixty days

after such termination, and payment of the quarterly, or, at the option of the employee or member, a less frequent premium applicable to the form and amount of insurance, an individual policy of insurance. The insurer may, at its option elect to provide the insurance coverage under a group insurance policy, delivered in this state, in lieu of the issuance of a converted individual policy of insurance. Such individual policy, or group policy, as the case may be is hereafter referred to as the converted policy. The benefits provided under the converted policy shall be those required by subsection (f) and (g) of this section, in the event of termination of the converted group policy of insurance, each insured thereunder shall have a right of conversion to a converted individual policy of insurance.

(2) The insurer shall not be required to issue a converted policy covering any person if such person is covered for similar benefits by another hospital or surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program or such person is eligible for similar benefits, whether or not covered therefor, under any arrangement of coverage for individuals in a group, other than under the converted policy, whether on an insured or uninsured basis or similar benefits are provided for or available to such person pursuant to any statute; and the benefits provided or available under any of such sources which together with the benefits provided under the converted policy would result in overinsurance or duplication of benefits according to standards on file with the superintendent.

(3) The converted policy shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group policy. Provided, however, that if the employee or member chooses the option of dependent coverage then dependents acquired after the permitted time to convert stated in paragraph one of this subsection shall be added to the converted family policy in accordance with the provisions of subsection (c) of

section thirty-two hundred sixteen of this article and any regulations promulgated or guidelines issued by the superintendent. The effective date of the individual's coverage under the converted policy shall be the date of the termination of the individual's insurance under the group policy as to those persons covered under the group policy.

(4) If delivery of an individual converted policy is to be made outside this state, it may be on such form as the insurer may then be offering for such conversion in the jurisdiction where such delivery is to be made.

(5) The conversion provision shall also be available upon the death of the employee or member, to the surviving spouse with respect to such of the spouse and children as are then covered by the group policy, and shall be available to a child solely with respect to himself upon his attaining the limiting age of coverage under the group policy while covered as a dependent thereunder. It shall also be available upon the divorce or annulment of the marriage of the employee or member, to the former spouse of such employee or member.

(6)

(A) Each certificate holder shall be given written notice of such conversion privilege and its duration within fifteen days before or after the date of termination of group coverage, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of group coverage, the time allowed for the exercise of such privilege of conversion shall be extended for forty-five days after the giving of such notice. If such notice be not given within ninety days after the date of termination of group coverage, the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days.

(B) Written notice by the policyholder given to the certificate holder or mailed to the certificate holder's last known address, or written notice by the insurer be sent by first class mail to the certificate holder at the last address furnished to the

insurer by the policyholder, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

(C) A group contract issued by an insurer may contain a provision to the effect that notice of such conversion privilege and its duration shall be given by the policyholder to each certificate holder upon termination of his group coverage.

(7) In addition to the right of conversion herein, the employee or member insured under the policy shall at his option, as an alternative to conversion, be entitled to have his coverage continued under the group policy in accordance with the conditions and limitations contained in subsection (m) of this section, and have issued at the end of the period of continuation an individual conversion policy subject to the terms of this subsection. The effective date for the conversion policy shall be the day following the termination of insurance under the group policy, or if there is a continuation of coverage, on the day following the end of the period of continuation. Notwithstanding the foregoing, the superintendent may require conversion or continuation of insurance under conditions as set forth in a regulation for insureds under a policy issued in accordance with subparagraph (E) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter.

(8) For purposes of this subsection, the term “dependent” shall include a child as described in subsection (f) of section four thousand two hundred thirty-five of this chapter.

(9), (10) [Repealed]

(11), (12) [Redesignated]

(f) If the group insurance policy insures the employee or member for hospital, medical or surgical expense insurance, or if the group insurance policy insures the employee or member for major medical or similar comprehensive-type coverage, then the conversion privilege shall entitle the employee or member to obtain coverage under a converted

policy providing, at the insured's option, coverage under any one of the plans described in subsection (g) of this section on an expense incurred basis.

(g) For conversion purposes, an insurer shall offer to the employee or member a policy at each level of coverage as defined in subsection (b) of section three thousand two hundred seventeen-i of this article that contains the essential health benefits package described in paragraph three of subsection (e) of section three thousand two hundred seventeen-i of this article. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of this subsection and subsections (e) and (f) of this section through the offering of policies that comply with this subsection by another insurer, corporation or health maintenance organization within the insurer's holding company system, as defined in article fifteen of this chapter.

(h) Every small group policy or association group policy delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health benefits package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in paragraph three of subsection (e) of section three thousand two hundred seventeen-i of this article;

(2) "grandfathered health plan" means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the affordable care act, 42 U.S.C. § 18011(e);

(3) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(4) “association group” means a group defined in subparagraphs (B), (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, provided that:

(A) the group includes one or more individual members; or

(B) the group includes one or more member employers or other member groups that are small groups.

(i) An insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section if the benefits must be covered pursuant to subsection (h) of this section. For any policy issued within the health benefit exchange established by this state, an insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section.

(j) No policy of group or blanket accident and health insurance shall be issued as excess coverage for volunteer firefighters over and above the coverage provided for pursuant to the volunteer firefighters’ benefit law unless such excess policy provides for each of the types of coverages set forth in subdivision one of section five of such law. Any excess policy which does not contain such provisions shall be construed as if such coverages were embodied therein.

(k)

(1)

(A) Every group policy delivered or issued for delivery in this state which provides coverage for in-patient hospital care shall provide coverage for home care to residents in this state, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. Such home care coverage shall be included at the inception of all new policies and, with respect to all other policies, added at any anniversary date of the policy subject to evidence of insurability.

(B) Such coverage may be subject to an annual deductible of not more than fifty dollars for each person covered under the policy and may be subject to a coinsurance provision which provides for coverage of not less than seventy-five percent of the reasonable charges for such services.

(C) Home care means the care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, would otherwise have been required if home care was not provided, and the plan covering the home health service is established and approved in writing by such physician.

(D) Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law and shall consist of one or more of the following:

(i) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).

(ii) Part-time or intermittent home health aide services which consist primarily of caring for the patient.

(iii) Physical, occupational or speech therapy if provided by the home health service or agency.

(iv) Medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency or licensed home care services agency to the extent such items would have been covered under the contract if the covered person had been hospitalized or confined in a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq.

(E) For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits, but not less than forty such visits in any calendar year or in any continuous period of twelve months, for each person covered under the contract; four hours of home health aide service shall be considered as one home care visit.

(2)

(A) Every insurer issuing a group policy delivered or issued for delivery in this state which provides coverage for in-patient hospital care shall include coverage for preadmission tests performed in hospital facilities prior to scheduled surgery, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) Such policy shall provide benefits for tests ordered by a physician which are 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:

(i) tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

(ii) reservations for a hospital bed and for an operating room were made prior to the performance of the tests;

(iii) the surgery actually takes place within seven days of such presurgical tests; and

(iv) the patient is physically present at the hospital for the tests.

(C) Coverage for abortion shall include coverage of any drug prescribed for the purpose of an abortion, including both generic and brand name drugs, even if such drug has not been approved by the food and drug administration for abortion, provided, however, that such drug shall be a recognized medication for abortion in one of the following established reference compendia:

(i) The WHO Model Lists of Essential Medicines;

(ii) The WHO Abortion Care Guidance; or

(iii) The National Academies of Science, Engineering, and Medicine Consensus Study Report.

(3) Every group policy delivered or issued for delivery in this state which provides coverage for in-patient surgical care shall include coverage for a second surgical opinion by a qualified physician on the need for surgery, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state.

(4)

(A) Every group policy delivered or issued for delivery in this state that provides coverage for inpatient hospital care shall include coverage for services to treat an emergency condition provided in hospital facilities, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state unless the policy otherwise provides coverage for services to treat an emergency condition provided in hospital facilities:

(i) without the need for any prior authorization determination;

(ii) regardless of whether the health care provider furnishing such services is a participating provider with respect to such services;

(iii) if the emergency services are provided by a non-participating provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; and

(iv) if the emergency services are provided by a non-participating provider, the cost-sharing requirement (expressed as a copayment or coinsurance) shall be the same requirement that would apply if such services were provided by a participating provider.

(B) Any requirements of section 2719A(b) of the Public Health Service Act, 42 U.S.C. § 300gg19a(b) and regulations thereunder that exceed the requirements of this paragraph with respect to coverage of emergency services shall be applicable to every policy subject to this paragraph.

(C) In this paragraph, an “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 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; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(D) In this paragraph, “emergency services” means, with respect to an emergency condition: (i) a medical screening examination as required under section 1867 of the Social Security Act, 42 U.S.C. § 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 section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, to stabilize the patient.

(E) In 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).

(5)

(A)

(i) Every group or blanket policy delivered or issued for delivery in this state which provides hospital, surgical or medical coverage shall include coverage for maternity care, including hospital, surgical or medical care to the same extent that coverage is provided for illness or disease under the policy. Such maternity care coverage, other than coverage for perinatal complications, shall include inpatient hospital coverage for mother and newborn for at least forty-eight hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six hours after a caesarean section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to article one hundred forty of the education law, practicing consistent with section sixty-nine hundred fifty-one of the education law and affiliated or practicing in conjunction with a facility licensed pursuant to article twenty-eight of the public health law, but no insurer shall be required to pay for duplicative routine services actually provided by both a licensed midwife and a physician.

(ii) Maternity care coverage shall also include, at minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

(iii) The mother shall have the option to be discharged earlier than the time periods established in item (i) of this subparagraph. In such case, the inpatient hospital coverage must include at least one home care visit which shall be in addition to, rather than in lieu of, any home health care coverage available under the policy. The policy must cover the home care visit, which may be requested at any time within forty-eight hours of the time of delivery (ninety-six hours in the case of caesarean section), and shall be delivered within twenty-four hours, (I) after discharge, or (II) of the time of the mother's request, whichever is later. Such home care coverage shall be pursuant to the policy and subject to the provisions of this subparagraph, and not subject to deductibles, coinsurance or copayments.

(B) Coverage provided under this paragraph for care and treatment during pregnancy shall include provision for not less than two payments, at reasonable intervals and for services rendered, for prenatal care and a separate payment for the delivery and postnatal care provided.

(5-a)

Every policy that provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for prenatal vitamins when prescribed by a health care practitioner licensed, certified, or authorized under title eight of the education law, and acting within their lawful scope of practice.

(6)

(A) Every group policy issued or delivered in this state which provides coverage for hospital care shall not exclude coverage for hospital care for diagnosis and

treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility; provided, however that:

(i) subject to the provisions of subparagraph (C) of this paragraph, in no case shall such coverage exclude surgical or medical procedures provided as part of such hospital care which would correct malformation, disease or dysfunction resulting in infertility; and

(ii) provided, further however, that subject to the provisions of subparagraph (C) of this paragraph, in no case shall such coverage exclude diagnostic tests and procedures provided as part of such hospital care that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage provided pursuant to this paragraph, including such diagnostic tests and procedures as hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound; and

(iii) provided, further however, every such policy which provides coverage for prescription drugs shall include, within such coverage, coverage for prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility in accordance with subparagraph (C) of this paragraph.

(B) Every group policy issued or delivered in this state which provides coverage for surgical and medical care shall not exclude coverage for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility; provided, however that:

(i) subject to the provisions of subparagraph (C) of this paragraph, in no case shall such coverage exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility; and

(ii) provided, further however, that subject to the provisions of subparagraph (C) of this paragraph, in no case shall such coverage exclude diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage provided pursuant to this paragraph, including such diagnostic tests and procedures as hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound; and

(iii) provided, further however, every such policy which provides coverage for prescription drugs shall include, within such coverage, coverage for prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility in accordance with subparagraph (C) of this paragraph.

(C) Coverage of diagnostic and treatment procedures, including prescription drugs, used in the diagnosis and treatment of infertility as required by subparagraphs (A) and (B) of this paragraph shall be provided in accordance with the provisions of this subparagraph.

(i) Diagnosis and treatment of infertility shall be prescribed as part of a physician’s overall plan of care and consistent with the guidelines for coverage as referenced in this subparagraph.

(ii) Coverage may be subject to co-payments, coinsurance and deductibles as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(iii) Except as provided in items (vi) and (vii) of this subparagraph, coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (I) in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (II) the reversal of elective sterilizations; (III) sex change procedures; (IV) cloning; or (V) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in item (iv) of this subparagraph.

(iv) The superintendent, in consultation with the commissioner of health, shall promulgate regulations which shall stipulate the guidelines and standards which shall be used in carrying out the provisions of this subparagraph, which shall include:

(I) The identification of experimental procedures and treatments not covered for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(II) The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(III) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

(v)

(I) For the purposes of this paragraph, “infertility” means a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual’s medical history or physical findings.

(II) For purposes of this paragraph, “iatrogenic infertility” means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(vi) Coverage shall also include standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(vii) Every large group policy delivered or issued for delivery in this state that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization used in the treatment of infertility. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy. For purposes of this item, a “cycle” is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial

preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.

(viii) No insurer providing coverage under this paragraph shall discriminate based on an insured's expected length of life, present of predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

(D) Every policy that provides coverage for prescription fertility drugs and requires or permits prescription drugs to be purchased through a network participating mail order or other non-retail pharmacy shall provide the same coverage for prescription fertility drugs when such drugs are purchased from 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, as well as the same applicable terms and conditions, that the insurer has established for a network participating mail order or other non-retail pharmacy. In such case, the policy shall not impose any fee, co-payment, co-insurance, deductible or other condition on any covered person who elects to purchase prescription fertility drugs through a network participating non-mail order retail pharmacy that it does not impose on any covered person who purchases prescription fertility drugs through a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a policy that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

(7)

(A) Every group or blanket accident and health insurance policy issued or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the

education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

(B) Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy; provided, however, that covered prescription insulin drugs shall not be subject to a deductible, copayment, coinsurance or any other cost sharing requirement.

(C) This paragraph shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons employed in more than one state unless such policy is issued under the New York state health insurance plan established under article eleven of the civil service law or issued to or through a local government.

(8)

(A) Every group or blanket policy delivered or issued for delivery in this state which provides coverage for inpatient hospital care shall provide such coverage for such period as is determined by the attending physician in consultation with the patient to be medically appropriate for such covered person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy. Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such policy and annually thereafter.

(B) An insurer providing coverage under this paragraph and any participating entity through which the insurer offers health services shall not:

(i) deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy or vary the terms of the policy for the purpose or with the effect of avoiding compliance with this paragraph;

(ii) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this paragraph;

(iii) penalize in any way or reduce or limit the compensation of a health care practitioner for recommending or providing care to a covered person in accordance with this paragraph;

(iv) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this paragraph intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this paragraph; or

(v) restrict coverage for any portion of a period within a hospital length of stay required under this paragraph in a manner which is inconsistent with the coverage provided for any preceding portion of such stay.

(C) The prohibitions in subparagraph (B) of this paragraph shall be in addition to the provisions of sections three thousand two hundred thirty-one and three thousand two hundred thirty-two of this article and nothing in this subparagraph shall be construed to suspend, supersede, amend or otherwise modify such sections.

(9)

(A) Every policy which provides medical, major medical, or similar comprehensive-type coverage must provide 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, subject to the following:

(i) In the case of a policy that requires, or provides financial incentives for, the insured to receive covered services from health care providers participating in a provider network maintained by or under contract with the insurer, the policy shall include 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 a non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating appropriate specialist. Provided, however that nothing herein shall impair an insured's rights (if any) under the policy to obtain the second medical opinion from a non-participating specialist without a written referral, subject to the payment of additional coinsurance (if any) required by the policy for services provided by non-participating providers. The insurer shall compensate the non-participating specialist at the usual, customary and reasonable rate, or at a rate listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement.

(ii) In the case of a policy that does not provide financial incentives for, and does not require, the insured to receive covered services from health care providers participating in a provider network maintained by or under contract with the insurer, the policy shall include coverage for a second medical opinion from a specialist at no additional cost to the insured beyond what the insured would have paid for comparable services covered under the policy.

(iii) Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with

those established for other benefits within a given policy, and, where applicable, consistent with the provisions of clauses (i) and (ii) of this subparagraph.

Nothing in this paragraph shall eliminate or diminish an insurer's obligation to comply with the provisions of section four thousand eight hundred four of this chapter where applicable. Written notice of the availability of such coverage shall be delivered to the policyholder prior to the inception of such policy and annually thereafter.

(B) An insurer providing coverage under this paragraph and any participating entity through which an insurer offers health services shall not:

(i) deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy or vary the terms of the policy for the purpose or with the effect of avoiding compliance with this paragraph;

(ii) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this paragraph;

(iii) penalize in any way or reduce or limit the compensation of a health care practitioner for recommending or providing care to a covered person in accordance with this paragraph; or

(iv) provide incentives (monetary or otherwise) to a health care practitioner relating to the coverage provided pursuant to this paragraph intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this paragraph.

(C) The prohibitions in subparagraph (B) of this paragraph shall be in addition to the provisions of sections three thousand two hundred thirty-one and three thousand two hundred thirty-two of this article and nothing in this subparagraph

shall be construed to suspend, supersede, amend or otherwise modify such sections.

(10)

(A) Every group or blanket policy delivered or issued for delivery in this state which provides medical, major medical, or similar comprehensive-type coverage shall provide the following coverage for breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy:

(i) all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; and

(ii) surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance;

in the manner determined by the attending physician and the patient to be appropriate. Chest wall reconstruction surgery shall include aesthetic flat closure as such term is defined by the National Cancer Institute. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such policy and annually thereafter.

(A-1) Every group or blanket policy providing coverage as required by subparagraph (A) of this paragraph shall also provide coverage for the tattooing of the nipple-areolar complex pursuant to or as part of such reconstruction if such tattooing is performed by a licensed physician or other health care practitioner licensed, certified, or authorized pursuant to title eight of the education law and acting within their scope of practice.

(B) An insurer providing coverage under this paragraph and any participating entity through which the insurer offers health services shall not:

(i) deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy or vary the terms of the policy for the purpose or with the effect of avoiding compliance with this paragraph;

(ii) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this paragraph;

(iii) penalize in any way or reduce or limit the compensation of a health care practitioner for recommending or providing care to a covered person in accordance with this paragraph;

(iv) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this paragraph intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this paragraph; or

(v) restrict coverage for any portion of a period within a hospital length of stay required under this paragraph in a manner which is inconsistent with the coverage provided for any preceding portion of such stay.

(C) The prohibitions in this paragraph shall be in addition to the provisions of sections three thousand two hundred thirty-one and three thousand two hundred thirty-two of this article and nothing in this paragraph shall be construed to suspend, supersede, amend or otherwise modify such sections.

(11) [There are two paragraphs (11)] Every policy that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the

enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein, contain modified protein, or are amino acid based that are medically necessary.

(11) [There are two paragraphs (11)]

(A) Every policy which is a "managed care product" as defined in subparagraph (D) of this paragraph that includes coverage for physician services in a physician's office, and every policy which is a "managed care product" that provides major medical or similar comprehensive-type coverage shall include coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, 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 of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive than those applicable under the same policy to care or services provided by other health 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. Nothing herein contained shall be construed as impeding or preventing either the provision or coverage of chiropractic care and services by duly licensed doctors of chiropractic, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

(B) [Repealed]

(C) Every policy which includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive-type coverage, other than a "managed care product" as defined in subparagraph (D) of this paragraph, shall provide coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, 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 of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts,

reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive that those applicable under the same policy to care or services provided by other health 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. Nothing herein contained shall be construed as impeding or preventing either the provision or coverage of chiropractic care and services by duly licensed doctors of chiropractic, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

(D) For purposes of this paragraph, a “managed care product” shall mean a policy which requires that medical or other health care services covered under the policy, other than emergency care services, be provided by, or pursuant to a referral from, a primary care provider, and that services provided pursuant to such a referral be rendered by a health care provider participating in the insurer’s managed care provider network. In addition, a managed care product shall also mean the in-network portion of a contract which requires that medical or other health care services covered under the contract, other than emergency care services, be provided by, or pursuant to a referral from, a primary care provider, and that services provided pursuant to such a referral be rendered by a health care provider participating in the insurer’s managed care provider network, in order for the insured to be entitled to the maximum reimbursement under the contract.

(E) The coverage required by this paragraph shall not be abridged by any regulation promulgated by the superintendent.

(12) No policy of group or blanket accident and health insurance delivered or issued for delivery in this state shall exclude coverage of a health care service, as defined in paragraph two of such subdivision (e) of section four thousand nine hundred of this chapter, rendered or proposed to be rendered to an insured on the basis that such service is experimental or investigational, is rendered as part of a clinical trial as defined in subsection (b-2) of section forty-nine hundred of this chapter, or a prescribed pharmaceutical product referenced in subparagraph (B) of paragraph two of subsection (e) of section forty-nine hundred of this chapter provided that coverage of the patient costs of such service has been recommended for the insured by an external appeal agent upon an appeal conducted pursuant to subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter. The determination of the external appeal agent shall be binding on the parties. For purposes of this paragraph, patient costs shall have the same meaning as such term has for purposes of subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter; provided, however, that coverage for the services required under this paragraph shall be provided subject to the terms and conditions generally applicable to other benefits provided under the policy.

(13) Every group or blanket policy delivered or issued for delivery in this state that provides major medical or similar comprehensive-type coverage shall provide such coverage for bone mineral density measurements or tests, and if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes. In determining appropriate coverage provided by subparagraphs (A), (B) and (C) of this paragraph, the insurer or health maintenance organization shall adopt standards that include the criteria of the federal Medicare program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(A) for purposes of subparagraphs (B) and (C) of this paragraph, bone mineral density measurements or tests, drugs and devices shall include those covered under the federal Medicare program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(B) for purposes of subparagraphs (A) and (C) of this paragraph, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, every group or blanket policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (E) of this paragraph, shall

provide coverage for the following items or services for bone mineral density and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for bone mineral density that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force; and

(ii) with respect to women, such additional preventive care and screenings for bone mineral density not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, “grandfathered health plan” means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e).

(14) No group or blanket policy delivered or issued for delivery in this state which provides medical, major medical or similar comprehensive-type coverage shall exclude coverage for services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article thirty of the mental hygiene law; provided, however, that reimbursement under such policy for services provided through such comprehensive care centers shall, to the extent possible and 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.

(15)

(A) No group or blanket managed care health insurance policy that provides coverage for hospital, medical or surgical care shall provide that services of a participating hospital will be covered as out-of-network services solely on the basis

that the health care provider admitting or rendering services to the insured is not a participating provider.

(B) No group or blanket managed care health insurance policy that provides coverage for hospital, medical or surgical care shall provide that services of a participating health care provider will be covered as out-of-network services solely on the basis that the services are rendered in a non-participating hospital.

(C) For purposes of this paragraph, a “health care provider” is a health care professional licensed, registered or certified pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

(D) For purposes of this paragraph, a “managed care health insurance policy” is a policy that requires that services be provided by a provider participating in the insurer’s network in order for the insured to receive the maximum level of reimbursement under the policy.

(16)

(A) Every group or blanket policy that includes coverage for dialysis treatment that requires such services to be provided by an in-network provider and that does not provide coverage for out-of-network dialysis treatment shall not deny coverage of such services because the services are provided by an out-of-network provider, provided that each of the following conditions are met:

(i) The out-of-network provider is duly licensed to practice and authorized to provide such treatment;

(ii) The out-of-network provider is located outside the service area of the insurer;

(iii) The in-network healthcare provider treating the insured for the condition issues a written order for dialysis treatment stating that in his or her opinion such treatment is necessary;

(iv) The insured has notified, in writing, the insurer at least thirty days in advance of the proposed date or dates of such out-of-network dialysis treatment. The notice shall include the authorization required by clause (iii) of this subparagraph. In the event the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has reasonable opportunity to review the travel and treatment plans of the insured;

(v) The insurer shall have the right to pre-approve the dialysis treatment and schedule; and

(vi) Such coverage is limited to no greater than ten out-of-network treatments in a calendar year.

(B) Where coverage for out-of-network dialysis treatment is provided pursuant to subparagraph (A) of this paragraph, no insurer shall be obligated to reimburse the out-of-network provider at an amount greater than it would have paid for the same treatment within a network, including all drugs and ancillary services tied to dialysis treatment, and any amount charged by a provider in excess of the amount reimbursed by the insurer shall be the responsibility of the insured receiving the out-of-network services.

(C) Such coverage of out-of-network dialysis services required by subparagraph (A) of this paragraph shall otherwise be subject to the limitations, exclusions and terms of the policy, including, but not limited to, utilization review, annual deductibles, copayments, and coinsurance, consistent with those required for other similar benefits under the policy.

(17) Notwithstanding title eleven of article five of the social services law or any other law to the contrary, every policy which provides coverage for prescription drugs shall, with regard to eye drop medication requiring a prescription that has been approved by the insurer for coverage, allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals. Provided, however, that any refill dispensed prior to the expiration of the prescribed and approved coverage period pursuant to this paragraph, shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. Provided, further, that such limited refilling shall not limit or restrict coverage with regard to any previously or subsequently approved prescription for eye drop medication and shall be subject to the terms and conditions of the policy otherwise applicable to this coverage. Provided, further, that a pharmacist may contact the prescribing physician or health care provider to verity the prescription.

(18) Every group or blanket policy which provides medical, major medical or similar comprehensive-type coverage that includes coverage for a physical or well care visit once in every three hundred sixty-five days shall be interpreted to mean that such physical or well care visit can be had once every calendar year, regardless of whether or not a period of three hundred sixty-five days has passed since the previous physical or well care visit.

(19) Every group or blanket accident and health insurance policy delivered or issued for delivery in this state that provides medical coverage that includes coverage for physician services in a physician’s office and every policy that provides major medical or similar comprehensive-type coverage shall include coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance

as deemed appropriate by the superintendent. The coverage required by this paragraph shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits as defined in subsection (a) of section three thousand two hundred seventeen-i of this article.

(20) No group or blanket policy delivered or issued for delivery in this state that provides reimbursement for non-physician surgical first assistant services when the services are provided by a non-physician surgical first assistant shall exclude such coverage on the basis that the non-physician surgical first assistant services were performed by a registered nurse first assistant provided that: (A) the registered nurse first assistant is certified in operating room nursing; (B) the services are within the scope of practice of a non-physician surgical first assistant; and (C) the terms and conditions of the policy otherwise provide for the coverage of the services. Nothing in this paragraph shall be construed to prevent the medical management or utilization review of the services or prevent a policy from requiring that services are to be provided through a network of participating providers who meet certain requirements for participation, including provider credentialing.

(21) Every group or blanket policy delivered or issued for delivery in this state that provides coverage for prescription drugs subject to a copayment shall charge a copayment for a limited initial prescription of an opioid drug, which is prescribed in accordance with paragraph (b) of subdivision five of section thirty-three hundred one of the public health law, that is either (i) proportional between the copayment for a thirty-day supply and the amount of drugs the patient was prescribed; or (ii) equivalent to the copayment for a full thirty-day supply of the opioid drug, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the thirty-day supply.

(22)

(A) Every policy which provides hospital, surgical, or medical coverage and which offers maternity care coverage pursuant to paragraph five of this subsection shall also provide coverage for abortion services for an enrollee.

(B) Coverage for abortion shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986, in which case coverage for abortion may be subject to the plan's annual deductible.

(C) Notwithstanding any other provision, a group policy that provides hospital, surgical, or medical expense coverage delivered or issued for delivery in this state to a religious employer, as defined in item one of subparagraph (E) of paragraph sixteen of subsection (l) of this section, may exclude coverage for abortion only if the insurer:

(i) obtains an annual certification from the group policyholder that the policyholder is a religious employer and that the religious employer requests a policy without coverage for abortion;

(ii) issues a rider to each certificate holder at no premium to be charged to the certificate holder or religious employer for the rider, that provides coverage for abortion subject to the same rules as would have been applied to the same category of treatment in the policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer abortion benefits, but that the insurer is issuing a rider for coverage of abortion, and shall provide the insurer's contact information for questions; and

(iii) provides notice of the issuance of the policy and rider to the superintendent in a form and manner acceptable to the superintendent.

(23)

(A) Every group or blanket policy of accident and health insurance delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage and provides coverage for prescription drugs shall provide coverage for medically necessary epinephrine auto-injector devices for the emergency treatment of life-threatening allergic reactions. Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent; provided however, the total amount that an insured is required to pay out-of-pocket for such devices shall be capped at an amount not to exceed one hundred dollars annually regardless of the insured's deductible, copayment, coinsurance or any other cost-sharing requirement. If under federal law, application of the annual cap would result in health savings account ineligibility under 26 USC 223, such coverage may be subject to the plan's annual deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

(B) For the purposes of this paragraph, "epinephrine auto-injector device" shall have the same meaning as provided in paragraph (b) of subdivision one of section three thousand-c of the public health law.

(l)

(1) Every insurer delivering a group policy or issuing a group policy for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, must make available and, if requested by the policyholder, provide coverage of supplemental home care visits beyond those provided by part A and part B, sufficient to produce an aggregate coverage of three hundred sixty-five home care visits per policy year. Such coverage shall be provided pursuant to regulations prescribed by the superintendent. Written

notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(2)

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, which provides coverage for in-patient hospital care must make available, and if requested by the policyholder, provide coverage for care in a nursing home. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at any anniversary date of the policy subject to evidence of insurability.

(C) In this paragraph, care in a nursing home means the continued care and treatment of a covered person who is under the care of a physician but only if:

(i) the care is provided in a nursing home as defined in section twenty-eight hundred one of the public health law or a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq;

(ii) the covered person has been in a hospital for at least three days immediately preceding admittance to the nursing home or the skilled nursing facility; and

(iii) further hospitalization would otherwise be necessary.

(D) In determining the total days of coverage for nursing home care the aggregate of the number of covered days of care in a hospital and the number of covered days of care in a nursing home, with two days of care in a nursing home equivalent to one day of care in a hospital, need not exceed the number of covered days of hospital care provided under the contract in a benefit period.

(E) The level of benefits to be provided for nursing home care must be reasonably related to the benefits provided for hospital care.

(3)

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, which provides coverage for in-patient hospital care must make available and if requested by the policyholder provide coverage to residents in this state for ambulatory care in hospital out-patient facilities, as a hospital is defined in section twenty-eight hundred one of the public health law, or subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, and physicians' offices. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) In this paragraph:

(i) "Ambulatory care in hospital out-patient facilities" means services for diagnostic X-rays, laboratory and pathological examinations, physical and occupational therapy and radiation therapy, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy, provided that such services and medications are related to and necessary for the treatment or diagnosis of the patient's illness or injury, are ordered by a physician and, in the case of physical therapy services, are to be furnished in

connection with the same illness for which the patient had been hospitalized or in connection with surgical care, but in no event need benefits for physical therapy be provided which commences more than six months after discharge from a hospital or the date surgical care was rendered, and in no event need benefits for physical therapy be provided after three hundred sixty-five days from the date of discharge from a hospital or the date surgical care was rendered.

(ii) "Ambulatory care in physicians' offices" means services for diagnostic X-rays, radiation therapy, laboratory and pathological examinations, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy, provided that such services and medications are related to and necessary for the treatment or diagnosis of the patient's illness or injury, and ordered by a physician.

(C) Such coverage shall be made available at the inception of all new policies and, with respect to policies issued before January first, nineteen hundred eighty-three, at the first annual anniversary date thereafter, without evidence of insurability and at any subsequent annual anniversary date subject to evidence of insurability.

(4)

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, that provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for 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 one hundred fifty-four of the education law and mental health counselors, marriage and family therapists, and psychoanalysts licensed pursuant

to article one hundred sixty-three of the education law, within the lawful scope of his or her practice. Nothing herein shall be construed to modify or expand the scope of practice of a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Further, nothing herein shall be construed to create a new mandated health benefit.

(B) The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this paragraph.

(C) Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at any subsequent annual anniversary date of the policy subject to evidence of insurability.

(D) [Repealed.]

(E) The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under subparagraph (D) of this paragraph.

(5)

(A) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services shall provide coverage for the diagnosis and treatment of mental health conditions and:

(i) where the policy provides coverage for inpatient hospital care, benefits for: inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law; sub-acute care in a residential facility licensed or operated by the office of mental health; outpatient care provided by a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or by a facility

operated by the office of mental health; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by the office of mental health or the office of addiction services and supports; outpatient and inpatient care for critical time intervention services and outpatient care for assertive community treatment services provided by facilities issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, beginning no later than thirty days following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law; or, for care provided in other states, to similarly licensed or certified hospitals, facilities, or licensed, certified or designated providers; and

(ii) where the policy provides coverage for physician services, it shall include benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, or a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law, or a licensed clinical social worker within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof. Nothing herein shall be construed to modify or expand the scope of practice of a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Further, nothing herein shall be construed to create a new mandated health benefit.

(B) Coverage required by this paragraph 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 policy. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the policy.

(C) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(D) The criteria for medical necessity determinations under the policy with respect to mental health benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(E) For purposes of this paragraph:

(i) “financial requirement” means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) “predominant” means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) “treatment limitation” means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates;

methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy;

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases;

(v) "assertive community treatment services" means a comprehensive and integrated combination of treatment, rehabilitation, case management, and support services primarily provided in an insured's residence or other community locations by a mobile multidisciplinary mental health treatment team licensed pursuant to article thirty-one of the mental hygiene law;

(vi) "critical time intervention services" means services rendered by a provider licensed under article thirty-one of the mental hygiene law that provides evidence-based, therapeutic interventions that include intensive outreach, engagement, and care coordination services that are provided to an insured before the insured is discharged from inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law and continue after discharge until the insured is stabilized; and

(vii) "residential facility" means crisis residence facilities and community residences for eating disorder integrated treatment programs licensed pursuant to article thirty-one of the mental hygiene law.

(F) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(G) This subparagraph shall apply to hospitals and crisis residence facilities in this state that are licensed or operated by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for sub-acute care in a crisis residence facility licensed or operated by the office of mental health shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review for individuals who have not attained the age of eighteen during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured to ensure that the inpatient care is medically necessary for the insured. For individuals who have attained age eighteen, coverage provided under this subparagraph shall also not be subject to concurrent review during the first thirty days of the inpatient or residential admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured, to ensure that the inpatient or residential care is medically necessary for the insured.

However, concurrent review may be performed during the first thirty days if an insured meets clinical criteria designated by the office of mental health or where the insured is admitted to a hospital or facility which has been designated by the office of mental health for concurrent review, in consultation with the commissioner of health and the superintendent. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(H) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care by a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(I) This subparagraph shall apply to mobile crisis intervention services providers licensed, certified, or designated by the office of mental health or the office of addiction services and supports. For purposes of this subparagraph, "mobile crisis intervention services" means mental health and substance use disorder services, consisting of: (1) telephonic crisis triage and response; (2) mobile crisis response to provide intervention and facilitate access to other behavioral health services; and (3) mobile and telephonic follow-up services after the initial crisis response until the insured is stabilized provided to an insured who is experiencing, or is at imminent risk of experiencing, a behavioral health crisis, which includes instances in which an insured cannot manage their primarily psychiatric or substance use

related symptoms without de-escalation or intervention. Mobile crisis intervention services do not include services provided to an insured after the insured has been stabilized.

(i) Benefits for covered services provided by a mobile crisis intervention services provider shall not be subject to preauthorization. Except where otherwise required by law, nothing in this subparagraph shall prevent services provided subsequent to the provision of mobile crisis intervention services from being subject to preauthorization.

(ii) Benefits for covered services provided by a mobile crisis intervention services provider shall be covered regardless of whether the mobile crisis intervention services provider is a participating provider.

(iii) If the covered services are provided by a non-participating mobile crisis intervention services provider, an insurer shall not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to covered services received from a participating mobile crisis intervention services provider.

(iv) If the covered services are provided by a non-participating mobile crisis intervention services provider, the insured’s copayment, coinsurance, and deductible shall be the same as would apply if such covered services were provided by a participating mobile crisis intervention services provider.

(v) A mobile crisis intervention services provider reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against, an insured for the services provided pursuant to this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the policy.

(J) This subparagraph shall apply to school-based mental health clinics that are licensed pursuant to article thirty-one of the mental hygiene law and provide outpatient care in pre-school, elementary, or secondary schools. An insurer shall provide reimbursement for covered outpatient care when provided by such school-based mental health clinics at a pre-school, elementary, or secondary school, regardless of whether the school-based mental health clinic furnishing such services is a participating provider with respect to such services. Reimbursement for such covered services shall be at the rate negotiated between the insurer and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law. Payment by an insurer pursuant to this section shall be payment in full for the services provided. The school-based mental health clinic reimbursed pursuant to this section shall not charge or seek any reimbursement from or have any recourse against, an insured for the services provided pursuant to this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the policy.

(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer’s provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the

medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

(6)

(A) Every policy that provides hospital, major medical or similar comprehensive coverage shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(B) Coverage provided under this paragraph may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse or chemical

dependence treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given policy.

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission. The facility shall perform daily clinical review of the patient, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient

treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) The criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(F) For purposes of this paragraph:

(i) “financial requirement” means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) “predominant” means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) “treatment limitation” means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider

specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(G) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(7)

(A) Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(B) Coverage under this paragraph may be limited to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence treatment programs and similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given policy.

(C-1) A large group policy that provides coverage under this paragraph shall not impose copayments or coinsurance for outpatient substance use disorder services that exceeds the copayment or coinsurance imposed for a primary care office visit. Provided that no greater than one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services to provide outpatient substance use disorder services.

(D) A policy providing coverage for substance use disorder services pursuant to this paragraph shall provide up to twenty outpatient visits per policy or calendar year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy pursuant to this paragraph. The coverage required by this paragraph shall include treatment as a family member pursuant to such family member's own policy provided such family member:

(i) does not exceed the allowable number of family visits provided by the applicable policy pursuant to this paragraph; and

(ii) is otherwise entitled to coverage pursuant to this paragraph and such family member's applicable policy.

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of

treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(F) The criteria for medical necessity determinations under the policy with respect to outpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(G) For purposes of this paragraph:

(i) “financial requirement” means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) “predominant” means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) “treatment limitation” means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) “substance use disorder” shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(H) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(I) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer’s provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(J) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

(7-a)

(A) No policy that provides medical, major medical or similar comprehensive-type small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and

drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every policy that provides medical, major medical or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance use disorder and shall not require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

(B) Coverage provided under this paragraph may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the policy.

(7-b) Every policy that provides coverage for treatment at an opioid treatment program shall not impose a co-payment fee during the course of treatment on any insured for such treatment. For the purposes of this section “opioid treatment program” means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.

(8)

(A) Every insurer issuing a group policy for delivery in this state that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(B) In subparagraphs (A), (C) and (D) of this paragraph, preventive and primary care services means the following services rendered to a covered child of an insured from the date of birth through the attainment of nineteen years of age:

(i) an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law). Coverage for such services rendered shall be provided only to the extent that such services are provided by or under the supervision of a physician, or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services. Coverage shall be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services;

(ii) at each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner’s office, as authorized by law, or in a clinical laboratory; and

(iii) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b, which meet the

standards approved by the United States public health service for such biological products.

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not be subject to annual deductibles or coinsurance.

(D) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not restrict or eliminate existing coverage provided by the policy.

(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every group policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (G) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force;

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(F) The requirements of this paragraph shall also be applicable to a blanket policy of hospital, medical or surgical expense insurance covering students pursuant to

subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter.

(G) For purposes of this paragraph, “grandfathered health plan” means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e).

(9) Every insurer issuing a group policy for delivery in this state which policy provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, must make available, and if requested by the contract holder, provide reimbursement for such service when such service is performed by a duly licensed registered professional nurse provided, however, that reimbursement shall not be made for nursing services provided to an insured in a general hospital, nursing home or a facility providing health related services, as such terms are defined in section twenty-eight hundred one of the public health law, or in a facility, as such term is defined in subdivision six of section 1.03 of the mental hygiene law, or in a physician’s office. Such coverage may be subject to annual deductibles and co-insurance as may be deemed appropriate by the superintendent and are consistent with those imposed on other benefits within a given policy. Such coverage shall not replace, restrict or eliminate existing coverage provided by the policy. Coverage for the services of a duly licensed registered professional nurse need be provided only if the nature of the patient’s illness or condition requires nursing care which can appropriately be provided by a person with the education and professional skill of a registered professional nurse and the nursing care is necessary in the treatment of the patient’s illness or condition. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two

hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(10)

(A) Every insurer issuing a group policy for delivery in this state which provides coverage for inpatient hospital care must make available and if requested by the policyholder provide coverage for hospice care. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) For the purposes of this paragraph, hospice care shall mean the care and treatment of a covered person who has been certified by such person's primary attending physician as having a life expectancy of six months or less and which is provided by a hospice organization certified pursuant to article forty of the public health law or under a similar certification process required by the state in which the hospice organization is located.

(C) Hospice care coverage shall be at least equal to: (i) a total of two hundred ten days of coverage beginning with the first day on which care is provided, for 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 (ii) five visits for bereavement counseling services, either before or after the insured's death, provided to the family of the terminally ill insured.

(D) Such coverage shall be made available at the inception of all new policies and, with respect to policies issued before the effective date of this provision, at the first annual anniversary date thereafter, without evidence of insurability and at any subsequent annual anniversary date subject to evidence of insurability.

(E) Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and are consistent with those imposed on other benefits within a given policy period.

(11)

(A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(i) upon the recommendation of a physician, a mammogram, which may be provided by breast tomosynthesis, 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;

(ii) a single baseline mammogram, which may be provided by breast tomosynthesis, for covered persons aged thirty-five through thirty-nine, inclusive;

(iii) an annual mammogram, which may be provided by breast tomosynthesis, for covered persons aged forty and older;

(iv) for large group policies that provide coverage for hospital, surgical or medical care, an annual mammogram for covered persons aged thirty-five through thirty-nine, inclusive, upon the recommendation of a physician, subject to the insurer’s determination that the mammogram is medically necessary; and

(v) upon the recommendation of a physician, screening and diagnostic imaging, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging, recommended by nationally recognized clinical practice guidelines for the detection of breast cancer. For the purposes of this item,

"nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

(B) Such coverage required pursuant to subparagraph (A) or (C) of this paragraph shall not be subject to annual deductibles or coinsurance. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

(C) For purposes of subparagraphs (A) and (B) of this paragraph, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast; provided, however, that mammography screening shall also include breast tomosynthesis.

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, every group or blanket policy that provides coverage for hospital, surgical or medical care, except for a grandfathered health plan under subparagraph (E) of this paragraph, shall provide coverage for the following mammography screening services, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for mammography that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force; and

(ii) with respect to women, such additional preventive care and screenings for mammography not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, “grandfathered health plan” means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e).

(F) [Repealed]

(11-a)

(A) Every policy delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician’s office and every policy which provides major medical or similar comprehensive-type coverage shall provide, upon the prescription of a health care provider legally authorized to prescribe under title eight of the education law, the following coverage for diagnostic screening for prostatic cancer:

(i) 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

(ii) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

(B) Such coverage shall not be subject to annual deductibles or coinsurance.

(11-b)

(A) Every large group policy delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every large group policy which provides major medical or similar comprehensive-type coverage shall provide, upon the prescription of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, coverage for colorectal cancer preventive screenings in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals. The coverage required by this paragraph shall also include coverage for all additional colorectal cancer examinations and laboratory tests recommended in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals, including an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test. A large group policy shall cover colorectal cancer screenings, examinations, and laboratory tests described in this paragraph upon any policy issuance or renewal that occurs six months after the date the guideline described in this paragraph is issued.

(B) An insured shall not be subject to a deductible, coinsurance, or any other cost-sharing requirements for services consistent with subparagraph (A) of this paragraph received from participating providers.

(11-c)

(A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker precision medical testing for the purposes of diagnosis, treatment, or appropriate

management of, or ongoing monitoring to guide treatment decisions for, an insured's disease or condition when one or more of the following recognizes the efficacy and appropriateness of biomarker precision medical testing for diagnosis, treatment, appropriate management, or guiding treatment decisions for an insured's disease or condition:

(i) labeled indications for a test approved or cleared by the federal food and drug administration or indicated tests for a food and drug administration approved drug;

(ii) centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations;

(iii) nationally recognized clinical practice guidelines; or

(iv) peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(B) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(C) As used in this paragraph, the following terms shall have the following meanings:

(i) "Biomarker" means a characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions.

(ii) "Biomarker precision medical testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests and multi-plex panel

tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration.

(iii) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

(12)

(A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state which provides coverage for prescribed drugs approved by the food and drug administration of the United States government for the treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

(i) the American Hospital Formulary Service-Drug Information (AHFS-DI);

(ii) National Comprehensive Cancer Networks Drugs and Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) 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 & Medicaid Services (CMS); or

recommended by review article or editorial comment in a major peer reviewed professional journal.

(B) Notwithstanding the provisions of this paragraph, coverage shall not be required for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. The provisions of this paragraph shall apply to cancer drugs only and nothing herein shall be construed to create, impair, alter, limit, modify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

(12-a)

(A) Every policy delivered or issued for delivery in this state that provides medical, major medical, or similar comprehensive-type coverage and provides coverage for prescription drugs and also provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. Such coverage may be subject to co-pays, coinsurance or deductibles, provided that the co-pays, coinsurance or deductibles are at least as favorable to an insured as the co-pays, coinsurance or deductibles that apply to coverage for intravenous or injected anticancer medications.

(B) An insurer providing coverage under this paragraph and any participating entity through which the insurer offers health services shall not:

(i) vary the terms of the policy for the purpose or with the effect of avoiding compliance with this paragraph;

(ii) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this paragraph;

(iii) penalize in any way or reduce or limit the compensation of a health care practitioner for recommending or providing care to a covered person in accordance with this paragraph;

(iv) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this paragraph intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this paragraph; or

(v) achieve compliance with this paragraph by imposing an increase in cost sharing for an intravenous or injected anticancer medication.

(12-b)

(A) Every large group policy delivered or issued for delivery in this state that provides medical, major medical, or similar comprehensive-type coverage and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment. Coverage provided under this paragraph may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(B) For the purposes of this paragraph, “scalp cooling system” means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(13) Consistent with federal law every insurer delivering a group policy or issuing a group policy for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, 42 USC §§ 1395 et seq., shall make available and, if requested by the policyholder, provide coverage for at least ninety days of care in a nursing home as defined in section twenty-eight

hundred one of the public health law, except where such coverage would duplicate coverage that is available under the aforementioned subchapter XVIII. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at each anniversary date of the policy.

(A) Coverage shall be subject to a copayment of twenty-five dollars per day.

(B) Brochures describing such coverage must be provided to the policyholder at the inception of all new policies and thereafter on each anniversary date of the policy, and with respect to all other policies annually at each anniversary date of the policy. Such brochures must be approved by the superintendent in consultation with the commissioner of health.

(C) The commensurate rate for the coverage must be approved by the superintendent.

(D) Such insurers shall report to the superintendent each year the number of contract holders to whom such insurers have issued such policies for nursing home coverage and the approximate number of persons covered by such policies.

(14)

(A) Every group or blanket policy delivered or issued for delivery in this state that provides hospital, surgical or medical coverage shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older.

(B) For purposes of subparagraphs (A) and (C) of this paragraph, cervical cytology screening shall include 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.

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph may be subject to annual deductibles and coinsurance as may be deemed

appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, every group or blanket policy that provides hospital, surgical or medical coverage, except for a grandfathered health plan under subparagraph (E) of this paragraph, shall provide coverage for the following cervical cytology screening services, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for cervical cytology that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force; and

(ii) with respect to women, such additional preventive care and screenings for cervical cytology not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, “grandfathered health plan” means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e).

(15)

(A) Every group or blanket policy delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall include coverage for prehospital 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 section three thousand five of the public health law.

(B) Payment by an insurer pursuant to this section shall be payment in full for the services provided. An ambulance service reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an insured for the services provided pursuant to this paragraph, except for the collection of copayments, coinsurance or deductibles for which the insured is responsible for under the terms of the policy.

(C) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable. The insurer shall send such payments directly to the provider of such ambulance services, if the ambulance service has on file an executed assignment of benefits form with the claim.

(D) The provisions of this paragraph shall have no application to transfers of patients between hospitals or health care facilities by an ambulance service as described in subparagraph (A) of this paragraph unless such services are covered under the policy.

(E) As used in this paragraph:

(i) “Prehospital emergency medical services” means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement shall be based on whether 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 affected 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; (IV) serious disfigurement of such person; or (V) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(ii) "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 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; [(][1] (III) serious dysfunction of any bodily organ or part of such person; (IV) serious disfigurement of such person; or (V) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(16)

(A) Every group or blanket policy that provides medical, major medical, or similar comprehensive type coverage that is issued, amended, renewed, effective or delivered on or after January first, two thousand twenty, shall provide coverage for all of the following services and contraceptive methods:

(1) All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. The following applies to this coverage:

(a) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a

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The bracketed extraneous punctuation was not deleted by the amendment.

contraceptive drug, device, or product, a group or blanket policy is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this paragraph;

(b) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a group or blanket policy shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final. The superintendent shall promulgate regulations establishing a process, including timeframes, for an insured, an insured's designee or an insured's health care provider to request coverage of a non-covered contraceptive drug, device, or product. Such regulations shall include a requirement that insurers use an exception form that shall meet criteria established by the superintendent;

(c) this coverage shall include emergency contraception without cost-sharing when provided pursuant to a prescription or order under section sixty-eight hundred thirty-one of the education law or when lawfully provided over the counter; and

(d) this coverage must allow for the dispensing of up to twelve months worth of a contraceptive at one time;

(2) Voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and identified in the comprehensive guidelines supported by the health resources

and services administration and thereby incorporated in the essential health benefits benchmark plan;

(3) Patient education and counseling on contraception; and

(4) Follow-up services related to the drugs, devices, products, and procedures covered under this paragraph, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(B) A group or blanket policy subject to this paragraph shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this paragraph.

(C) Except as otherwise authorized under this paragraph, a group or blanket policy shall not impose any restrictions or delays on the coverage required under this paragraph.

(D) Benefits for an enrollee under this paragraph shall be the same for an enrollee’s covered spouse or domestic partner and covered nonspouse dependents.

(E) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for federal food and drug administration approved contraceptive methods that are contrary to the religious employer’s religious tenets. If so requested, such contract shall be provided without coverage for contraceptive methods. This paragraph shall not be construed to deny an enrollee coverage of, and timely access to, contraceptive methods.

(1) For purposes of this subsection, a “religious employer” is an entity for which each of the following is true:

(a) The inculcation of religious values is the purpose of the entity.

(b) The entity primarily employs persons who share the religious tenets of the entity.

(c) The entity serves primarily persons who share the religious tenets of the entity.

(d) The entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(2) Every religious employer that invokes the exemption provided under this paragraph shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(F)

(1) Where a group policyholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with subparagraph (E) of this paragraph each certificateholder covered under the policy issued to that group policyholder shall have the right to directly purchase the rider required by this paragraph from the insurer which issued the group policy at the prevailing small group community rate for such rider whether or not the employee is part of a small group.

(2) Where a group policyholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with subparagraph (E) of this paragraph, the insurer that provides such coverage shall provide written notice to certificateholders upon enrollment with the insurer of their right to directly purchase a rider for coverage for the cost of contraceptive drugs or devices. The notice shall also advise the certificateholders of the additional premium for such coverage.

(G) Nothing in this paragraph shall be construed as authorizing a group or blanket policy which provides coverage for prescription drugs to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes.

(H) For the purposes of this paragraph, “over-the-counter contraceptive products” shall mean those products provided for in comprehensive guidelines supported by the health resources and services administration as of January twenty-first, two thousand nineteen.

(17)

(A) Every group or blanket accident and health insurance policy delivered or issued for delivery in this state which provides coverage for hospitalor surgical care coverage shall not exclude coverage for screening, diagnosis and treatment of medical conditions otherwise covered by the policy because the treatment is provided to diagnose or treat autism spectrum disorder.

(B) Every group or blanket policy that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the group or blanket policy. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the group or blanket policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization

review and external appeals of health care services pursuant to article forty-nine of this chapter as well as case management and other managed care provisions.

(C) For purposes of this paragraph:

(i) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders.

(ii) "applied behavior analysis" 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.

(iii) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided by a person licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(iv) "diagnosis of autism spectrum disorder" means assessments, evaluations, or tests to diagnose whether an individual has autism spectrum disorder.

(v) "pharmacy care" means medications prescribed by a licensed health care provider legally authorized to prescribe under title eight of the education law.

(vi) "psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(vii) "psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(viii) "therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists.

(ix) "treatment of autism spectrum disorder" shall include 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:

(1) behavioral health treatment;

(2) psychiatric care;

(3) psychological care;

(4) medical care provided by a licensed health care provider;

(5) therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and

(6) pharmacy care in the event that the policy provides coverage for prescription drugs.

(D) Coverage may be denied on the basis that such treatment is being provided to the covered person pursuant to an individualized education plan under article eighty-nine of the education law. The provision of services pursuant to an individualized family service plan under section twenty-five hundred forty-five of the public health law, an individualized education plan under article eighty-nine of the education law, or an individualized service plan pursuant to regulations of the office for persons with developmental disabilities shall not affect coverage under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

(E) Nothing in this paragraph shall be construed to affect any obligation to provide services to an individual under an individualized family service plan under section twenty-five hundred forty-five of the public health law, an individualized education plan under article eighty-nine of the education law, or an individualized service plan pursuant to regulations of the office for persons with developmental disabilities.

(F) [Repealed.]

(G) Nothing in this paragraph shall be construed to prevent a group or blanket policy from providing services through a network of participating providers who shall meet certain requirements for participation, including provider credentialing.

(H) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(I) The criteria for medical necessity determinations under the policy with respect to autism spectrum disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(J) For purposes of this paragraph:

(i) “financial requirement” means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) “predominant” means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(iii) “treatment limitation” means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical

necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy.

(K) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(18)

(A) Definitions. For the purpose of this paragraph:

(i) “Same reimbursement amount” shall mean that any coverage described under subparagraph (B) of this paragraph shall provide the same benchmark index, including the same average wholesale price, maximum allowable cost and national prescription drug codes to reimburse all pharmacies participating in the insurance network regardless of whether a pharmacy is a mail order pharmacy or a non-mail order pharmacy.

(ii) “Mail order pharmacy” means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to patients through the use of the United States mail or other common or contract carrier services and provides any consultation with patients electronically rather than face-to-face.

(B) Any insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for prescription drugs shall permit each insured to fill any covered 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 to the same reimbursement amount that the insurer has established for the network participating mail order or other non-retail pharmacy. In such a case, the policy shall not impose a co-payment fee or other condition on any insured who elects to purchase drugs from a network participating non-mail order retail pharmacy which is not also imposed on insureds electing to purchase drugs from a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a policy that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

(19) Whenever in this section an insurer is required to provide benefits with no coinsurance or deductible, the requirement only applies with respect to participating providers in the insurer's network, or with respect to non-participating providers, if the insurer does not have a participating provider in the in-network benefits portion of its network with the appropriate training and experience to meet the particular health care needs of the insured pursuant to subsection (d) of section three thousand two hundred seventeen-d of this article.

(20) [There are two paragraphs (20)] Health care forensic examinations performed pursuant to section twenty-eight hundred five-i of the public health law covered under the policy shall not be subject to annual deductibles or coinsurance.

(20) [There are two paragraphs (20)] Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically

indicated, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

(21) [There are two paras (21)] Every large group policy which provides medical, major medical, or comprehensive-type coverage shall include coverage for the cost of pre-exposure prophylaxis (PrEP) for the prevention of HIV and post-exposure prophylaxis to prevent HIV infection. Such coverage may be subject to annual deductibles, coinsurance, and copayments as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy, unless the pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis has in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force.

(21) [There are two paras (21)] Every group or blanket policy delivered or issued for delivery in this state that provides coverage for a prescription drug shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured’s deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual’s overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible

under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied. This paragraph only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

(22) Every group or blanket policy delivered or issued for delivery in this state that provides coverage for antiretroviral prescription drugs for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) shall not subject such drug to a prior authorization requirement.

(m) A group policy providing hospital, surgical or medical expense insurance for other than accident only shall provide 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 his hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of benefits and to the following conditions:

(1) Continuation shall cease on the date which the employee, member or dependant first becomes, after the date of election: (A) entitled to coverage under title XVIII of the United States Social Security Act (Medicare) as amended or superseded; or (B) 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, except the group insurance policy conversion option of this section shall not be considered as such an arrangement under which an employee, member or dependent could become covered.

(2)

(A) An employee or member who wishes continuation of coverage must request such continuation in writing within the sixty day period following the later of: (i) the date of such termination; or (ii) the date the employee is sent notice by first class mail of the right of continuation by the group policyholder.

(B) An employee or member who wishes continuation of coverage under subparagraph (D) of paragraph four of this subsection must give notice to the employer or group policyholder within sixty days of the determination under title II or title XVI of the United States Social Security Act that such employee or member was disabled at the time of termination of employment or membership or at any time during the first sixty days of continuation of coverage.

(3) An employee or member electing continuation must pay to the group policyholder or his employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment, but not more than one hundred two percent of the group rate for the benefits being continued under the group policy on the due date of each payment. The employee’s or member’s written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, must be given to the policyholder or employer within sixty days of the date the employee’s or member’s benefits would otherwise terminate.

(4) Subject to paragraph one of this subsection, continuation of benefits under the group policy for any person shall terminate at the first to occur of the following:

(A) The date thirty-six months after the date the employee's or member's benefits under the policy would otherwise have terminated because of termination of employment or membership; or

(B) The end of the period for which premium payments were made, if the employee or member fails to make timely payment of a required premium payment; or

(C) In the case of an eligible dependent of an employee or member, the date thirty-six months after the date such person's benefits under the policy would otherwise have terminated by reason of:

(i) the death of the employee or member;

(ii) the divorce or legal separation of the employee or member from his or her spouse;

(iii) the employee or member becoming entitled to benefits under title XVIII of the United States Social Security Act (Medicare); or

(iv) a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy; or

(D) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this clause applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with this subparagraph had a termination described in this subparagraph not occurred, and

(ii) The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy, and

(iii) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.

(5) A notification of the continuation privilege and the time period in which to request continuation shall be included in each certificate of coverage.

(6) This subsection shall not be applicable where a continuation benefit is available to the employee or member pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300 bb-1 et seq. However, a group policy shall offer an insured who has exhausted continuation coverage pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300 bb-1 et seq. the opportunity to continue coverage for up to thirty-six months from the date the employee's or member's continuation coverage began, if the employee or member is entitled to less than thirty-six months of continuation benefits under federal law.

(7)

(A) Special enrollment period. An individual who does not have an election of continuation coverage as described in this subsection in effect on the effective date of the American Recovery and Reinvestment act of 2009, but who would be an assistance eligible individual under Title III of such act if such election were in effect, may elect continuation coverage pursuant to this subsection. Such election shall be made no later than sixty days after the date the administrator of the group health plan (or other entity involved) provides the notice required by section 3001(a)(7) of the American Recovery and Reinvestment act of 2009. The

administrator of the group health plan (or other entity involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this paragraph within sixty days of the date of enactment of the American Recovery and Reinvestment act of 2009.

(B) Continuation coverage elected pursuant to subparagraph (A) of this paragraph shall commence with the first period of coverage beginning on or after the date of the enactment of the American Recovery and Reinvestment act of 2009 and shall not extend beyond the period of continuation coverage that would have been required if the coverage had instead been elected pursuant to paragraph two of this subsection.

(C) With respect to an individual who elects continuation coverage pursuant to subparagraph (A) of this paragraph, the period beginning on the date of the qualifying event and ending on the date of the first period of coverage on or after the enactment of the American Recovery and Reinvestment act of 2009 shall be disregarded for purposes of determining the sixty-three day period referred to in section three thousand two hundred thirty-two of this article.

(8) For purposes of this subsection, the term “dependent” shall include a child as described in subsection (f) of section four thousand two hundred thirty-five of this chapter.

(n) In addition to all the rights of conversion and continuation otherwise provided for herein, employees or members insured under the policy who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled to have supplementary conversion and continuation rights in certain circumstances as follows:

(1) If the employee or member insured enters upon active duty as defined in subsection (o) of this section, and the employer or group policyholder does not voluntarily maintain coverage for such employee or member insured, the employee or

member insured shall be entitled to have his or her coverage continued under the group policy in accordance with the conditions and limitations contained in paragraph seven of this subsection and have issued at the end of the period of continuation an individual conversion policy subject to the terms of this subsection. The effective date for the conversion policy shall be the day following the termination of insurance under the group policy, or if there is a continuation of coverage on the day following the end of the period of continuation.

(2) If the employer or group policyholder does not voluntarily maintain coverage for the employee or member insured during the period of active duty, and such employee or member insured does not elect the supplementary conversion and continuation rights provided for herein, coverage for such employee or member insured shall be suspended during the period of active duty.

(3) If the employee or member insured elects the supplementary continuation right provided for herein or coverage under the group plan is suspended, and such employee or member insured dies during the period of active duty, the conversion right provided by this section shall be available to the surviving spouse and children, and shall be available to a child solely with respect to himself or herself upon his or her attaining the limiting age of coverage under the group policy while covered as a dependent thereunder. It shall also be available upon the divorce or annulment of the marriage of the employee or member insured, to the former spouse of such employee or member insured, if such divorce or annulment occurs during the period of active duty.

(4) If the employee or member insured elects the supplementary conversion and continuation right provided for herein or coverage under the group plan is suspended, and such employee or member insured is either reemployed or restored to participation in the group upon return to civilian status, he or she shall be entitled to resume participation in insurance offered by the group pursuant to this section, with

no limitations or conditions imposed as a result of such period of active duty except as set forth in subparagraphs (A) and (B) herein. The right of resumption provided for herein shall extend to coverage for the spouse and dependents of the employee or member insured and shall be in addition to other existing rights granted pursuant to state and federal laws and regulations and shall not be deemed to qualify or limit such rights in any way. No exclusion or waiting period may be imposed in connection with coverage of a health or physical condition of a person entitled to such right of resumption, or a health or physical condition of any other person who is covered by the policy unless:

(A) the condition arose during the period of active duty and the condition has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty; or

(B) a waiting period was imposed and had not been completed prior to the period of suspension; in no event, however, shall the sum of the waiting periods imposed prior to and subsequent to the period of suspension exceed the length of the waiting period originally imposed.

(5) If the employee or member insured elects the supplementary conversion and continuation coverage provided for herein:

(A) when such employee or member insured is either reemployed or restored to participation in the group, coverage under the supplementary rights provided for herein shall terminate on the date that coverage is effective due to resumption of participation in the group.

(B) when such employee or member insured is not reemployed or restored to participation in the group upon return to civilian status, he or she shall be entitled to the conversion and continuation rights provided by subsections (e) and (m) of this section.

(i) To elect an individual conversion policy pursuant to subsection (e) of this section, the employee or member insured must apply to the insurer within thirty-one days of the termination of active duty or discharge from hospitalization incident to such active duty, which hospitalization continues for a period of not more than one year. Upon commencement of coverage under the conversion right provided pursuant to subsection (e) of this section, coverage under the supplementary continuation right provided for herein shall terminate.

(ii) To elect continuation of coverage pursuant to subsections (e) and (m) of this section, the employee or member insured must request such continuation of the employer within thirty-one days of the termination of active duty or discharge from hospitalization incident to such active duty, which hospitalization continues for a period of not more than one year. Upon commencement of coverage under the continuation right provided pursuant to subsection (e) of this section, coverage under the supplementary continuation right provided for herein shall terminate. The employee or member insured shall be entitled to have issued at the end of the period of continuation an individual conversion policy.

(6) If coverage under the group plan is suspended during the period of active duty:

(A) when the employee or member insured returns to participation in the group plan, coverage under the group plan shall be retroactive to the date of termination of the period of active duty.

(B) when such employee or member insured is not reemployed or restored to participation in the group upon return to civilian status, he or she shall be entitled to the conversion and continuation rights provided by subsections (e) and (m) of this section.

(i) To elect an individual conversion policy pursuant to subsection (e) of this section, the employee or member insured must apply to the insurer within thirty-one days of the termination of active duty or discharge from hospitalization incident to such active duty, which hospitalization continues for a period of not more than one year.

(ii) To elect continuation of coverage pursuant to subsections (e) and (m) of this section, the employee or member insured must request such continuation of the employer within thirty-one days of the termination of active duty or discharge from hospitalization incident to such active duty, which hospitalization continues for a period of not more than one year. The employee or member insured shall be entitled to have issued at the end of the period of continuation an individual conversion policy.

(7) A group policy providing hospital, surgical or medical expense insurance for other than accident only shall provide that if all or any portion of the insurance on an employee or member insured under the policy ceases because the employee or member insured is ordered to active duty as defined in subsection (o) of this section, such employee or member insured shall be entitled, without evidence of insurability, upon application to continue his or her hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents, under the supplementary conversion and continuation rights provided for herein, subject to all of the group policy's terms and conditions applicable to those forms of benefits and to the following conditions:

(A) continuation shall not be available for: (i) any person who is covered, becomes covered or could be covered by title XVIII of the United States Social Security Act (Medicare) as amended or superseded or (ii) an employee, member or dependent who is covered, becomes covered or could become 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, except that the coverage available to active duty members of the uniformed services and their family members shall not be considered a group under the terms of this subsection, and except that the group insurance policy conversion option of this section shall not be considered as such an arrangement under which an employee, member or dependent could become covered.

(B) an employee or member insured who wishes continuation of coverage pursuant to this subsection must request such continuation in writing within sixty days of being ordered to active duty.

(C) an employee or member insured electing continuation pursuant to this subsection must pay to the group policyholder or his or her employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment, but not more than the group rate for the benefits being continued under the group policy on the due date of each payment.

(8) The supplementary conversion and continuation rights provided for herein shall apply to:

(A) policies not covered by Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq;

(B) policies covered by Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq, when active duty for reservists and the refusal of an employer to voluntarily maintain coverage for such period of active duty is not considered a qualifying event.

(o) To be entitled to the right defined in subsection (n) of this section a person must be a member of a reserve component of the armed forces of the United States, including the National Guard, who either:

(A) voluntarily or involuntarily enters upon active duty (other than for the purpose of determining his or her physical fitness and other than for training), or

(B) has his or her active duty voluntarily or involuntarily extended during a period when the president is authorized to order units of the ready reserve or members of a reserve component to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

(C) serves no more than four years of active duty.

(p)

(1) Except as provided in this section, if an insurer delivers or issues for delivery in this state a group or blanket policy which provides hospital, surgical or medical expense coverage for other than accident only, the insurer must renew or continue in force such coverage at the option of the policyholder.

(2) An insurer may nonrenew or discontinue coverage under such a group or blanket policy based only on one or more of the following:

(A) The policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.

(B) The policyholder 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 coverage.

(C) The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section four thousand two hundred thirty-five of this chapter.

(D) The insurer is ceasing to offer group or blanket policies in a market in accordance with paragraph three or seven of this subsection.

(E) The policyholder ceases to meet the requirements for a group under section four thousand two hundred thirty-five of this chapter or a participating employer, labor union, association or other entity ceases membership or participation in the group to which the policy is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.

(F) In the case of an insurer that offers a group or blanket policy in a market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the insurer (or in the area for which the insurer is authorized to do business).

(G) Such other reasons as are acceptable to the superintendent 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.

(3)

(A) In any case in which an insurer decides to discontinue offering a particular class of group or blanket policy of hospital, surgical or medical expense insurance offered in the small or large group market, the policy of such class may be discontinued by the insurer in accordance with this chapter in such market only if:

(i) the insurer provides written notice to each policyholder provided coverage of this class in such market (and to all employees and member insureds covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage. In addition to any other information required of notices by the superintendent, this written notice shall conspicuously include an explanation, in plain language, of the policyholder’s

and covered employee's or member insured's rights under this subparagraph and (B) of this paragraph, including:

(I) a statement that if the superintendent determines that the covered employee, member insured, or a dependent has a serious medical condition, and the covered employee, member insured or dependent within the previous twelve months utilized a benefit under the policy related to the serious medical condition that is not covered by the replacement coverage offered to the policyholder as a result of the discontinuance, then the superintendent shall require the insurer to offer the policyholder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the policy that the insurer discontinued; and

(II) an explanation as to how to contact the superintendent, and the date by which the superintendent shall be contacted, if the policyholder, covered employee or member insured believes that the covered employee, member insured or a dependent has a serious medical condition, and the covered employee, member insured or dependent within the previous twelve months utilized a benefit related to the serious medical condition that may not be covered by the replacement coverage offered to the policyholder as a result of the discontinuance;

(ii) the insurer offers to each policyholder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage currently being offered by the insurer to a group in such market;

(iii) in exercising the option to discontinue coverage of this class and in offering the option of coverage under item (ii) of this subparagraph, the insurer acts uniformly without regard to the claims experience of those policyholders or

any health status-related factor relating to any particular covered employee, member insured or dependent or particular new employee, member insured or dependent who may become eligible for such coverage, and the insurer is not discontinuing the coverage of this class with the intent or as a pretext to discontinuing the coverage of any such employee, member insured or dependent; and

(iv) at least ninety days prior to the date of discontinuance of such coverage, the insurer provides written notice to the superintendent of such discontinuance, including the reason for the discontinuance, and an officer or director of the insurer certifies to the superintendent that the insurer has complied with items (i), (ii) and (iii) of this paragraph. If such notice does not include the date or dates that the insurer mailed or delivered the notice to all policyholders, covered employers [employees][2] and member insureds, the insurer shall notify the superintendent of such date within seven days of the completion of the mailing or delivery.

(B) If the superintendent determines that the insurer has not complied with item (iii) of subparagraph (A) of this paragraph, then the superintendent may prohibit the insurer from discontinuing the class of policies and require the insurer to promptly notify every policyholder, covered employee and member insured that the insurer is not discontinuing the policies. If the superintendent determines that the insurer wrongfully discontinued the class of policies pursuant to item (iii) of subparagraph (A), then the superintendent shall require that the insurer take remedial action, including offering to group policyholders the option of reinstating the discontinued policy forms. If the superintendent determines that the insurer discontinued the class of policies without compliance with items (i), (ii), or (iv) of subparagraph (A), and an employee, member insured or dependent covered under

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The bracketed word has been inserted by the Publisher.

the discontinued policy would have been entitled to relief under this paragraph, then the superintendent may require that the insurer offer replacement coverage to an affected policyholder consistent with item (ii) of subparagraph (C) of this paragraph.

(C)

(i) If, within forty-five days after the insurer mails or delivers the written notice of discontinuance required by item (i) of subparagraph (A) of this paragraph, the superintendent is notified by a policyholder or covered employee or member insured that a covered employee, member insured or dependent has a serious medical condition and that a benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition may not be covered by the replacement coverage offered to the policyholder as a result of the discontinuance, then the superintendent shall, within twenty days of the notification, ask the insurer to confirm that the covered employee, member insured or dependent utilize a benefit within the previous twelve months to treat the medical condition that the covered employee, member insured or dependent asserts is a serious medical condition, and that the benefit is not covered by the replacement coverage. The superintendent may request such additional information as the superintendent may require. The insurer shall provide all requested information to the superintendent within five days of receipt of the request.

(ii) If, within twenty days of the superintendent’s receipt of all additional information requested from the insurer, the superintendent determines that (I) the covered employee, member insured or dependent has a serious medical condition; and (II) the benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition is not covered by the replacement coverage offered to the

policyholder as a result of the discontinuance, then the superintendent shall require the insurer to offer to the policyholder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the policy that the insurer discontinued. If the replacement coverage is not available, at the time that the policy would otherwise be discontinued, then the insurer shall keep the existing policy in force for the affected policyholder until the replacement coverage with the substantially similar benefit is available.

(D) The remedies as provided in this paragraph shall be in addition to and not in lieu of any other authority or power of the superintendent to impose monetary or other penalties for violations of this paragraph.

(E) In any case in which an insurer elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in this state, health insurance coverage may be discontinued by the insurer only if:

(i) the insurer provides written notice to the superintendent and to each policyholder (and all employees and member insureds covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

(ii) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and

(iii) in addition to the notice to the superintendent referred to in item (i) of this subparagraph, the insurer shall provide the superintendent with a written plan to minimize potential disruption in the marketplace occasioned by the insurer’s withdrawal from the market.

(F) In the case of a discontinuance under subparagraph (E[])[*] of this paragraph in a market, the insurer may not provide for the issuance of any group or blanket policy of hospital, surgical or medical expense insurance in that market in this state during the five year period beginning on the date of the discontinuance of the last health insurance policy not so renewed.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a group or blanket policy offered to a large or small group policyholder so long as such modification is consistent with this chapter and effective on a uniform basis among all small group policyholders with that policy form.

(5) For purposes of this subsection the term “network plan” shall mean a health insurance policy under which the financing and delivery of health care (including items and services paid for as such care) are provided, in whole or in part, through a defined set of providers under contract either with the insurer or another entity which has contracted with the insurer.

(6) For purposes of this subsection, the term “dependent” shall include a child as described in subsection (f) of section four thousand two hundred thirty-five of this chapter.

(7) Notwithstanding paragraph three of this subsection, an insurer may discontinue offering a particular class of group or blanket policy of hospital, surgical or medical expense insurance offered in the small or large group market, and instead offer a group or blanket policy of hospital, surgical or medical expense insurance that complies with the requirements of section 2707 of the public health service act, § 42 U.S.C. 300gg-6 that become applicable to such policy as of January first, two thousand fourteen, provided that the insurer:

[*] The bracketed closing parenthesis has been inserted by the Publisher.

(A) discontinues the existing class of policy in such market as of either December thirty-first, two thousand thirteen or the policy renewal date occurring in two thousand fourteen in accordance with this chapter;

(B) provides written notice to each policyholder provided coverage of the class in the market (and to all employees and member insureds covered under such coverage) of the discontinuance at least ninety days prior to the date of discontinuance of such coverage. The written notice shall be in a form satisfactory to the superintendent;

(C) offers to each policyholder provided coverage of the class in the market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage that complies with the requirements of section 2707 of the public health service act, 42 U.S.C. § 300gg-6 that become applicable to such coverage as of January first, two thousand fourteen, currently being offered by the insurer to a group in that market;

(D) in exercising the option to discontinue coverage of the class and in offering the option of coverage under subparagraph (C) of this paragraph, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any particular covered employee, member insured or dependent, or particular new employee, member insured, or dependent who may become eligible for such coverage, and does not discontinue the coverage of the class with the intent or as a pretext to discontinuing the coverage of any such employee, member insured, or dependent; and

(E) at least one hundred twenty days prior to the date of the discontinuance of such coverage, provides written notice to the superintendent of the discontinuance, including certification by an officer or director of the insurer that the reason for the discontinuance is to replace the coverage with new coverage that complies with the requirements of section 2707 of the public health service

act, § 42 U.S.C. 300gg-6 that become effective January first, two thousand fourteen. The written notice shall be in such form and contain such information the superintendent requires.

(q)

(1) No insurer delivering or issuing for delivery in this state a group or blanket policy which provides hospital, surgical or medical expense coverage shall establish rules for eligibility (including continued eligibility) of any individual or dependent of the individual to enroll under the policy based on any of the following health status-related factors:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) For purposes of paragraph one of this subsection, rules for eligibility include rules defining any applicable waiting periods for such enrollment.

(3) No insurer may, on the basis of any health status-related factor in relation to the insured or dependent of the insured, require any insured (as a condition of enrollment or continued enrollment under the policy) to pay a premium or contribution which is greater than such premium for a similarly situated insured enrolled in the plan.

(4) Nothing in this subsection shall require an insurer to issue a group or blanket policy to a group comprised of fifty-one or more lives exclusive of spouses and dependents.

(5) Where an eligible insured or dependent of an insured rejects initial enrollment in a group or blanket policy that provides hospital, surgical or medical expense insurance, an insurer shall permit an insured or dependent of an insured to enroll for coverage under the terms of the policy if each of the following conditions is met:

(A) The insured or dependent was covered under another plan or policy at the time coverage was initially offered.

(B)

(i) Coverage under the other plan or policy was provided in accordance with continuation required by federal or state law and was exhausted; or

(ii) Coverage under the other plan or policy was subsequently terminated as a result of loss of eligibility for one or more of the following reasons:

(I) termination of employment;

(II) termination of the other plan or policy;

(III) death of the spouse;

(IV) legal separation, divorce, or annulment;

(V) reduction in the number of hours of employment; or

(iii) Policyholder contributions toward the payment of premium for the other plan or contract were terminated.

(C) Coverage must be applied for within thirty days of termination for one of the reasons set forth in subparagraph (B) of this paragraph.

(6) With respect to group or blanket policies delivered or issued for delivery in this state covering between two and fifty employees or members, the provisions of this

subsection shall in no way diminish the rights of such groups pursuant to section three thousand two hundred thirty-one of this article.

(7) For purposes of this subsection, the term “dependent” shall include a child as described in subsection (f) of section four thousand two hundred thirty-five of this chapter.

(r)

(1) As used in this subsection, “child” means an unmarried child through age twenty-nine of an employee or member insured under a group policy of hospital, medical or surgical expense insurance, regardless of financial dependence, who is not insured by or eligible for coverage under any employer health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the insurer and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (e) of this section and the continuation privilege afforded by subsection (m) of this section, every group policy delivered or issued for delivery in this state that provides hospital, medical or surgical expense insurance coverage for other than specific diseases or accidents only, and which provides coverage of a child that terminates at a specified age, shall, upon application of the employee, member or child, as set forth in subparagraph (B) of this paragraph, provide coverage to the child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group policy and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a child provided pursuant to this subsection;

(B) An employee, member or child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group policy;

(ii) within sixty days after meeting the requirements for child status set forth in paragraph one of this subsection when coverage for the child previously terminated; or

(iii) during an annual thirty-day open enrollment period, as described in the policy;

(C) An employee, member or child electing continuation as described in this subsection shall pay to the group policyholder or employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group policyholder or employer within the time periods set forth in subparagraph (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

(D) For any child electing coverage within sixty days of the date the child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation coverage shall be the date coverage would have otherwise terminated. For any child electing to resume coverage during an annual open enrollment period, the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

(E) Coverage for a child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the policy for any group of similarly situated employees

or members, then the coverage shall also be modified in the same manner for any child;

(F) Coverage shall terminate on the first to occur of the following:

(i) the date the child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph (C) of this paragraph; or

(iii) the date on which the group policy is terminated and not replaced by coverage under another group policy; and

(G) The insurer shall provide written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; and

(ii) at least sixty days prior to termination at the specified age as provided in the policy.

(3)

(A) Insurers shall submit such reports as may be requested by the superintendent to evaluate the effectiveness of coverage pursuant to this subsection including, but not limited to, quarterly enrollment reports.

(B) The superintendent may promulgate regulations to ensure the orderly implementation and operation of the continuation coverage provided pursuant to this subsection, including premium rate adjustments.

(s) An insurer subject to the provisions of this article or an insurance producer subject to this chapter shall not permit the renewal of a small group policy that provides hospital,

surgical or medical expense coverage that renews on or after January first, two thousand fourteen, but before July first, two thousand fourteen, so as to renew the same policy prior to the policy's annual renewal date for the sole purpose of evading the requirements of the affordable care act and regulations promulgated thereunder with respect to such policy. An isolated, inadvertent renewal date change which was not made for the sole purpose of evading the requirements of the affordable care act shall not be deemed a violation of this subsection.

(t)

(1) Any insurer that delivers or issues for delivery in this state hospital, surgical or medical expense group policies in the small group or large group market shall offer to any employer in this state all such policies in the applicable market, and shall accept at all times throughout the year any employer that applies for any of those policies.

(2) The requirements of paragraph one of this subsection shall apply with respect to an employer that applies for coverage either directly from the insurer or through an association or trust to which the insurer has issued coverage and in which the employer participates.

(u)

(1) Every policy that provides coverage for physician services, medical, major medical or similar comprehensive-type coverage shall, upon the referral of a physician, provide coverage for comprehensive neuropsychological examinations for dyslexia when performed by a health care professional licensed, certified, or authorized pursuant to title eight of the education law and acting within their scope of practice and in accordance with this subsection and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy.

(2) Nothing in this subsection shall be construed to prevent the medical management or utilization review of the services or prevent a policy from requiring that services be provided through a network of participating providers.

History

Add, L 1984, ch 367, § 1, eff Sept 1, 1984; amd, L 1984, ch 370, § 1, eff Jan 1, 1985; L 1984, ch 404, § 1, eff Jan 1, 1985; L 1984, ch 805, § 146, eff Sept 1, 1984; L 1984, ch 806, § 1, eff Sept 1, 1984; L 1984, ch 869, § 2, eff Aug 5, 1984; L 1984, ch 990, § 1, eff Jan 1, 1985; L 1984, ch 996, § 1; L 1985, ch 268, § 1; L 1985, ch 369, §§ 4, 5, eff Jan 1, 1986; L 1985, ch 569, § 1, eff Jan 1, 1986; L 1987, ch 210, § 1, eff Aug 6, 1987; L 1987, ch 306, § 1, eff Sept 1, 1987; L 1988, ch 692, § 2, eff Jan 15, 1989; L 1989, ch 417 § 3, eff Jan 1, 1990; L 1989, ch 689, § 5; L 1990, ch 21, § 1, eff Sept 12, 1990; L 1990, ch 853, § 2, eff Jan 1, 1991; L 1990, ch 897, § 2, eff Jan 1, 1991; L 1991, ch 165, § 4, eff Dec 8, 1991; L 1991, ch 467, § 23, eff Jan 1, 1992; L 1992, ch 501, § 3, eff Jan 1, 1993; L 1992, ch 771, § 3; L 1993, ch 43, § 2, eff May 17, 1993; L 1993, ch 378, § 2, eff Jan 1, 1994; L 1993, ch 380, § 3; L 1993, ch 555, § 10, eff July 28, 1993; L 1993, ch 677, §§ 1, 2, eff Aug 4, 1993; L 1993, ch 677, §§ 3, 4, eff Sept 1, 1993; L 1993, ch 728, § 2, eff April 1, 1994; L 1994, ch 344, §§ 7, 8, eff Sept 1, 1994; L 1996, ch 56, § 3; L 1996, ch 705, § 18, eff April 1, 1997; L 1997, ch 20, § 2, eff Jan 1, 1998; L 1997, ch 21, § 2, eff Jan 1, 1998; L 1997, ch 177, §§ 3, 4, eff Jan 4, 1998; L 1997, ch 426, § 3, eff Jan 1, 1998; L 1997, ch 659, § 77, eff Sept 24, 1997; L 1997, ch 661, §§ 3–7, eff Sept 24, 1997, deemed eff on and after July 1, 1997; L 1998, ch 495, § 2, eff July 29, 1998; L 1998, ch 586, § 40, eff July 1, 1999; L 2000, ch 557, § 2, eff March 1, 2001; L 2000, ch 565, § 2, eff Jan 20, 2001; L 2000, ch 593, § 1, eff Sept 1, 2001; L 2000, ch 601, § 2, eff Jan 1, 2001; L 2001, ch 391, § 1, eff Dec 30, 2001; L 2001, ch 506, § 2, eff Jan 1, 2002; L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002; L 2002, ch 420, § 6, eff Sept 1, 2004; L 2002, ch 554, §§ 5, 10, 12, 15, eff Jan 1, 2003; L 2003, ch 338, § 3, eff Jan 1, 2004; L 2004, ch 114, § 4, eff June 21, 2004; L 2004, ch 230, § 16, eff Sept 1, 2004; L 2006, ch 557, § 1, eff Jan 1, 2007; L 2006, ch 748, § 3, eff Jan 1, 2007; L 2007, ch 502, § 1, eff Aug 1,

2007, deemed eff on and after Jan 1, 2007; L 2009, ch 7, § 1, eff March 20, 2009; L 2009, ch 236, § 1, eff July 1, 2009; L 2009, ch 237, § 5, eff Jan 1, 2011; L 2009, ch 237, § 13, eff Jan 1, 2010; L 2009, ch 240, § 2, eff Sept 1, 2009; repealed by L 2009, ch 498, L 2009, ch 498, § 1, eff Nov 19, 2009, effective November 19, 2009; L 2010, ch 238, § 3, eff Oct 28, 2010; L 2010, ch 357, § 2, eff Jan 1, 2011; L 2010, ch 398, § 2, eff Jan 1, 2011; L 2010, ch 457, § 2, eff Jan 1, 2011; L 2010, ch 536, § 4, eff Oct 31, 2010; L 2011, ch 219, §§ 11–13, 19–22, eff July 20, 2011; L 2011, ch 219, §§ 14–18, eff Jan 1, 2012; L 2011, ch 559, § 3, eff Jan 1, 2012; L 2011, ch 589, § 2, eff Oct 14, 2011; L 2011, ch 595, § 2, eff Nov 1, 2012; L 2011, ch 596, § 2, eff Nov 1, 2012; L 2011, ch 597, § 2, eff Jan 11, 2012; L 2011, ch 598, § 2, eff Jan 11, 2012; L 2012, ch 10, § 1, eff Jan 11, 2012; L 2012, ch 11, § 2, eff Jan 11, 2012; L 2012, ch 12, § 2, eff Jan 1, 2012; L 2012, ch 273, § 2, eff Oct 30, 2012; L 2012, ch 302, § 2, eff Aug 1, 2012; L 2013, ch 56, §§ 55-a, 64, 65 (Part D), eff March 28, 2013, deemed eff on and after Jan 1, 2013; L 2013, ch 56, §§ 39, 40-a, 47, 48, 49, 50, 54 (Part D), eff Jan 1, 2014; L 2013, ch 388, § 3, eff Jan 1, 2014; L 2014, ch 41, § 2, effective April 1, 2015; L 2014, ch 364, § 2, effective January 1, 2015; L 2014, ch 377, § 2, effective January 1, 2015; L 2014, ch 388, § 3, effective September 23, 2014; L 2014, ch 550, § 3, effective January 1, 2016; L 2015, ch 6, § 5, effective January 1, 2016; L 2015, ch 536, § 2, effective June 8, 2016; L 2016, ch 23, § 2, effective June 8, 2016; L 2016, ch 69, § 2 (Part B), effective January 1, 2017; L 2016, ch 71, § 2 (Part B), effective January 1, 2017; L 2016, ch 71, § 3 (Part C), effective July 22, 2016; L 2016, ch 74, §§ 4–6, effective June 27, 2016; L 2017, ch 414, § 2, effective January 28, 2018; L 2018, ch 57, § 5 (Part HH), effective April 12, 2018; L 2018, ch 57, §§ 4, 11 (Part MM), effective April 12, 2018; L 2018, ch 335, § 3, effective November 5, 2018; L 2018, ch 469, § 2, effective January 1, 2019; L 2018, ch 476, § 229, effective December 28, 2018; L 2019, ch 25, § 2, effective January 1, 2020; L 2019, ch 57, § 1 (Part J, Subpart A), effective April 12, 2019; L 2019, ch 57, §§ 11–14, 16 (Part J, Subpart B), effective January 1, 2020; L 2019, ch 57, § 1 (Part L), effective January 1, 2020; L 2019, ch 57, § 1 (Part M), effective January 1, 2020; L 2019, ch 57, §§ 11–21 (Part BB, Subpart A), effective January 1, 2020; L 2019, ch 143, § 2, effective September 1, 2019; L 2019, ch 748, § 2, effective February 29, 2020; L 2020, ch 56, § 11 (Part AA), effective April 3, 2020; L 2020, ch

56, § 2 (Part DDD), effective April 3, 2020; L 2021, ch 57, §§ 14–17 (Part AA), effective October 1, 2021; L 2021, ch 820, § 11, effective January 1, 2022; L 2021, ch 827, § 2, effective December 31, 2021; L 2022, ch 57, § 2 (Part R), effective January 1, 2023; L 2022, ch 571, § 2, effective January 1, 2023; L 2022, ch 721, § 2, effective December 21, 2022; L 2022, ch 734, § 2, effective January 1, 2023; L 2022, ch 736, § 2, effective July 1, 2023; L 2022, ch 739, § 2, effective December 23, 2022; L 2022, ch 758, § 3, effective June 23, 2024; L 2022, ch 818, §§ 2–4, effective January 1, 2023; L 2023, ch 29, § 3, effective June 23, 2024; L 2023, ch 57, §§ 5–7 (Part II, Subpart A), effective May 3, 2025; L 2023, ch 57, § 8 (Part II, Subpart A), effective January 1, 2024; L 2023, ch 57, § 2 (Part II, Subpart B), effective May 3, 2024; L 2023, ch 57, § 2 (Part II, Subpart E), effective May 3, 2023; L 2023, ch 57, § 2 (Part LL), effective May 3, 2023; L 2023, ch 62, §§ 2, 3, effective January 1, 2023; L 2023, ch 78, § 2, effective December 23, 2022; L 2023, ch 79, § 1, effective March 3, 2023; L 2023, ch 117, § 2, effective July 1, 2023; L 2023, ch 649, § 3, effective January 1, 2025; L 2023, ch 754, § 2, effective January 1, 2025; L 2024, ch 29, § 2, effective January 1, 2025; L 2024, ch 57, §§ 3, 4 (Part AA), effective January 1, 2025; L 2024, ch 58, § 2 (Part EE), effective January 1, 2025; L 2024, ch 152, § 2, effective December 25, 2024; L 2024, ch 180, § 1, effective June 28, 2024; L 2024, ch 228, § 2, effective January 1, 2025; L 2024, ch 421, § 2, effective January 1, 2025; L 2024, ch 422, § 2, effective January 1, 2025; L 2024, ch 424, §§ 3, 4, effective January 1, 2026; L 2024, ch 548, § 4, effective January 1, 2025; L 2024, ch 553, § 2, effective January 1, 2026; L 2024, ch 595, § 2, effective January 1, 2026; L 2025, ch 8, § 2, effective January 1, 2025; L 2025, ch 14, § 2, effective January 1, 2026; L 2025, ch 74, § 2, effective January 1, 2025; L 2025, ch 81, § 2, effective January 1, 2026.

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