§ 3216. Individual accident and health insurance policy provisions.
(a) In this section the term:
(1) "Policy of accident and health insurance" includes any individual policy or contract covering the kind or kinds of insurance described in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter.
(2) "Indemnity" means benefits promised.
(3) "Family" may include the policyholder's spouse, or dependent children, or any other person dependent upon the policyholder.
(4) "Dependent children" (A) shall include any children under a specified age which shall not exceed age nineteen except:
   (i) Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation as defined in the mental hygiene law, or physical handicap and who became so incapable prior to the age at which dependent coverage would otherwise terminate, shall be included in coverage subject to any pre-existing conditions limitation applicable to other dependents; or
   (ii) Any unmarried student at an accredited institution of learning may be considered a dependent child until attaining age twenty-three for a policy other than hospital, medical, surgical, or prescription drug expense insurance; or
   (iii) Any married or unmarried child shall be considered a dependent child until attaining age twenty-six without regard to financial dependence, residency with the policyholder, student status, or employment, for a policy of hospital, medical, surgical, or prescription drug expense insurance.
   (B) may include, at the option of the insurer, any unmarried child until attaining age twenty-five for a policy other than hospital, medical, surgical, or prescription drug expense insurance.
   (C) In addition to the requirements of subparagraphs (A) and (B) of this paragraph, every insurer issuing a policy of hospital, medical, or surgical expense insurance pursuant to this section that provides coverage for dependent children must make available and, if requested by the policyholder, extend coverage under the policy to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under an 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. Such coverage shall be made available at the inception of all new policies. Written notice of the availability of such coverage shall be delivered to the policyholder thirty days prior to the inception of such policy.
   (b) No policy of accident and health insurance, including non-cancellable disability insurance, except as provided in subsection (h) hereof, shall be delivered or issued for delivery in this state until the rate manual showing rates, rules and classifications of risks for use in connection with such accident and health insurance policies or with riders or endorsements thereon, has been filed with the superintendent.
   (c) No policy of accident and health insurance shall be delivered or issued for delivery to any person in this state unless:
      (1) The entire money and other considerations therefor are expressed therein.
      (2) The time at which the insurance takes effect and terminates is expressed therein.
      (3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, members of a family, as
defined herein, upon the application of an adult member of the family who shall be deemed the policyholder.

(4) (A) Coverage of an unmarried dependent child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate and who is chiefly dependent upon such policyholder for support and maintenance, shall not terminate while the policy remains in force and the dependent remains in such condition, if the policyholder has within thirty-one days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein.

(B) Coverage of a dependent spouse or named insured which would terminate upon such spouse or named insured attaining the age prescribed in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq. ("medicare"), as the age of first eligibility for the benefits provided by such law shall not so terminate, if such dependent spouse is not then eligible for all of such benefits, for as long as the policy remains in force and such dependent spouse remains ineligible to receive any of such "medicare" benefits, provided proof of such ineligibility is submitted to the insurer within thirty-one days of the date notice of termination of coverage be sent by first class mail by the insurer to the last known address of the policyholder.

(C) Any family coverage shall provide that coverage of newborn infants, including newly born infants adopted by the insured or subscriber if such insured or subscriber takes physical custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law within thirty days of birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked, shall be effective from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. In the case of individual coverage the insurer must also permit the person to whom the policy is issued to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium or contribution is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than thirty days of the day of birth to make coverage effective from the moment of birth. This election shall not be required in the case of student insurance.

(5) (A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to that person by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within sixty days after such insurance shall have terminated, an individual conversion policy that contains the essential health benefits package described in paragraph three of subsection (f) of section three thousand two hundred seventeen-i of this article. The
(A) Each insurance company or group of insurance companies reinsuring insurance companies shall offer one policy at each level of coverage as defined in subsection (b) of section three thousand two hundred seventeen-i of this article. The individual may choose any such policy offered by the insurer. 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 subparagraph through the offering of policies that comply with this subparagraph by another insurer, corporation or health maintenance organization within the insurer's holding company system, as defined in article fifteen of this chapter. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

(B) Written notice of entitlement to a conversion policy shall be given by the insurer to the policyholder at least fifteen and not more than sixty days prior to the termination of coverage due to the initial limiting age of the covered dependent. Such notice shall include an explanation of the rights of the dependent with respect to the dependent being enrolled in an accredited institution of learning or his incapacity for self-sustaining employment by reason of mental illness, developmental disability or mental retardation as defined in the mental hygiene law or physical handicap.

(C) Such individual conversion policy shall be subject to the following terms and conditions:

(i) The premium shall be that applicable to the form and amount of insurance therefor.

(ii) The benefits provided under such policy shall become effective upon the date that such person was no longer eligible under the family policy.

(iii) No insurer shall be required to issue a conversion policy if it appears that the person applying for such policy shall have at that time in force another insurance policy or hospital service or medical expense indemnity contract providing similar benefits or is covered by or is eligible for coverage by a group insurance policy or contract providing similar benefits or shall be covered by similar benefits required by any statute or provided by any welfare plan or program, which together with the conversion policy would result in over insurance or duplication of benefits according to standards on file with the superintendent relating to individual policies.

(6) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions).

(7) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in subsection (d) of this section, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(8) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof.
(9) It contains no provision purporting to make any portion of the charter, rules, constitution, or by-laws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the superintendent.

(10) There is prominently printed on the first page thereof or there is attached thereto a notice to the effect that during a specified period of time, which shall not be less than ten days nor more than twenty days from the date the policy is delivered to the policyholder, it may be surrendered to the insurer together with a written request for cancellation of the policy and in such event the insurer will refund any premium paid therefor including any policy fees or other charges, provided, however, that this paragraph shall not apply to single premium nonrenewable policies insuring against accidents only or accidental bodily injuries only; provided, however, that a contract or certificate sold by mail order and a contract or certificate providing medicare supplemental insurance or long-term care insurance must contain a provision permitting the contract or certificate holder a thirty day period for such surrender.

(11) The age limit or date or period, if any, after which the coverage provided by the policy will not be effective or the age limit, date or period after which the policy may not be renewed is stated in a renewal provision set forth on the first page of the policy or as a separate provision bearing an appropriate caption on the first page of the policy or in a brief description in not less than fourteen-point bold face type set forth on the first page of the policy. Nothing herein contained shall limit or restrict the right of the insurer to continue the policy after the age or period so stated.

(12) Any policy, 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 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."

(13) Any persons covered by 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, upon written request, to have their coverage suspended during a period of active duty as described herein. The policy shall provide that the insurer will refund any unearned premiums for the period of such suspension. Persons covered by the policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within sixty days after the date of termination of the period of active duty, 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. Coverage shall be retroactive to the date of termination of the period of active duty. Such right of resumption provided for herein 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.

(14) To be entitled to the right defined in paragraph thirteen of this subsection a person must be a member of a 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.

(d) Each policy of accident and health insurance delivered or issued for delivery to any person in this state shall contain the provisions specified herein in the words in which the same appear in this subsection, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the superintendent which are not less favorable in any respect to the insured or the beneficiary. Each provision contained in the policy shall be preceded by the applicable caption herein or, at the insurer's option, by such appropriate captions or subcaptions as the superintendent may approve.

(1) Each policy shall, except with respect to designation by numbers or letters as used below, contain the following provisions:

(A) ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent or broker has authority to change this policy or to waive any of its provisions.

(B) TIME LIMIT ON CERTAIN DEFENSES:

(i) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of subparagraphs (A) through (E), inclusive, of this paragraph in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)
(ii) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(C) GRACE PERIOD: A grace period of ......................... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision, the following clause:

"Unless not less than thirty days prior to the renewal date the insurer has delivered to the insured or has sent by first class mail to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,"

Furthermore, such a policy, except an accident only policy, shall also provide in substance, in a provision thereof, or in an endorsement thereon or in a rider attached thereto, that the insurer may refuse renewal of the policy only as of the renewal date occurring on, or nearest its first anniversary, or as of an anniversary of such renewal date, or at the option of the insurer as of the renewal date occurring on or nearest the anniversary of its date of last reinstatement.)

(D) REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of the premium by the insurer or by any agent or broker duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent or broker requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue.)

(E) NOTICE OF CLAIM: 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, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ------------- (insert the location of such office as
the insurer may designate for the purpose), or to any authorized agent
of the insurer or to any authorized broker, with information sufficient
to identify the insured, shall be deemed notice to the insurer. (In a
policy providing a loss-of-time benefit which may be payable for at
least two years, an insurer may at its option insert the following
between the first and second sentences of the above provision: Subject
to the qualifications set forth below, if the insured suffers loss of
time on account of disability for which indemnity may be payable for at
least two years, he shall, at least once in every six months after
having given notice of claim, give to the insurer notice of continuance
of said disability, except in the event of legal incapacity. The period
of six months following any filing of proof by the insured or any
payment by the insurer on account of such claim or any denial of
liability in whole or in part by the insurer shall be excluded in
applying this provision. Delay in the giving of such notice shall not
impact the insured's right to any indemnity which would otherwise have
accrued during the period of six months preceding the date on which such
notice is actually given.)

(F) CLAIM FORMS: The insurer, upon receipt of a notice of claim, will
furnish to the claimant such forms as are usually furnished by it for
filing proofs of loss. If such forms are not furnished within fifteen
days after the giving of such notice the claimant shall be deemed to
have complied with the requirements of this policy as to proof of loss
upon submitting, within the time fixed in the policy for filing proofs
of loss, written proof covering the occurrence, the character and extent
of the loss for which claim is made.

(G) PROOFS OF LOSS: Written proof of loss must be furnished to the
insurer at its said office in case of claim for loss for which this
policy provides any periodic payment contingent upon continuing loss
within ninety days after the termination of the period for which the
insurer is liable and in case of claim for any other loss within one
hundred twenty days after the date of such loss. Failure to furnish such
proof within the time required shall not invalidate nor reduce any claim
if it was not reasonably possible to give proof within such time,
provided such proof is furnished as soon as reasonably possible and in
no event, except in the absence of legal capacity, later than one year
from the time proof is otherwise required.

(H) TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy
for any loss other than loss for which this policy provides any periodic
payment will be paid immediately upon receipt of due written proof of
such loss. Subject to due written proof of loss, all accrued indemnities
for loss for which this policy provides periodic payment will be
paid ------------ (insert period for payment which must not be less
frequently than monthly) and any balance remaining unpaid upon the
termination of liability will be paid immediately upon receipt of due
written proof.

(I) PAYMENT OF CLAIMS: Any indemnity for loss of life will be payable
in accordance with the beneficiary designation and the provisions
respecting such payment which may be prescribed herein and effective at
the time of payment. If no such designation or provision is then
effective, such indemnity shall be payable to the estate of the insured.
Any other accrued indemnities unpaid at the insured's death may, at the
option of the insurer, be paid either to such beneficiary or to such
estate. All other indemnities will be payable to the insured. (The
following provisions, or either of them, may be included with the
foregoing provision at the option of the insurer: If any indemnity of
this policy shall be payable to the estate of the insured, or to an
insured or beneficiary who is a minor or otherwise not competent to give
a valid release, the insurer may pay such indemnity, up to an amount not exceeding $------------- (insert an amount which shall not exceed one thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

(J) PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(K) LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(L) CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(M) "CONVERSION PRIVILEGE" (under this caption) a provision which shall set forth in substance the conversion privileges and related provisions required of certain policies by paragraph five of subsection (c) of this section.

(2) Other provisions. No such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words (not including the designation by number or letter) in which the same appear in this paragraph except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the superintendent which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing herein or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent may approve.

(A) CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as
less hazardous than that stated in this policy, the insurer, upon
receipt of proof of such change of occupation, will reduce the premium
rate accordingly, and will return the excess pro-rata unearned premium
from the date of change of occupation or from the policy anniversary
date immediately preceding receipt of such proof, whichever is the more
recent. In applying this provision, the classification of occupational
risk and the premium rates shall be such as have been last filed by the
insurer prior to the occurrence of the loss for which the insurer is
liable or prior to date of proof of change in occupation with the state
official having supervision of insurance in the state where the insured
resided at the time this policy was issued; but if such filing was not
required, then the classification of occupational risk and the premium
rates shall be those last made effective by the insurer in such state
prior to the occurrence of the loss or prior to the date of proof of
change in occupation.

(B) MISSTATEMENT OF AGE: If the insured's age has been misstated, all
amounts payable under this policy shall be such as the premium paid
would have purchased at the correct age.

(C) OTHER INSURANCE IN THIS INSURER: If an accident or sickness or
accident and health policy or policies previously issued by the insurer
to the insured be in force concurrently herewith,

making the aggregate indemnity for -----------(insert type of
coverage or coverages) in excess of $-------------(insert maximum limit
of indemnity or indemnities) the excess insurance shall be void and all
premiums paid for such excess shall be returned to the insured or to his
estate,
or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy
or policies in this insurer is limited to the one such policy elected by
the insured, his beneficiary or his estate, as the case may be, and the
insurer will return all premiums paid for all other such policies.

(D) INSURANCE WITH OTHER INSURERS: If there be other valid coverage,
not with this insurer, providing benefits for the same loss on a
provision of service basis or on an expense incurred basis and of which
this insurer has not been given written notice prior to the occurrence
or commencement of loss, the only liability under any expense incurred
coverage of this policy shall be for such proportion of the loss as the
amount which would otherwise have been payable hereunder plus the total
of the like amounts under all such other valid coverages for the same
loss of which this insurer had notice bears to the total like amounts
under all valid coverages for such loss, and for the return of such
portion of the premiums paid as shall exceed the pro-rata portion for
the amount so determined. For the purpose of applying this provision
when other coverage is on a provision of service basis, the "like
amount" of such other coverage shall be taken as the amount which the
services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also
contains the next following policy provision there shall be added to the
caption of the foregoing provision the phrase "--- EXPENSE INCURRED
BENEFITS". The insurer may, at its option, include in this provision a
definition of "other valid coverage", approved as to form by the
superintendent, which definition shall be limited in subject matter to
coverage provided by organizations subject to regulation by insurance
law or by insurance authorities of this or any other state of the United
States or any province of Canada, and by hospital or medical service
organizations, and to any other coverage the inclusion of which may be
approved by the superintendent. In the absence of such definition such
term shall not include group insurance, automobile medical payments
insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".)

(E) INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "--- OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".)

(F) RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable for only such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser,
nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by the insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(G) UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(H) CANCELLATION: Within the first ninety days after the date of issue, the insurer may cancel this policy by written notice delivered to the insured, or sent by first class mail to his last address as shown by the records of the insurer, stating when, not less than ten days thereafter, such cancellation shall be effective. In the event of cancellation, the insurer will return promptly the pro-rata unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(Nothing in this subsection shall be construed to prohibit an insurer from granting to the insured the right to cancel a policy at any time and to receive in such event a refund of the unearned portion of any premium paid, computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued).

(I) CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(J) ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(K) INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(3) If any provision of this subsection is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the superintendent, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) The provisions which are the subject of paragraphs one and two of this subsection, or any corresponding provisions which are used in lieu
thereof in accordance with such paragraphs, shall be printed in the
consecutive order of the provisions in such paragraphs or, at the option
of the insurer, any such provision may appear as a unit in any part of
the policy, with other provisions to which it may be logically related,
provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a
person to whom the policy is offered, delivered or issued.
(5) The word "insured", as used in this section, shall not be
construed as preventing a person other than the insured with a proper
insurable interest from making application for and owning a policy
covering the insured or from being entitled under such a policy to any
indemnities, benefits and rights provided therein.
(6) The superintendent may make such reasonable rules and regulations
concerning the procedure for the filing or submission of policies
subject to this section as are necessary, proper or advisable to the
administration of this section. This provision shall not abridge any
other authority granted the superintendent by law.
(e) The acknowledgment by any insurer of the receipt of notice given
under any policy covered by this section, or the furnishing of forms for
filing proofs of loss, or the acceptance of such proofs, or the
investigation of any claim thereunder, shall not operate as a waiver of
any of the rights of the insurer in defense of any claim arising under
such policy.
(f) If any such policy contains a provision establishing, as an age
limit or otherwise, a date after which the coverage provided by the
policy will not be effective, and if such date falls within a period for
which premium is accepted by the insurer or if the insurer accepts a
premium after such date, the coverage provided by the policy will
continue in force subject to any right of cancellation until the end of
the period for which premium has been accepted. In the event the age of
the insured has been misstated and if, according to the correct age of
the insured, the coverage provided by the policy would not have become
effective, or would have ceased prior to the acceptance of such premium
or premiums, then the liability of the insurer shall be limited to the
refund, upon request, of all premiums paid for the period not covered by
the policy.
(g) (1) No insurer shall refuse to renew a policy of hospital, surgical
or medical expense insurance, an individual converted policy, or any
other policy in which one-third or more of the total premium is
allocable to hospital, surgical or medical expense benefits, or any
combination thereof (but not including insurance against accidental
injury only), except for one or more of the following reasons:
(A) nonpayment of premiums,
(B) fraud in applying for the policy or in applying for any benefits
under the policy or intentional misrepresentation of material fact under
the terms of the coverage,
(C) discontinuance of a class of policies in accordance with paragraph
two of this subsection, except that no insurer or organization certified
pursuant to article forty-four of the public health law shall refuse to
renew the policies of insureds holding contracts which provide major
medical or similar comprehensive type coverage in effect prior to June
first, two thousand one who are ineligible to purchase policies offered
pursuant to section four thousand three hundred twenty-one or four
thousand three hundred twenty-two of this chapter due to the provisions
of section 42 USC 1395ss in effect on January first, two thousand one,
and who are eligible for Medicare benefits by reason of disability.
(i) Coverage shall be reinstated only for such insureds terminated on
or after January first, two thousand one and such coverage shall be
reinstated on a prospective basis only, irrespective of any pre-existing conditions.

(ii) In the event any such insured becomes eligible to purchase policies offered pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this chapter, then such insured may be discontinued upon not less than five months prior written notice. In the event any such insured becomes eligible for Medicare by reason of age, then such insured may be terminated by not less than thirty days notice with prior written notice.

(iii) Within sixty days of this item taking effect, the insurer or organization shall notify the insured of the prospective reinstatement of coverage under this section. Within thirty days of receipt of such notice, an insured shall notify the insurer or organization of his or her election for prospective coverage,

(D) discontinuance of all hospital, surgical and medical expense coverage in the individual market in this state in accordance with paragraph three of this subsection,

(E) in the case of an insurer that offers coverage in the individual market through a network plan, termination of an individual who no longer resides, lives or works in the service area (or in an area for which the insurer is authorized to do business) but only if such coverage is terminated under this subparagraph uniformly without regard to any health status-related factor of covered individuals, and

(F) for 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.

In no event shall any insurer refuse to renew any such policy because of the physical or mental condition or the health of any person covered thereunder. Furthermore, no insurer shall require as a condition for the renewal of any such policy any rider, endorsement or other attachment which shall limit the nature or extent of the benefits provided thereunder. The superintendent may require every insurer to file with him such documents, statistics or other information regarding the refusal to renew permitted by this subsection as he may deem necessary for the proper administration of this subsection.

(2) In any case in which an insurer decides to discontinue offering a class of hospital, surgical or medical expense policies in the individual health insurance market, coverage of the class of policies may be discontinued by the insurer only if:

(A) the insurer gives at least ninety days prior written notice of such discontinuance to the superintendent;

(B) the insurer provides written notice of such discontinuance to each covered individual at least ninety days prior to the date of discontinuance of such coverage;

(C) the insurer offers to each covered individual the option to purchase all other individual hospital, surgical and medical expense coverage currently being offered by the insurer in the individual health insurance market; and

(D) in exercising the option to discontinue coverage of a class of policies and in offering the option of coverage under subparagraph (C) of this paragraph, the insurer acts uniformly without regard to claims experience or to any health status-related factor of insured individuals or individuals who may become eligible for such coverage.

(E) 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 subparagraph (C) of this paragraph through
the offering of policies 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 by another insurer, corporation or health maintenance organization within the insurer’s same holding company system, as defined in article fifteen of this chapter.

(3) In any case in which an insurer elects to discontinue offering all hospital, surgical and medical expense coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if:

(A) the insurer gives at least one hundred eighty days prior written notice of such discontinuance to the superintendent;

(B) the insurer provides written notice of such discontinuance to each covered individual at least one hundred eighty days prior to the date of termination of such coverage;

(C) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in the individual market is discontinued and coverage under such health insurance coverage in such market is not renewed; and

(D) in addition to the notice referred to in subparagraph (A) of this paragraph, the insurer must provide the superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the individual market.

(4) In the case of a discontinuance under paragraph three of this subsection, the insurer may not provide for the issuance of any policy of hospital, surgical or medical expense insurance in the individual market in this state during the five year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

(5) At the time of coverage renewal, an insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with this chapter and effective on a uniform basis among all individuals with that policy form.

(6) 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 with the insurer or another entity which has contracted with the insurer.

(h) This section shall not apply to or affect:

(1) Any contract of non-cancellable disability insurance which is governed by or excepted from section three thousand two hundred fifteen of this article.

(2) Any policy or contract of reinsurance.

(3) Any policy of group or blanket insurance which is governed by section three thousand two hundred twenty-one of this article except that the provisions of subsection (b) hereof and paragraphs one through ten of subsection (i) hereof and the provisions of subsection (j) hereof shall be applicable to a policy of group insurance authorized under subparagraph (J) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter.

(4) Any policy providing disability benefits pursuant to article nine of the workers' compensation law.

(5) Any policy of a co-operative life and accident insurance company except as was provided in section two hundred thirty-seven of the former insurance law.
(6) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as provide additional benefits in case of death or dismemberment or loss of sight by accident, or as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

(i) Every person insured under a policy of accident and health insurance delivered or issued for delivery in this state shall be entitled to the reimbursements and coverages specified below.

(1) If a policy provides for reimbursement for any optometric service which is within the lawful scope of practice of a licensed optometrist, the insured shall be entitled to reimbursement for such service whether it is performed by a physician or licensed optometrist. Unless such policy shall otherwise provide there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances thereto.

(2) If a policy provides for reimbursement for any podiatrical service within the lawful scope of practice of a licensed podiatrist, the insured shall be entitled to reimbursement for such service whether it is performed by a physician or licensed podiatrist.

(3) If a policy provides for reimbursement for any dental service within the lawful scope of practice of a licensed dentist, the insured shall be entitled to reimbursement for such service whether it is performed by a physician or a licensed dentist.

(4) If a policy provides for reimbursement for psychiatric or psychological services or for diagnosis and treatment of mental health conditions however defined in the policy, the insured shall be entitled to reimbursement for such services, diagnosis or treatment whether performed by a physician, psychiatrist, a certified and registered psychologist, or a nurse practitioner when the services rendered are within the lawful scope of their practice.

(5) Every policy providing for reimbursement for laboratory tests or reimbursement for diagnostic X-ray services shall provide for reimbursement at the same percentage of reimbursement whether such tests or services are provided to the insured as an admitted patient in a health care facility or as an out-patient.

(6) Every policy which provides coverage for in-patient hospital care shall provide coverage for home care to residents in this state. Such home care coverage shall be included 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.

(A) 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. 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 title subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq.

(B) 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. 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.

(7) Every policy which provides coverage for in-patient hospital care shall also provide coverage for pre-admission tests performed in hospital out-patient facilities prior to scheduled surgery provided:

(A) the tests are ordered by a physician as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital;

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

(C) reservations for a hospital bed and for an operating room shall have been made prior to the performance of the tests;

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

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

(8) Every policy 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.

(9)(A) Every policy that provides coverage for inpatient hospital care shall also include coverage for services to treat an emergency condition 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) For purposes of 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) For purposes of 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) For purposes of this paragraph, "to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).

(10) (A) (i) Every policy which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical 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 for 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.
(11) (A) Every policy 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; and

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

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

(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 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) Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging, covered under the policy shall not be subject to annual deductibles or coinsurance.

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

(12) (A) Every policy 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.
(13) (A) Every policy 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.
(B) Every policy 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.
(C) Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for 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.
   (i) For purposes of this subparagraph, "iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.
   (ii) No insurer providing coverage under this paragraph shall discriminate based on an insured’s expected length of life, present or 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.
(13-a) 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 insured who elects to purchase prescription fertility drugs through a network participating non-mail order retail pharmacy that it does not impose on any insured who purchases prescription fertility drugs through a network participating mail order or other non-retail pharmacy.
(14) If a policy provides for reimbursement for the services of licensed health professionals who can bill for services, the insured shall be entitled to reimbursement for such service provided pursuant to a clinical practice plan established pursuant to subdivision fourteen of section two hundred six of the public health law.
(15) (A) Every policy that provides hospital, surgical or medical care coverage or provides reimbursement for laboratory tests or reimbursement for diagnostic X-ray services 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 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 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) (A) Every policy 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, the total amount that a covered person is required to pay out of pocket for covered prescription insulin drugs shall be capped at an amount not to exceed one hundred dollars per thirty-day supply, regardless of the amount or type of insulin needed to fill such covered person’s prescription and regardless of the insured’s deductible, copayment, coinsurance or any other cost sharing requirement.

(16) If a policy provides for reimbursement for speech-language pathology or audiology service which is within the lawful scope of practice of a duly licensed speech-language pathologist or audiologist, an insured shall be entitled to reimbursement for such service whether the said service is performed by a physician or duly licensed speech-language pathologist or audiologist, provided however, that nothing contained herein shall be construed to impair any terms of such policy which may require said service to be performed pursuant to a medical order, or a similar or related service of a physician, in which case coverage need not be provided for any tests, evaluations or diagnoses if such tests, evaluations or diagnoses have already been provided by or through a physician within twelve months of the referral or order from the physician. However, nothing herein shall be construed as preventing an insurer from covering more than one test or evaluation provided by a speech-language pathologist or audiologist within a twelve-month period where such test or evaluation is ordered by a physician as medically necessary. Nor shall anything herein be construed as prohibiting the limitation of such services, where covered, to specified settings other than offices, such as hospitals or to services provided by such professionals as part of a home care agency’s services.

(17) (A) Every policy that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(B) For the purposes of 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;

(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
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 policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (F) 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.

(v) all FDA-approved contraceptive drugs, devices, and other products, including all over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law; 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; patient education and counseling on contraception; and follow-up services related to the drugs, devices, products, and procedures covered under this clause, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Except as otherwise authorized under this clause, a contract shall not impose any restrictions or delays on the coverage required under this clause. However, where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, a contract 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 clause. If the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a contract shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. (a) 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. (b) 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 must allow for the dispensing of up to twelve months worth of a contraceptive at one time. (d) For the purposes of this clause, "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.

(F) 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).

(18) (A) Every policy 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.
(19) (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 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; or

(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.

(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.

(20) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide the following coverage for breast reconstruction surgery after a mastectomy or partial mastectomy:

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

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

in the manner determined by the attending physician and the patient to be appropriate. 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.

(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.

* (21) 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.

* NB There are 2 par (21)'s

* (21)(A) Every policy which is a "managed care product" as defined in subparagraph (D) of this paragraph that provides 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.

(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 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.

(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.

* NB There are 2 par (21)'s

(22) No policy shall exclude coverage of a health care service, as defined in paragraph two of subsection (e) of section four thousand nine hundred nine 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 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.

(23) If a policy provides for reimbursement for physical and occupational therapy service which is within the lawful scope of practice of a duly licensed physical or occupational therapist, an insured shall be entitled to reimbursement for such service whether the said service is performed by a physician or through a duly licensed physical or occupational therapist, provided however, that nothing contained herein shall be construed to impair any terms of such policy
including appropriate utilization review and the requirement that said service be performed pursuant to a medical order, or a similar or related service of a physician.

(24)(A) Every policy 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.

(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.

(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 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.

(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; (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.

(25) (A) Every policy which provides coverage for hospital or surgical coverage shall not exclude coverage for screening, diagnosis and treatment of medical conditions otherwise covered by the policy solely because the treatment is provided to diagnose or treat autism spectrum disorder.
(B) Every 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 policy. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the 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) Nothing in this paragraph shall be construed to affect any
obligation to provide coverage for otherwise-covered services solely on
the basis that the services constitute early intervention program
services pursuant to section three thousand two hundred thirty-five-a of
this article or an individualized service plan pursuant to regulations
of the office for persons with developmental disabilities.

(G) Nothing in this paragraph shall be construed to prevent a 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).

(26)(A) No 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 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.

* (27) 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).

* NB There are 2 par (27)'s

* (27)(A) Every 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.

* NB There are 2 par (27)'s

(28) 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 verify the prescription.

* NB There are 2 par (28)'s

(28) Any policy 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 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 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 prescription 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.

* NB There are 2 par (28)'s

(29) Every individual 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.
*(30)(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) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits.

(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).

* NB There are 2 par (30)’s

(30) Every policy 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.

* NB There are 2 par (30)’s

(31) (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 New York state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services to provide outpatient substance use disorder services and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse 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) 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.
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.

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.

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).

(A) No policy that provides medical, major medical or similar comprehensive-type 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 all buprenorphine products, methadone or long acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder 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.

No 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.
*(33) Every 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.

* NB There are 2 par (33)'s
*(33) 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.

* NB There are 2 par (33)'s
*(34) 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.

* NB There are 2 par (34)'s
*(34) Every policy 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 inpatient use, 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.

* NB There are 2 par (34)'s
*(35) (A) Every policy delivered or issued for delivery in this state that provides coverage for inpatient hospital care or coverage for physician services shall provide coverage for the diagnosis and treatment of mental health conditions as follows:

(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 and benefits for outpatient care 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, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

(ii) where the policy provides coverage for physician services, benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subparagraph (D) of paragraph four of subsection (1) of section three thousand two hundred twenty-one of this article, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof.
(B) Coverage required by this paragraph 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 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; and
   (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.

(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 in this state that are licensed 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 provided to individuals who have not attained the age of eighteen shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review 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 patient, 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 patient, to ensure
that the inpatient care is medically necessary for the patient. 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) (1) Every insurer issuing a policy of accident and health insurance 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. 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.

(A) In this paragraph nursing home care 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 admission, and (iii) further hospitalization would otherwise be necessary. 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, may not exceed the number of covered days of hospital care provided under the contract in a benefit period. The level of benefits to be provided for nursing home care must be reasonably related to the benefits provided for hospital care.

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

(2) Every insurer issuing a policy of accident and health insurance 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 insured, 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 case visits per policy year. Such coverage shall be provided pursuant to regulations prescribed by the superintendent.

(3) Consistent with federal law, every insurer issuing a policy of accident and health insurance 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 insured, 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 all applicants at the time of application for 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.

(k) Any person, partnership or corporation willfully violating any provision of this section, regulation or order of the superintendent made in accordance with this section, shall forfeit to the people of the state a sum not to exceed one hundred dollars for each such violation. The superintendent may also suspend or revoke the license of an insurer or agent or broker for any such willful violation.

(l) An insurer shall not offer individual hospital, medical or surgical expense insurance policies unless the policies meet the requirements of subsection (b) of section four thousand three hundred twenty-eight of this chapter. Such policies that are offered within the health benefit exchange established by this state also shall meet any requirements established by the health benefit exchange.

(m) 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 as essential health benefits. 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. For purposes of this subsection, "essential health benefits" shall have the meaning set forth in subsection (a) of section three thousand two hundred seventeen-i of this article.