

NY CLS Ins § 3221

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Practitioner's Toolbox



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INSURANCE LAW
ARTICLE 32. INSURANCE CONTRACTS--LIFE,
ACCIDENT AND HEALTH, ANNUITIES

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THIS JURISDICTION**

NY CLS Ins § 3221 (2004)

§ 3221. Group or blanket accident and health insurance policies; standard provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) That benefits payable under the policy other than benefits for loss of time will be

payable not more than sixty days after receipt of proof, and that, subject to due proof of loss all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

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

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

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

"NOTICE -- THIS POLICY OR CERTIFICATE DOES NOT MEET THE REQUIREMENTS OF A CONTINUING CARE RETIREMENT CONTRACT. AVAILABILITY OF THIS COVERAGE WILL NOT QUALIFY A RESIDENTIAL FACILITY AS A CONTINUING CARE RETIREMENT COMMUNITY."

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

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

(d) (1) The superintendent may approve any form of certificate to be issued under a blanket accident and health insurance policy as defined in section four thousand two hundred thirty-seven of this chapter, which omits or modifies any of the provisions hereinbefore required, if he deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder.

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

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

(e) (1) A group policy providing hospital or surgical expense insurance for other than specific diseases or accident only, shall provide that if the insurance on an employee or member insured under the group policy ceases because of termination of (I) employment or of membership in the class or classes eligible for coverage under the policy or (II) the policy, for any reason whatsoever, unless the policyholder has replaced the group policy with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group policy for at least three months shall be entitled to have issued to him by the insurer without evidence of insurability upon application made to the insurer within forty-five days after such termination, and payment of the quarterly, or, at the option of the employee or member, a less frequent premium applicable to the class of risk to which the person belongs, the age of such person, and the form and amount of insurance, an individual policy of insurance. The insurer may, at its option elect to provide the insurance coverage under a group insurance policy, delivered in this state, in lieu of the issuance of a converted individual policy of insurance. Such individual policy, or group policy, as the case may be is hereafter referred to as the converted policy. The benefits provided under the converted policy shall be those required by subsection (f), (g), (h) or (i) hereof, whichever is applicable and, in the event of termination of the converted group policy of insurance, each insured thereunder shall have a right of conversion to a converted individual policy of insurance.

(2) The insurer shall not be required to issue a converted policy covering any person if such person is covered for similar benefits by another hospital or surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program or such person is eligible for similar benefits, whether or not covered therefor, under any arrangement of

coverage for individuals in a group, other than under the converted policy, whether on an insured or uninsured basis or similar benefits are provided for or available to such person pursuant to any statute; and the benefits provided or available under any of such sources which together with the benefits provided under the converted policy would result in overinsurance or duplication of benefits according to standards on file with the superintendent.

(3) The converted policy shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group policy. Provided, however, that if the employee or member chooses the option of dependent coverage then dependents acquired after the permitted time to convert stated in paragraph one of this subsection shall be added to the converted family policy in accordance with the provisions of subsection (c) of section thirty-two hundred sixteen of this article and any regulations promulgated or guidelines issued by the superintendent. The converted policy need not provide benefits in excess of those provided for such persons under the group policy from which conversion is made and may contain any exclusion or benefit limitation contained in the group policy or customarily used in individual policies. The effective date of the individual's coverage under the converted policy shall be the date of the termination of the individual's insurance under the group policy as to those persons covered under the group policy.

(4) The converted policy shall not exclude a pre-existing condition not excluded by the group policy but may provide that any benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder, and during the first year of such individual's coverage under the converted policy the benefits payable under the policy may be reduced so that they are not in excess of those that would have been payable had the individual's insurance under the group policy remained in effect. The converted policy may provide for termination of coverage thereunder on any person when he is or could be covered by Medicare (subchapter XVIII of the federal Social Security Act, [42 U.S.C. §§ 1395](#) et seq) by reason of age.

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

(6) (A) A converted policy may include a provision whereby the insurer, during the first two years of an individual's coverage under the policy, may request information in advance of any premium due date of such policy of any person covered thereunder as to whether he is covered for similar benefits by another hospital or surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program or similar benefits are provided for, or available to, such person pursuant to any statute.

(B) If any such person is so covered or such statutory benefits are provided or available, and such person fails to furnish the insurer the details of such coverage within thirty-one days after such request, the benefits payable under the converted policy with

respect to such person may be based on the hospital or surgical or medical expenses actually incurred after excluding expenses to the extent of the amount of benefits provided or available therefor from any of the sources referred to in subparagraph (A) hereof.

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

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

(B) Written notice by the policyholder given to the certificate holder or mailed to the certificate holder's last known address, or written notice by the insurer be sent by first class mail to the certificate holder at the last address furnished to the insurer by the policyholder, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

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

(9) This subsection shall not apply to a group policy issued to a policyholder whose principal activities are located outside this state by any life insurance company organized and operated without profit to any private shareholder or individual, and operated exclusively for the purpose of aiding and strengthening charitable, religious, missionary, education or philanthropic institutions, by issuing insurance contracts only to or for the benefit of such institutions, to individuals engaged in the services of such institutions and to members of the immediate families of such individuals.

(10) (A) This subsection shall not apply to a group policy insuring persons employed in an establishment located outside this state and their dependents issued by a life insurance company which has been organized for the purpose of establishing a non-profit voluntary employee beneficiary association to provide life, sickness, accident or other benefits to eligible employees or their beneficiaries, is operated exclusively for said purposes and without profit, direct or indirect, to any private shareholder or individual, and is duly exempt from income taxation, pursuant to the federal Internal Revenue Code.

(B) Notwithstanding the provisions of subparagraph (A) hereof, any resident of this

state and his dependents who are insured under a group policy providing hospital or surgical expense insurance for other than specific diseases or accident only which is issued by a life insurance company organized as aforementioned, shall be entitled to the conversion privileges specified in this subsection.

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

(f) Any employee or member who upon becoming entitled to obtain coverage under a converted policy has attained age sixty, and has been insured for at least two years under the group policy immediately preceding the date the employee or member first became entitled to a converted policy shall have the privilege of obtaining such policy for a premium computed at a rate which in any policy year shall not exceed one hundred twenty percent of a net level premium approved by the superintendent and determined, according to the attained age of the insured at the time of conversion and the plan of reimbursement elected, on the basis of current experience of licensed insurers providing such coverage and of reasonable assumptions as to morbidity, mortality and interest. Such net level premium may be changed in accordance with experience and with the approval of the superintendent at intervals of not more frequently than five years. Notwithstanding the foregoing provisions of this subsection, nothing herein shall be construed so as to avoid the requirements of open enrollment and community rating as set forth elsewhere in this chapter.

(g) The conversion privilege shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance, or if the group insurance policy insures the employee or member for comprehensive medical expense insurance, entitle the employee or member to obtain coverage under a converted policy providing, at his option, coverage under any one of the following plans on an expense incurred basis:

(1) Plan I.

(A) hospital room and board expense benefits of one hundred thirty dollars per day for a maximum duration of twenty-one days,

(B) miscellaneous hospital expense benefits of a maximum amount of one thousand three hundred dollars, and

(C) surgical operation expense benefits according to a one thousand four hundred dollar maximum benefit schedule, or

(2) Plan II.

(A) hospital room and board expense benefits of two hundred thirty dollars per day for a maximum duration of thirty days,

(B) miscellaneous hospital expense benefits of a maximum amount of two thousand three hundred dollars, and

(C) surgical operation expense benefits according to a two thousand four hundred dollar maximum benefit schedule, or

(3) Plan III.

(A) hospital room and board expense benefits of three hundred thirty dollars a day for a maximum duration of seventy days,

(B) miscellaneous hospital benefits of a maximum amount of three thousand three hundred dollars, and

(C) surgical operation expense benefits according to a three thousand five hundred dollar maximum benefit schedule.

(h) The conversion privilege shall, if the group insurance policy insures the employee or member for major medical expense insurance, or if the group insurance policy insures the employee or member for comprehensive medical expense insurance, entitle the employee or member to obtain coverage under a converted policy providing major medical coverage under one of the following plans or one at least as favorable to the covered persons:

(1) A maximum conforming to subparagraph (A) or (B) hereof:

(A) A maximum payment of two hundred thousand dollars for all covered medical expenses combined during the covered person's lifetime, with an annual restoration on each January first while coverage is in force, up to five thousand dollars of the amount counted against the maximum benefit and not previously restored.

(B) A maximum payment of two hundred thousand dollars for each unrelated injury or sickness.

(2) Payment of benefits up to eighty percent of covered medical expenses which are in excess of the deductible, except that when the combined deductible and other out-of-pocket covered medical expenses not reimbursed by any other hospital, surgical or medical insurance policy, or hospital or medical subscriber contract, or other prepayment plan, exceed two thousand dollars, then payment of benefits shall be at one hundred percent of covered medical expenses.

(3) (A) A deductible which is the greater of one thousand dollars and the benefits deductible.

(B) The term "benefits deductible", as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance

with the requirements of any statute and, if pursuant to subsection (i) hereof, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

(C) The insurer may require that the deductible be satisfied during a period of not less than three months.

(4) (A) The benefit period shall be each calendar year when the maximum payment is determined by subparagraph (A) of paragraph one hereof or twenty-four months when the maximum payment is determined by subparagraph (B) of paragraph one hereof.

(B) For the purpose of determining the benefits payable, the term "covered medical expenses", as used above, is defined as the actual expense incurred, provided however, for hospital room and board charges an insurer may limit the maximum major medical benefit payable to the lesser of the hospital's most common semi-private room and board charge or three hundred thirty dollars per day and, in the case of surgical charges, an insurer may limit the maximum major medical benefit payable to the lesser of seventy-five percent of the prevailing reasonable and customary charges or the benefit payable pursuant to a four thousand five hundred dollar maximum benefit schedule.

(i) The conversion privilege shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in subsections (g) and (h) hereof. At the option of the insurer, such plans of benefits may be provided under one policy.

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

(k) (1) (A) Every group policy delivered or issued for delivery in this state which provides coverage for in-patient hospital care shall provide coverage for home care to residents in this state, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. Such home care coverage shall be included at the inception of all new policies and, with respect to all other policies, added at any anniversary date of the policy subject to evidence of insurability.

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

(C) Home care means the care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a [fig 1] nursing facility as defined in subchapter XVIII of the federal Social Security Act, [42 U.S.C. §§ 1395](#) et

seq, would otherwise have been required if home care was not provided, and the plan covering the home health service is established and approved in writing by such physician.

(D) Home care shall be provided by [fig 1] an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law and shall consist of one or more of the following:

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

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

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

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

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

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

(B) Such policy shall provide benefits for tests ordered by a physician which are performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital, provided that:

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

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

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

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

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

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

(B) In this paragraph, an "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

(5) (A) (i) Every group or blanket policy delivered or issued for delivery in this state which provides hospital, surgical or medical coverage shall include coverage for maternity care, including hospital, surgical or medical care to the same extent that coverage is provided for illness or disease under the policy. Such maternity care coverage, other than coverage for perinatal complications, shall include inpatient hospital coverage for mother and newborn for at least forty-eight hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six hours after a caesarean section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to article one hundred forty of the education law, practicing consistent with a written agreement pursuant to 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.

(6)

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

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

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

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

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

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

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

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

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

(i) Coverage shall be provided for persons whose ages range from twenty-one through forty-four years, provided that nothing herein shall preclude the provision of coverage to persons whose age is below or above such range.

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

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

(iv) Coverage shall be limited to those individuals who have been previously covered under the policy for a period of not less than twelve months, provided that for the purposes of this subparagraph "period of not less than twelve months" shall be determined by calculating such time from either the date the insured was first covered under the existing policy or from the date the insured was first covered by a previously in-force converted policy, whichever is earlier.

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

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

(I) The determination of "infertility" in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

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

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

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

(7) (A) Every group or blanket accident and health insurance policy issued or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a

physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the [fig 1] visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the [fig 2] 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 [fig 3] 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 [fig 4] 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.

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

(8)

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

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

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

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

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

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

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

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

(9) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage must provide coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer, subject to the following:

(i) In the case of a policy that requires, or provides financial incentives for, the insured to receive covered services from health care providers participating in a provider network maintained by or under contract with the insurer, the policy shall include coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, when the attending physician provides a written referral to a non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating appropriate specialist. Provided, however that nothing herein shall impair an insured's rights (if any) under the policy to obtain the second medical opinion from a non-participating specialist without a written referral, subject to the payment of additional coinsurance (if any) required by the policy for services provided by non-participating providers. The insurer shall compensate the non-participating specialist at the usual, customary and reasonable rate, or at a rate listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement.

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

services covered under the policy.

(iii) Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy, and, where applicable, consistent with the provisions of clauses (i) and (ii) of this subparagraph.

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

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

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

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

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

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

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

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

(i) all stages of reconstruction of the breast on which the 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.

(11) [n1]Every policy which provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use 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 for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases 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 with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. Enteral formulas which 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 shall include modified solid food products that are low protein or which contain modified protein which are medically necessary, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars.

(11) [n2]

(A) Every policy which is a "managed care product" as defined in subparagraph (D) of this paragraph that includes coverage for physician services in a physician's office, and every policy which is a "managed care product" that provides major medical or similar comprehensive-type coverage shall include coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, in connection with the detection or correction by manual or mechanical means of structural

imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive than those applicable under the same policy to care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments, even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. Nothing herein contained shall be construed as impeding or preventing either the provision or coverage of chiropractic care and services by duly licensed doctors of chiropractic, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

(B) [Repealed]

(C) Every policy which includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive-type coverage, other than a "managed care product" as defined in subparagraph (D) of this paragraph, shall provide coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive than [than] [n3] those applicable under the same policy to care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments, even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. Nothing herein contained shall be construed as impeding or preventing either the provision or coverage of chiropractic care and services by duly licensed doctors of chiropractic, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

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

care provider, and that services provided pursuant to such a referral be rendered by a health care provider participating in the insurer's managed care provider network, in order for the insured to be entitled to the maximum reimbursement under the contract.

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

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

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

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

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

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

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

- (iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or
- (iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- (v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

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.

(14) No group or blanket policy delivered or issued for delivery in this state which provides medical, major medical or similar comprehensive-type coverage shall exclude coverage for services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article twenty-seven-J of the public health law; provided, however, that reimbursement under such policy for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

(1) (1) Every insurer delivering a group policy or issuing a group policy for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, [42 U.S.C. §§ 1395](#) et seq, must make available and, if requested by the policyholder, provide coverage of supplemental home care visits beyond those provided by part A and part B, sufficient to produce an aggregate coverage of three hundred sixty-five home care visits per policy year. Such coverage shall be provided pursuant to regulations prescribed by the superintendent. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

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

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

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

- (i) the care is provided in a nursing home as defined in section twenty-eight

hundred one of the public health law or a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, [42 U.S.C. §§ 1395](#) et seq;

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

(iii) further hospitalization would otherwise be necessary.

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

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

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

(B) In this paragraph:

(i) "Ambulatory care in hospital out-patient facilities" means services for diagnostic X-rays, laboratory and pathological examinations, physical and occupational therapy and radiation therapy, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy, provided that such services and medications are related to and necessary for the treatment or diagnosis of the patient's illness or injury, are ordered by a physician and, in the case of physical therapy services, are to be furnished in connection with the same illness for which the patient had been hospitalized or in connection with surgical care, but in no event need benefits for physical therapy be provided which commences more than six months after discharge from a hospital or the date surgical care was rendered, and in no event need benefits for physical therapy be provided after three hundred sixty-five days from the date of discharge from a hospital or the date surgical care was rendered.

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

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

(4) (A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, which provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in such policy, by physicians, psychiatrists or psychologists, must make available and if requested by the policyholder provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law [fig 1] . Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) The state board for social work shall maintain a list of all [fig 1] licensed clinical social workers qualified for reimbursement under this paragraph.

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

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state which policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in such policy, by physicians, psychiatrists or psychologists, must provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to [fig 1] subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either (i) [fig 2] three or more additional years [fig 3] experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous or emotional disorders or ailments, or (ii) [fig 4] three or more additional years [fig 5] experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (h) of this section, or (iii) a combination of the experience specified in items (i) and (ii) totaling [fig 6] three years, satisfactory to the state board for social work. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subparagraph.

(5)

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, which provides coverage for inpatient hospital care must make available, and if requested by policyholder provide, coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the following:

(i) with respect to benefits based upon confinement as an inpatient in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law, such benefits may be limited to not less than thirty days of active treatment in any calendar year;

(ii) with respect to benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental hygiene pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the department of mental hygiene, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation thereof, such benefits may be limited to not less than seven hundred dollars in any calendar year.

(B) Such coverage shall be made available at the inception of all new policies and with respect to all other policies and at any anniversary date of the policy subject to evidence of insurability. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

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

(D) In this paragraph, "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental hygiene.

(6) (A) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care must make available and, if requested by the policyholder, provide coverage for the diagnosis and treatment of chemical abuse and chemical dependence, however defined in such policy, provided, however, that the term chemical abuse shall mean and include alcohol and substance abuse and chemical dependence shall mean and include alcoholism and substance dependence, however defined in such policy. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) Such coverage shall be at least equal to the following:

(i) with respect to benefits for detoxification as a consequence of chemical dependence, inpatient benefits in a hospital or a detoxification facility may not be limited to less than seven days of active treatment in any calendar year; and

(ii) with respect to benefits for rehabilitation services, such benefits may not be limited to less than thirty days of inpatient care in any calendar year.

(C) Such coverage may be limited to facilities in New York state which are certified by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission on accreditation of hospitals as alcoholism, substance abuse or chemical dependence treatment programs.

(D) 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.

(E) Such coverage may be subject to annual deductibles and co-insurance as may be deemed appropriate by the superintendent and are consistent with those imposed on other benefits within a given policy. Further, each insurer shall report to the superintendent each year the number of contract holders to whom it has issued policies for the inpatient treatment of chemical dependence, and the approximate number of persons covered by such policies.

(F) Such coverage shall not replace, restrict or eliminate existing coverage provided by the policy.

(7) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery in this state which provides coverage for inpatient hospital care must provide coverage for at least sixty outpatient visits in any calendar year for the diagnosis and treatment of chemical dependence of which up to twenty may be for family members, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. Such coverage may be limited to facilities in New York state [fig 1] certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinics or medically supervised ambulatory substance abuse programs and, in other states, to those which are accredited by the joint commission on accreditation of hospitals as alcoholism or chemical dependence treatment programs. Such coverage may be subject to annual deductibles and co-insurance as may be deemed appropriate by the superintendent and are consistent with those imposed on other benefits within a given policy. Such coverage shall not replace, restrict, or eliminate existing coverage provided by the policy. Except as otherwise provided in the applicable policy or contract, no insurer delivering a group or school blanket policy or issuing a group or school blanket policy providing coverage for alcoholism or substance abuse services pursuant to this section shall deny coverage to a family member who identifies themselves as a family member of a person suffering from the disease of alcoholism, substance abuse or chemical dependency and who seeks treatment as a family member who is otherwise covered by the applicable policy or contract pursuant to this section. The coverage required by this paragraph shall include treatment as a family member pursuant to such family members' own policy or contract provided such family member (i) does not exceed the allowable number of family visits provided by the applicable policy or contract pursuant to this section, and (ii) is otherwise entitled to coverage pursuant to this section and such family members' applicable policy or contract.

(8)

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

(B) In this paragraph, preventive and primary care services means the following services rendered to a dependent child of an insured from the date of birth through the

attainment of nineteen years of age:

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

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

(iii) necessary immunizations as determined by the superintendent in consultation with the commissioner of health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b which meet the standards approved by the United States public health service for such biological products.

(C) Such coverage shall not be subject to annual deductibles and/or coinsurance.

(D) Such coverage shall not restrict or eliminate existing coverage provided by the policy.

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

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

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

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

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

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

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

(11)

(A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state which provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer [fig 1] :

(i) upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or [fig 1] who have a first degree relative with a prior history of breast cancer;

(ii) a single baseline mammogram for covered persons aged thirty-five through thirty-nine, inclusive; and

(iii) an annual mammogram for covered persons aged [fig 1] forty and older.

(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.

(C) For purposes 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.

(11-a)

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

(i) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and

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

(B) Such coverage 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.

(12)

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

(i) the American Medical Association Drug Evaluations;

(ii) the American Hospital Formulary Service Drug Information; or

(iii) the United States Pharmacopeia Drug Information; 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 contra-indicated 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.

(13) Consistent with federal law every insurer delivering a group policy or issuing a group policy for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, [42 USC §§ 1395](#) et seq., shall make available and, if requested by the policyholder, provide coverage for at least

ninety days of care in a nursing home as defined in section twenty-eight hundred one of the public health law, except where such coverage would duplicate coverage that is available under the aforementioned subchapter XVIII. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at each anniversary date of the policy.

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

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

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

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

(14)

(A) Every group or blanket policy delivered or issued for delivery in this state which provides hospital, surgical or medical coverage shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older [fig 1] .

(B) For purposes 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 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.

(15)

(A) Every group or blanket policy delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall include coverage for prehospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to section three thousand five of the public health law.

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

(C) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable.

(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 will 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 (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

(ii) "Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) 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; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

(16) Every group or blanket policy which provides coverage for prescription drugs shall include coverage for the cost of contraceptive drugs or devices approved by the federal food and drug administration or generic equivalents approved as substitutes by such food and drug administration under the prescription of a health care provider legally authorized to prescribe under title eight of the education law. The coverage required by this section shall be included in policies and certificates only through the addition of a rider.

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

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

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

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

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

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

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

religious reasons.

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

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

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

(D) Such coverage may be subject to reasonable annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other drugs or devices covered under the policy.

(m) A group policy providing hospital, surgical or medical expense insurance for other than accident only shall provide that if all or any portion of the insurance on an employee or member insured under the policy ceases because of termination of employment or membership in the class or classes eligible for coverage under the policy, such employee or member shall be entitled without evidence of insurability upon application to continue his hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of benefits and to the following conditions:

(1) Continuation shall [fig 1] cease on the date which the employee, member or dependant first becomes, after the date of election: (A) [fig 2] entitled to coverage under title XVIII of the United States Social Security Act (Medicare) as amended or superseded; or (B) [fig 3] covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent, except the group insurance policy conversion option of this section shall not be considered as such an arrangement under which an employee, member or dependent could become covered.

(2)

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

(B) An employee or member who wishes continuation of coverage under subparagraph (D) of paragraph four of this subsection must give notice to the employer or

group policyholder within sixty days of the determination under title II or title XVI of the United States Social Security Act that such employee or member was disabled at the time of termination of employment or membership or at any time during the first sixty days of continuation of coverage.

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

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

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

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

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

(i) the death of the employee or member;

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

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

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

(D) In the case of an employee or member who is determined, under title II or title XVI of the Social Security Act, to have been disabled at the time of termination of employment or membership or at any time during the first sixty days of continuation of coverage, the date twenty-nine months after the date the employee's or member's benefits under the policy would otherwise have terminated because of termination of employment or membership; provided, however, that if such employee or member is no longer disabled, the benefits provided in this subparagraph shall terminate the later of (i) the date provided by subparagraph (A) of this paragraph, or (ii) the month that begins more than thirty-one days after the date of the final determination under title II or title XVI of the United States Social Security Act that the employee or member is no longer disabled; or

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

(i) The employee or member shall have the right to become covered under that

other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with this subparagraph had a termination described in this subparagraph not occurred, and

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

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

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

(6) This subsection shall not be applicable where a continuation benefit is available to the employee or member pursuant to Chapter 18 of the Employee Retirement Income Security Act, [29 U.S.C. § 1161](#) et seq or Chapter 6A of the Public Health Service Act, [42 U.S.C. § 300](#) bb-1 et seq.

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

(1) If the employee or member insured enters upon active duty as defined in subsection (o) of this section, and the employer or group policyholder does not voluntarily maintain coverage for such employee or member insured, the employee or member insured shall be entitled to have his or her coverage continued under the group policy in accordance with the conditions and limitations contained in paragraph seven of this subsection and have issued at the end of the period of continuation an individual conversion policy subject to the terms of this subsection. The effective date for the conversion policy shall be the day following the termination of insurance under the group policy, or if there is a continuation of coverage on the day following the end of the period of continuation.

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

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

member insured, to the former spouse of such employee or member insured, if such divorce or annulment occurs during the period of active duty.

(4) If the employee or member insured elects the supplementary conversion and continuation right provided for herein or coverage under the group plan is suspended, and such employee or member insured is either reemployed or restored to participation in the group upon return to civilian status, he or she shall be entitled to resume participation in insurance offered by the group pursuant to this section, with no limitations or conditions imposed as a result of such period of active duty except as set forth in subparagraphs (A) and (B) herein. The right of resumption provided for herein shall extend to coverage for the spouse and dependents of the employee or member insured and shall be in addition to other existing rights granted pursuant to state and federal laws and regulations and shall not be deemed to qualify or limit such rights in any way. No exclusion or waiting period may be imposed in connection with coverage of a health or physical condition of a person entitled to such right of resumption, or a health or physical condition of any other person who is covered by the policy unless:

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

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

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

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

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

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

(ii) To elect continuation of coverage pursuant to subsections (e) and (m) of this section, the employee or member insured must request such continuation of the employer within thirty-one days of the termination of active duty or discharge from hospitalization incident to such active duty, which hospitalization continues for a period of not more than one year. Upon commencement of coverage under the continuation right provided pursuant to subsection (e) of this section, coverage under the supplementary continuation

right provided for herein shall terminate. The employee or member insured shall be entitled to have issued at the end of the period of continuation an individual conversion policy.

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

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

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

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

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

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

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

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

(C) an employee or member insured electing continuation pursuant to this subsection must pay to the group policyholder or his or her employer, but not more frequently than

on a monthly basis in advance, the amount of the required premium payment, but not more than the group rate for the benefits being continued under the group policy on the due date of each payment.

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

(A) policies not covered by Chapter 18 of the Employee Retirement Income Security Act, [29 U.S.C. section 1161](#) et seq [seq.] [n4] or Chapter 6A of the Public Health Service Act, [42 U.S.C. section 300bb-1](#) et seq [seq.] [n5];

(B) policies covered by Chapter 18 of the Employee Retirement Income Security Act, [29 U.S.C. section 1161](#) et seq [seq.] [n6] or Chapter 6A of the Public Health Service Act, [42 U.S.C. section 300bb-1](#) et seq [seq.] [n7], when active duty for reservists and the refusal of an employer to voluntarily maintain coverage for such period of active duty is not considered a qualifying event.

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

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

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

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

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

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

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

(B) The policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

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

(D) The insurer is ceasing to offer group or blanket policies in a market in accordance

with paragraph three of this subsection.

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

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

(G) Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

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

(i) the insurer provides written notice to each policyholder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage;

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

(iii) in exercising the option to discontinue coverage of this class and in offering the option of coverage under item (ii) of this subparagraph, the insurer acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.

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

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

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

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

terms of the policy if each of the following conditions is met:

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

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

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

(I) termination of employment;

(II) termination of the other plan or policy;

(III) death of the spouse;

(IV) legal separation, divorce, or annulment;

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

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

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

(6) With respect to group or blanket policies delivered or issued for delivery in this state covering between two and fifty employees or members, the provisions of this subsection shall in no way diminish the rights of such groups pursuant to section three thousand two hundred thirty-one of this article.

HISTORY:

History:

Add, L 1984, ch 367, § 1, eff Sept 1, 1984.

Sub (a), par (15), add, L 1989, ch 689, § 5 (see 1989 note below); amd, L 1997, ch 659, § 77, eff Sept 24, 1997 (see 1997 note below).

Sub (e), par (1), amd, L 1987, ch 306, § 1, eff Sept 1, 1987 (see 1987 note below).

Sub (e), par (3), amd, L 1984, ch 370, § 1, eff Jan 1, 1985, L 1984, ch 869, § 2, eff Aug 5, 1984, and applicable to policies issued, renewed, modified, altered or amended on or after such date.

Sub (e), par (4), amd, L 1993, ch 677, § 1, eff Aug 4, 1993 (see 1993 note below).

Sub (e), par (8), subpar (B), amd, L 1994, ch 344, § 7, eff Sept 1, 1994.

Sub (e), par (11), add, L 1985, ch 369, § 4, eff Jan 1, 1986 (see 1985 note below).

Sub (f), amd, L 1993, ch 677, § 2, eff Aug 4, 1993 (see 1993 note below).

Sub (g), amd, L 1985, ch 268, § 1, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (1), subpar (A), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (1), subpar (B), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (1), subpar (C), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (2), subpar (A), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (2), subpar (B), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (2), subpar (C), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (3), subpar (A), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (3), subpar (B), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (g), par (3), subpar (C), amd, L 1993, ch 677, § 3, eff Sept 1, 1993 (see 1993 note below).

Sub (h), amd, L 1985, ch 268, § 2, L 1993, ch 677, § 4, eff Sept 1, 1993 (see 1993 note below).

Sub (h), par (1), subpar (A), amd, L 1993, ch 677, § 4, eff Sept 1, 1993 (see 1993 note below).

Sub (h), par (1), subpar (B), amd, L 1993, ch 677, § 4, eff Sept 1, 1993 (see 1993 note below).

Sub (h), par (3), subpar (A), amd, L 1993, ch 677, § 4, eff Sept 1, 1993 (see 1993 note below).

Sub (h), par (4), subpar (B), amd, L 1993, ch 677, § 4, eff Sept 1, 1993 (see 1993 note below).

Sub (k), par (1), subpar (C), amd, L 2000, ch 557, § 2, eff March 1, 2001 (see 2000 note below).

The 2000 act deleted at fig 1 "skilled"

Sub (k), par (1), subpar (D), amd, L 2000, ch 557, § 2, eff March 1, 2001 (see 2000 note below).

Sub (k), par (1), subpar (D), opening par, amd, L 2000, ch 557, § 2, eff March 1, 2001 (see 2000 note below).

The 2000 act deleted at fig 1 "a certified home health"

Sub (k), par (1), subpar (D), subpar (iv), amd, L 2000, ch 557, § 2, eff March 1, 2001 (see 2000 note below).

Sub (k), par (4), add, L 1996, ch 705, § 18, eff April 1, 1997 (see 1996 note below).

Former sub (k), par (4), repealed, L 1996, ch 705, § 18, eff April 1, 1997.

Sub (k), par (5), amd, L 1984, ch 404, § 1, eff Jan 1, 1985, and applicable to policies

and contracts issued, renewed or amended on or after such date.

Sub (k), par (5), subpar (A), cl (i), formerly entire subpar (A), so designated and amd, L 1996, ch 56, § 3 (see 1996 note below), L 1997, ch 661, § 3 (see 1997 note below), L 1998, ch 495, § 2, eff July 29, 1998 (see 1998 note below).

Sub (k), par (5), subpar (A), cl (ii), add, L 1996, ch 56, § 3, eff Jan 1, 1997 (see 1996 note below).

Sub (k), par (5), subpar (A), cl (iii), add, L 1996, ch 56, § 3, eff Jan 1, 1997 (see 1996 note below).

Sub (k), par (6), add, L 1990, ch 897, § 2, eff Jan 1, 1991 (see 1990 note below).

Sub (k), par (6), subpar (A), opening par, formerly entire sub (k), par (6), subpar (A), so designated sub (k), par (6), subpar (A), opening par and amd, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (A), cl (i), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (A), cl (ii), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (A), cl (ii), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (B), opening par, formerly entire sub (k), par (6), subpar (B), so designated sub (k), par (6), subpar (B), opening par and amd, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (B), cl (i), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (B), cl (ii), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002

(see 2002 note below).

Sub (k), par (6), subpar (B), cl (ii), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (6), subpar (C), add, L 2002, ch 82, § 1 (Part K), eff Sept 1, 2002 (see 2002 note below).

Sub (k), par (7), add, L 1993, ch 378, § 2, eff Jan 1, 1994 (see 1993 note below).

Sub (k), par (7), amd, L 2003, ch 338, § 3, eff Jan 1, 2004 (see 2003 note below).

Another sub (k), par (7), add, L 1993, ch 380, § 3 (see 1993 note below); repealed, L 1997, ch 177, § 3, eff Jan 4, 1998 (see 1997 note below).

Sub (k), par (7), subpar (A), amd, L 2003, ch 338, § 3, eff Jan 1, 2004 (see 2003 note below).

The 2003 act deleted at figs 1 and 2 "legally blind", at fig 3 "legall" and at fig 4 "cre"

Sub (k), par (7), subpar (C), amd, L 2003, ch 338, § 3, eff Jan 1, 2004 (see 2003 note below).

Sub (k), par (8), add, L 1997, ch 20, § 2, eff Jan 1, 1998 (see 1997 note below).

Sub (k), par (9), add, L 1997, ch 20, § 2, eff Jan 1, 1998 (see 1997 note below).

Sub (k), par (10), add, L 1997, ch 21, § 2, eff Jan 1, 1998 (see 1997 note below).

Sub (k), par (11) [first setout], add, L 1997, ch 177, § 4, eff Jan 4, 1998 (see 1997 note below).

Sub (k), par (11) [second setout], add, L 1997, ch 426, § 3, eff Jan 1, 1998 (see 1997 note below).

Sub (k), par (12), add, L 1998, ch 586, § 40, eff July 1, 1999 (see 1998 note below).

Sub (k), par (13), add, L 2002, ch 554, § 12, eff Jan 1, 2003 (see 2002 note below).

Sub (k), par (14), add, L 2004, ch 114, § 4, eff June 21, 2004.

Sub (l), par (1), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (2), subpar (A), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (2), subpar (C), item i, amd, L 1984, ch 805, § 146, eff Sept 1, 1984.

Sub (l), par (3), subpar (A), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (3), subpar (B), item (i), amd, L 2000, ch 593, § 1, eff Sept 1, 2001 (see 2000 note below).

Sub (l), par (4), subpar (A), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (4), subpar (A), amd, L 2002, ch 420, § 6, eff Sept 1, 2004 (see 2002 note below), L 2004, ch 230, § 16, eff Sept 1, 2004.

The 2004 act deleted at fig 1 "and in addition shall have either: three years post degree experience in psychotherapy, which for the purposes of this paragraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous or emotional disorders or ailments; or three years post degree experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement"

Sub (l), par (4), subpar (B), amd, L 2002, ch 420, § 6, eff Sept 1, 2004 (see 2002 note below).

The 2002 act deleted at fig 1 "certified"

Sub (l), par (4), subpar (D), add, L 1984, ch 990, § 1, eff Jan 1, 1985.

Sub (l), par (4), subpar (D), amd, L 2002, ch 420, § 6, eff Sept 1, 2004 (see 2002 note below), L 2004, ch 230, § 16, eff Sept 1, 2004.

The 2004 act deleted at fig 1 "article one hundred fifty-four", at figs 2, 4 and 6 "six" and at figs 3 and 5 "post degree"

Sub (l), par (5), subpar (A), amd, L 1993, ch 555, § 10, eff July 28, 1993.

Sub (l), par (5), subpar (B), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (6), amd L 1984, ch 806, § 1, eff Sept 1, 1984.

Sub (l), par (6), subpar (A), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (7), amd, L 1984, ch 806, § 1, eff Sept 1, 1984.

Sub (l), par (7), amd, L 2000, ch 565, § 2, eff Jan 20, 2001.
The 2000 act deleted at fig 1 "which are"

Sub (l), par (8), subpar (A), amd, L 1990, ch 21, § 1, L 1993, ch 728, § 2, eff April 1, 1994 (see 1993 note below).

Sub (l), par (9), add, L 1984, ch 996, § 1; amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (10), add, L 1985, ch 569, § 1, eff Jan 1, 1986.

Sub (l), par (10), subpar (A), amd, L 1990, ch 21, § 1, eff Sept 12, 1990.

Sub (l), par (11), add L 1988, ch 692, § 2, eff Jan 15, 1989 (see 1988 note below).

Sub (l), par (11), amd, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

Sub (l), par (11), subpar (A), amd, L 1989, ch 417 § 3, eff Jan 1, 1990 (see 1989 note below).

Sub (l), par (11), subpar (A), opening par, amd, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

The 2002 act deleted at fig 1 ", except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons employed in more than one state"

Sub (l), par (11), subpar (A), cl (i), add, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Sub (l), par (11), subpar (A), cl (i), amd, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

The 2002 act deleted at fig 1 "whose mother or sister has"

Sub (l), par (11), subpar (A), cl (ii), add, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Sub (l), par (11), subpar (A), cl (ii), amd, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

Sub (l), par (11), subpar (A), cl (iii), formerly sub (l), par (11), subpar (A), cl (iv), add, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below); so designated sub (l), par (11), subpar (A), cl (iii) and amd, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

The 2002 act deleted at fig 1 "fifty"

Former sub (l), par (11), subpar (A), cl (iii), deleted, L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

Sub (l), par (11), subpar (A), cl (iv), redesignated sub (l), par (11), subpar (A), cl (iii), L 2002, ch 554, § 5, eff Jan 1, 2003 (see 2002 note below).

Sub (l), par (11), subpar (B), formerly sub (l), par (11), subpar (D), so designated, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Former sub (l), par (11), subpar (B), deleted, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Sub (l), par (11), subpar (C), formerly sub (l), par (11), subpar (E), so designated, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Former sub (l), par (11), subpar (C), deleted, L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1989 note below).

Sub (l), par (11), subpar (D), redesignated sub (l), par (11), subpar (B), L 1989, ch 417, § 3, eff Jan 1, 1989 (see 1989 note below).

Sub (l), par (11), subpar (E), redesignated sub (l), par (11), subpar (C), L 1989, ch 417, § 3, eff Jan 1, 1990 (see 1990 note below).

Sub (l), par (11-a), add, L 2000, ch 601, § 2, eff Jan 1, 2001.

Sub (l), par (12), add, L 1990, ch 853, § 2, eff Jan 1, 1991 (see 1990 note below).

Sub (l), par (13), add, L 1991, ch 165, § 4, eff Dec 8, 1991.

Sub (l), par (14), add, L 1992, ch 771, § 3 (see 1992 note below); amd, L 1993, ch 43, § 2, eff May 17, 1993.

Sub (l), par (14), amd, L 2002, ch 554, § 10, eff Jan 1, 2003 (see 2002 note below).

Sub (l), par (14), subpar (A), amd, L 2002, ch 554, § 10, eff Jan 1, 2003 (see 2002 note below).

The 2002 act deleted at fig 1 ", except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than

one state

Sub (l), par (14), subpar (B), formerly sub (l), par (14), subpar (C), so designated sub (l), par (14), subpar (B), L 1993, ch 43, § 2, eff May 17, 1993.

Former sub (l), par (14), subpar (B), deleted, L 1993, ch 43, § 2, eff May 17, 1993.

Sub (l), par (14), subpar (C), formerly sub (l), par (14), subpar (D), so designated sub (l), par (14), subpar (C), L 1993, ch 43, § 2, eff May 17, 1993.

Former sub (l), par (14), subpar (C), redesignated sub (l), par (14), subpar (B), L 1993, ch 43, § 2, eff May 17, 1993.

Sub (l), par (14), subpar (D), redesignated sub (l), par (14), subpar (C), L 1993, ch 43, § 2, eff May 17, 1993.

Sub (l), par (15), add, L 2001, ch 506, § 2, eff Jan 1, 2002 (see 2001 note below).

Sub (l), par (16), add, L 2002, ch 554, § 15, eff Jan 1, 2003 (see 2002 note below).

Sub (m), add, L 1985, ch 369, § 5, eff Jan 1, 1986 (see 1985 note below).

Sub (m), par (1), amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (1), amd, L 2001, ch 391, § 1, eff Dec 30, 2001.

The 2001 act deleted at fig 1 "not be available for", at fig 2 "any person who is covered, becomes covered or could be covered by" and at fig 3 "an employee, member or dependent who is covered, becomes covered or could become"

Former sub (m), par (2), redesignated sub (m), par (2), subpar (A), L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (2), subpar (A), formerly entire sub (m), par (2), so designated and amd, L 1992, ch 501, § 3 (see 1992 note below); amd, L 1994, ch 344, § 8, eff Sept 1, 1994.

Sub (m), par (2), subpar (B), add, L 1992, ch 501, § 3 (see 1992 note below); amd, L 1997, ch 661, § 4, eff Sept 24, 1997, deemed eff on and after July 1, 1997 (see 1997 note below).

Sub (m), par (3), amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (4), amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (4), subpar (A), amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (4), subpar (C), add, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Former sub (m), par (4), subpar (C), redesignated sub (m), par (4), subpar (E), L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (4), subpar (D), add, L 1992, ch 501, § 3 (see 1992 note below); amd, L 1997, ch 661, § 5, eff Sept 24, 1997, deemed eff on and after July 1, 1997 (see 1997 note below).

Sub (m), par (4), subpar (E), formerly par (4), subpar (C), so designated and amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (4), subpar (E), cl (i), amd, L 1992, ch 501, § 3, eff Jan 1, 1993 (see 1992 note below).

Sub (m), par (6), add, L 1987, ch 210, § 1, eff Aug 6, 1987 (see 1987 note below).

Sub (n), add, L 1991, ch 467, § 23, eff Jan 1, 1992 (see 1991 note below).

Sub (o), add, L 1991, ch 467, § 23, eff Jan 1, 1992 (see 1991 note below).

Sub (p), add, L 1997, ch 661, § 6, eff Sept 24, 1997, deemed eff on and after July 1, 1997 (see 1997 note below).

Sub (q), add, L 1997, ch 661, § 7, eff Sept 24, 1997, deemed eff on and after July 1, 1997 (see 1997 note below).

NOTES:

Notes:

Editor's Notes

This section formerly appeared, in part, as Ins §§ 162, 162-a as added by L 1939, ch 882; 1976, ch 843; amd, L 1941, ch 144; L 1949, ch 600; L 1951, ch 630; L 1958, chs 357, 944; L 1959, ch 583; L 1960, chs 660, 820; L 1961, chs 483, 763, L 1962, ch 475; L 1966, ch 624; L 1971, chs 860, 899; L 1972, ch 918; L 1973, ch 101; L 1975, chs 49, 647; L 1976, chs 928, 929, 955; L 1977, chs 166, 893, 894, 895; L 1979, ch 671; L 1980, ch 246; L 1981, chs 28, 438; L 1982, chs 509, 721, 772; L 1983, ch 595; L 1984, chs 245, 869, 990, 996.

Laws 1985, ch 369, §§ 18, 19, eff Jan 1, 1986, provides as follows:

§ 18. This act shall apply to a group policy issued outside the state to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry, of the type described in paragraph four of subsection (b) of section four thousand two hundred sixteen or subparagraph (D) of paragraph one of subsection (c) of section four thousand two hundred thirty-five, with respect to an employer principally located within the state, when the coverage for such employer becomes effective under the policy on or after January first, nineteen hundred eighty-six. For employers principally located within the state covered under such a group policy on the effective date of this act, this act shall apply to all certificate holders of that employer on the anniversary date of the effective date of coverage of the employer under the policy occurring on or after January first, nineteen hundred eighty-seven.

§ 19. This act shall take effect January first, nineteen hundred eighty-six and shall be applicable to all policies and contracts issued or delivered on or after such date and to all certificates except as stated in section eighteen of this act, issued or delivered on or after such date, regardless of the effective date of the policies or contracts.

Laws 1987, ch 210, § 3, provides as follows:

§ 3. This act shall take effect on the thirtieth day after it shall have become a law and shall be applicable to all group policies and contracts issued or delivered on or after such effective date and, with respect to those group policies and contracts issued or delivered prior to such effective date, on the date such policies and contracts are renewed, modified, altered or amended.

Laws 1987, ch 306, § 6, eff Sept 1, 1987, provides as follows:

§ 6. This act shall take effect on the first day of September next succeeding the date on which it shall have become a law and shall apply to policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1987, ch 444, § 4, eff Jan 1, 1988, provides in part as follows:

§ 4. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply to policies and contracts issued, renewed, modified, altered or amended on or after such date. . .

Laws 1988, ch 692, § 4, eff Jan 15, 1989, provides as follows:

§ 4. This act shall take effect on the fifteenth day of January next succeeding the date on which it shall have become a law and shall apply according to its terms to all policies and contracts issued or renewed on or after such date.

Laws 1989, ch 417, § 5, eff Jan 1, 1990, provides as follows:

§ 5. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1989, ch 689, § 11, eff July 22, 1989, provides as follows:

§ 11. This act shall take effect immediately; except that section 4600 and sections 4605

through 4619 of the public health law, as added by section one of this act, and sections three through ten of this act shall take effect January 1, 1990; and provided further that any regulations that are necessary to effectuate the purposes of this act may be promulgated in accordance with the provisions of this act prior to such date.

Laws 1990, ch 853, § 4, eff Jan 1, 1991, provides as follows:

§ 4. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such effective date.

Laws 1990, ch 897, § 4, eff Jan 1, 1991, provides as follows:

§ 4. This act shall take effect the first day of January next succeeding the date on which it shall have become a law and shall apply according to its terms to all policies and contracts issued or renewed on or after such date, provided, however, effective immediately the superintendent of insurance is authorized to promulgate regulations to implement the provisions of this act.

Laws 1991, ch 467, § 30, eff July 19, 1991, provides as follows:

§ 30. This act shall take effect immediately; provided, however, that no person who is receiving any benefit on such effective date by reason of his or her active duty in the armed forces of the United States during the period of the Korean conflict shall suffer any diminution of such benefit because of amendments made by this act; and provided further that sections one and two of this act shall take effect on August 1, 1991; and provided further that sections twenty-two through twenty-five of this act shall take effect on January 1, 1992 and shall apply to contracts, policies, and certificates of insurance renewed, issued, modified, altered, or amended on and after such date; sections twenty-seven and twenty-eight of this act shall take effect on the sixtieth day after they have become a law; and provided further that sections eighteen, nineteen, twenty and twenty-one of this act shall be deemed to have been in full force and effect on and after August 2, 1990.

Laws 1992, ch 501, §§ 18, 21, eff July 17, 1992, provide as follows:

§ 18. Notwithstanding any other provision of law, and specifically those sections of this act that may be applicable to labor organizations or insurers thereof, nothing contained in

this act shall be applicable to organizations, associations or trusts maintained pursuant to one or more collective bargaining agreements, including, but not limited to, any trust which qualifies as a Taft Hartley Trust pursuant to Title 29 of the United States Code.

§ 21. This act shall take effect immediately; provided, however, that sections three, five, seven, eight, nine, ten and fifteen shall take effect January 1, 1993 and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date; provided further, that sections two, four, thirteen, fourteen and seventeen shall take effect April 1, 1993, except that (i) these sections shall apply to new policies and contracts delivered and coverage effectuated in this state on or after such date, (ii) new policies and contracts delivered in this state and new coverage effectuated in this state on or after the date this act is signed into law, but on or before March 31, 1993, shall have initial rating periods which terminate March 31, 1993 so that these sections will apply to such policies, contracts and coverages as of April 1, 1993, (iii) these sections shall apply to existing policies and contracts delivered in this state and existing coverage effectuated in this state on or after April 1, 1992 but before the date this act is signed into law at their next renewal rating period, (iv) existing policies and contracts delivered in this state and existing coverage effectuated in this state before April 1, 1992 shall have their next renewal rating period terminate March 31, 1993 so that these sections will apply to such policies, contracts and coverages as of April 1, 1993, and (v) in the case of multi-year rating periods which began prior to the effective date of this act, such sections shall apply as of the next renewal rating period, but if the next renewal rating period begins prior to April 1, 1993 that rating period shall terminate March 31, 1993 so that these sections will apply to such policies and contracts as of April 1, 1993 instead; and provided further, that the superintendent of insurance and the commissioner of health may take all actions necessary prior to the effective date of this act for the purposes of timely implementation of this act.

Laws 1992, ch 771, §§ 1, 5, eff Jan 1, 1993, provide as follows:

Section 1. Legislative findings. The legislature finds and determines that there are thousands of cases of cervical cancer each year and that thousands of women die from the disease; that if detected early, cervical cancer is curable; that there is a general consensus among medical professionals that women who have reached eighteen years of age should have an annual pelvic examination and cervical cytology screening ("Pap smear") to detect the presence of cancerous and pre-cancerous cells; and that if women are not promptly diagnosed and treated, it may ultimately lead to prolonged hospitalization or death from cervical cancer.

§ 5. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply according to its terms to all policies and contracts issued or renewed on or after such date.

Laws 1993, ch 378, § 4, eff Jan 1, 1994, provides as follows:

§ 4. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply according to its terms to all policies and contracts issued, renewed, modified, altered or amended on, or after, such date.

Laws 1993, ch 380, §§ 1, 5, 6, eff Jan 1, 1994, provide as follows:

Section 1. Legislative intent and findings. The legislature recognizes that the following aminoacidopathies are rare hereditary genetic metabolic disorders: phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. Lacking in these aminoacidopathies is the body's ability to process or metabolize amino acids. If left untreated or without proper therapeutic management, these disorders cause severe mental retardation and chronic physical disabilities. The only form of treatment is by restricting food intake in order to remove the problem amino acids (which are necessary in the diet) and then replenishing them in carefully controlled measured amounts of a nutritional food substitute. For purposes of this section, nutritional food substitute is defined as any specially formulated food substitute (formula) that is medically necessary to enable the body to process or metabolize needed amino acids, used for the therapeutic treatment of rare aminoacidopathies and administered under close medical supervision.

It is the finding of the legislature that in an attempt to encourage the development of new products, increase availability and reduce cost, formulas were removed from the Federal prescription list and reclassified as "medical foods". An unfortunate side effect has been the reluctance of many insurance companies to cover the cost of these formulas. In instances where coverage is provided, it is random and subject to inconsistent interpretation.

It is not the intent of this legislation to require insurance coverage for normal food products used in the dietary management of these disorders, but to provide for such coverage of formulas that are equivalent to a prescription drug, medically necessary for the therapeutic treatment of such rare hereditary genetic metabolic disorders and administered under the direction of a physician.

In recognition by the legislature that such formulas are medically necessary and critical to the well-being of individuals afflicted with rare hereditary genetic metabolic disorders, it shall be required that every health insurance policy issued in this state shall include such coverage.

§ 5. The superintendent of insurance is authorized to promulgate regulations to implement the provisions of this act.

§ 6. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply according to its terms to all policies and contracts issued or renewed on or after such date.

Laws 1993, ch 677, § 6, eff Aug 4, 1993, provides as follows:

§ 6. This act shall take effect immediately, except that sections one and five of this act shall apply to all contracts, policies and certificates issued, renewed, modified, altered or amended on or after such date; and sections three and four of this act shall take effect September 1, 1993 and shall apply to all contracts, policies and certificates issued, renewed, modified, altered or amended on or after such date.

Laws 1993, ch 728, § 4, eff April 1, 1994, provides as follows:

§ 4. This act shall take effect on the first day of April next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1996, ch 56, §§ 1 and 8, eff Jan 1, 1997, provide as follows:

Section 1. Legislative findings and intent. The legislature finds that certain health insurance carriers, health maintenance organizations, health plans, and hospitals have been restricting maternity coverage and care with respect to the length of hospital stay following delivery in ways that jeopardize the life and health of mothers and newborns and violate reasonable professional standards. The provisions of this act are necessary to provide a reasonable and uniform standard of coverage and care to protect the public health.

The provisions of this act relating to home visits are intended to insure that in those instances where a mother chooses to leave the hospital earlier than the time periods specified in the act, she and the newborn will still receive the full scope of appropriate professional maternity care.

The intent of this act is to require maternity inpatient care providers to offer care, and third-party payers to provide coverage for care, as set out in this act. This act shall not be construed (i) to limit a mother's choice of care for herself and her newborn, (ii) to permit the mother's maternity care coverage to be affected by her choice of care, or (iii) to limit a provider's ability to make reasonable arrangements for care consistent with this act.

§ 8. This act shall take effect January 1, 1997 and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such effective date; provided, however, that any regulations necessary for the implementation of this act on its effective date shall be promulgated on or before such effective date.

Laws 1996, ch 705, § 21, eff Oct 9, 1996, provides as follows:

§ 21. This act shall take effect immediately; provided, however that:

1. Sections three, four, twelve and fourteen of this act, sections 4801 and 4803 of the insurance law, as added by section fifteen of this act, and section twenty of this act shall take effect January 1, 1997.

2. Sections one, two, six, seven, eight, nine, ten, eleven, and thirteen of this act, sections 4802 and 4804 of the insurance law, as added by section fifteen of this act, and sections sixteen, seventeen, eighteen, and nineteen of this act shall take effect April 1, 1997, and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such effective date.

Laws 1997, ch 20, § 6, eff Jan 1, 1998, provides as follows:

§ 6. This act shall take effect January 1, 1998, and sections one through three of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1997, ch 21, § 4, eff Jan 1, 1998, provides as follows:

§ 4. This act shall take effect January 1, 1998, and sections one through three of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1997, ch 177, § 7, eff Dec 25, 1997, provides as follows:

§ 7. This act shall take effect on the one hundred eightieth day after it shall have become a law, and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date.

Laws 1997, ch 426, §§ 1 and 7, eff Jan 1, 1998, provide as follows:

Section 1. Legislative intent. The legislature recognizes that multiple health professions are trained and licensed to diagnose and treat the same or similar conditions through the use of modalities, therapies, services and philosophies that vary from profession to profession. It is the specific intent of this legislature to assure that health insurance policies, plans and contracts that provide coverage for the diagnosis and treatment of conditions, complaints, ailments, disorders or injuries by any health care profession, that may be diagnosed and treated by a doctor of chiropractic, must provide access to and equivalent coverage for the diagnosis and treatment of those conditions, complaints, ailments, disorders or injuries by a duly licensed doctor of chiropractic, within the lawful scope of chiropractic practice even if different terminology, philosophy, services, treatments or modalities are used by the various health professions; and such equivalent coverage shall not be abridged by any regulation heretofore promulgated or to be promulgated.

§ 7. This act shall take effect January 1, 1998 and shall apply to policies and contracts issued, renewed, modified, altered or amended on or after such date; provided, however, that subparagraph (B) of paragraph 21 of subsection (i) of section 3216, subparagraph (B) of paragraph 11 of subsection (k) of section 3221 and of paragraph (2) of subsection (y) of section 4303 of the insurance law, as added by sections two, three and four of this act shall expire and be deemed repealed on December 31, 1999; and upon such date the provisions of subparagraph (C) of paragraph 21 of subsection (i) of section 3216, subparagraph (C) of paragraph 11 of subsection (k) of section 3221 and of paragraph (3) of subsection (y) of section 4303 of the insurance law, as added by sections two, three and four of this act, shall take effect.

Laws 1997, ch 659, §§ 1 and 2, eff Sept 24, 1997, provide as follows:

Section 1. Legislative purpose. The purpose of this act is to facilitate the creation of the necessary components for the development of a broader and more integrated continuum of long term care, financed by a range of private, public and public/private options.

§ 2. This act may be cited as the "Long Term Care Integration and Finance Act of 1997".

Laws 1997, ch 661, § 23, eff Sept 24, 1997, provide as follows:

§ 23. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1997 and sections two through nine, eleven, thirteen through twenty, and twenty-two of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 1998, ch 495, § 4, eff July 29, 1998, provides as follows:

§ 4. This act shall take effect immediately and shall apply to all policies and contracts issued, renewed, altered or modified on and after such date.

Laws 1998, ch 586, §§ 42, 43 and 45 subs 1(a), (b), 2 and 3, eff Aug 5, 1998, provides as follows:

§ 42. Nothing in this act shall bar, limit, impair, diminish or affect in any way any rights or remedies in any judicial or other forum pursuant to state or federal law of any enrollee, whether or not eligible to elect external appeal under this act, for coverage of a health service, including but not limited to an experimental or investigational service, a clinical trial treatment, or provision of a pharmaceutical product pursuant to prescription for a use other than those uses for which such pharmaceutical product has been approved for marketing by the federal Food and Drug Administration. No enrollee may be required to pursue or exhaust external appeal prior to seeking judicial relief.

§ 43. The provisions of this act shall not apply to claims under the workers' compensation law nor shall the provisions of this act be construed to alter, limit, modify, or repeal any provision of such law.

§ 45. This act shall take effect immediately, provided:

1. Sections one through forty-one-e of this act shall take effect July 1, 1999; provided that:

(a) the commissioner of health and the superintendent of insurance may promulgate regulations prior to such date;

(b) a standard or expedited appeal in progress on the effective date of this act shall be subject to the provisions of law in effect when such an appeal was initiated, provided that any final adverse determination pursuant to such an appeal made after the effective date of this act may be externally appealed pursuant to the provisions of this act;

2. Sections thirty-nine through forty-one-a of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date; and.

3. Notwithstanding any contrary provisions of sections 3216, 3221, 3231, 4304, 4305 and 4317 of the insurance law, or of any later amendments or success or provision or regulations or rules that implement said sections, an insurer, company, organization or other entity subject to article forty-nine of the public health law or article forty-nine of the insurance law may elect to unilaterally modify the coverage for a policy or contract of hospital, surgical or medical expense insurance, effective April 1, 2000, to comply with the requirements of sections thirty-nine through forty-one-a of this act without regard to the time of coverage renewal and without providing for the termination, non-renewal or discontinuance of said coverage.

Laws 1999, ch 558, §§ 55-57, eff Oct 5, 1999, provide as follows:

§ 55. Existing rules, policies, and regulations for the reimbursement of alcohol, substance abuse, or chemical dependence costs under the medical assistance program shall remain unchanged until an affirmative action is taken by the department of health, in consultation with the office of alcoholism and substance abuse services, and approved by the division of budget.

§ 56. Continuity of rules, regulations, and other acts. All rules, regulations, acts, orders, determinations, licenses, operating certificates, and decisions of the office of alcoholism and substance abuse services in force at the time of the effective date of this act shall continue in force and effect as rules, regulations, orders, determinations, licenses, operating certificates, and decisions of the office of alcoholism and substance abuse services until duly modified, abrogated, or repealed by such office or the commissioner of alcoholism and substance abuse services.

§ 57. This act shall take effect immediately; provided, however, that nothing contained in this act shall be deemed to affect the application, qualification, expiration, reversion or repeal of any provision of law amended by any section of this act and the provisions of this act shall be applied or qualified or shall expire or revert or be deemed repealed in the same manner, to the same extent and on the same date as the case may be as otherwise provided by law.

Laws 2000, ch 557, § 5, eff March 1, 2000, provides as follows:

§ 5. This act shall take effect 120 days after it shall have become a law and shall apply to policies or contracts issued, renewed, modified, altered, or amended on or after such date (Amd, L 2003, ch 170, § 1, eff June 22, 2003, deemed eff on and after Dec 31, 2003.).

Laws 2000, ch 593, § 8, eff Sept 1, 2001, provides as follows:

§ 8. This act shall take effect on the first day of September next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date.

Laws 2001, ch 506, § 4, eff Jan 1, 2002, provides as follows:

§ 4. This act shall take effect January 1, 2002 and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Laws 2002, ch 82, § 5 (Part K), eff Sept 1, 2002, provides as follows:

§ 5. This act shall take effect September 1, 2002 and shall apply to all policies and contracts issued, renewed or modified on or after such date; provided, however, effective immediately the superintendent of insurance is authorized and directed to promulgate any regulations necessary for the implementation of the provisions of this act.

Laws 2002, ch 420, §§ 9 and 11, eff Sept 1, 2004, provide as follows:

§ 9. Nothing in this act shall prohibit or limit the activities or services on the part of any

person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local government unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except that this section shall be deemed repealed on January 1, 2010. (Amd, L 2003, ch 433, § 1, eff Sept 1, 2004.).

§ 11. This act shall take effect September 1, 2004; and provided, further, however, that the commissioner of education and the board of regents are authorized, prior to such effective date, to promulgate such rules or regulations as may be necessary for the timely implementation of this act.

Laws 2002, ch 554, § 18, eff Jan 1, 2003, provides as follows:

§ 18. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law and shall apply to all policies issued, renewed, modified or altered on or after such date.

Laws 2003, ch 170, § 1, eff July 22, 2003, amended L 2000, ch 557, § 5, so as to delete and expiration provision of Dec 31, 2003, applicable to amendments of subdivision (k), paragraph (1), subparagraphs (C) and (D).

Laws 2003, ch 338, § 5, eff Jan 1, 2004, provides as follows:

§ 5. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

Cross References:

This section referred to in §§ 1101, 1108, 3216, 4235

Definitions, CLS [Men Hyg § 1.03](#)

Regulation and quality control of services for the mentally disabled, CLS Men Hyg Art
31

Definitions, CLS [Pub Health § 2801](#)

Hospitals, CLS Pub Health Art 28

Home care services, CLS Pub Health Art 36

Payments; insurance, CLS [Soc Serv § 367-a](#)

Disability benefits, CLS Work Comp Art 9

Coverage, CLS CLS [Vol Fire Ben § 5](#)

Codes, Rules and Regulations:

Insurance department: minimum standards for an insurance plan qualifying under the long term care security demonstration program. [11 NYCRR §§ 39.1](#) et seq

Insurance department: minimum standards for the form, content and sale of health insurance; dental care exclusion. [11 NYCRR § 52.16](#) (Regulation 62)

Minimum standards for form, content and sale of health insurance. [11 NYCRR §§ 52.1](#) et seq

Disclosure requirements for health insurance. [11 NYCRR §§ 52.54](#) et seq

Insurance department: external appeals of adverse determinations of health care plans. [11 NYCRR Part 410](#) (Regulation 166)

Insurance department: the Health New York and Direct Payment Market Stop-Loss Relief Programs. [11 NYCRR Part 362](#) (Regulation 172)

Federal Aspects:

The Health Insurance Portability and Accountability Act of 1996, cited in statutory text, appears generally as [42 USCS §§ 1320a-7](#) et seq

Research References & Practice Aids:

68 NY Jur 2d, Insurance § 18

69 NY Jur 2d, Insurance §§ 1150, 1356

71 NY Jur 2d, Insurance §§ 2217, 2223, 2224, 2228-2230, 2232, 2233, 2238, 2240, 2246, 2247, 2250, 2254, 2258, 2260, [2327](#)

14A Am Jur Pl & Pr Forms (Rev ed), Insurance, Forms 401-403, 503 et seq

Annotations:

Admissibility against beneficiary of life or accident insurance policy of statements of third persons included in or with proof of death.[1 ALR2d 365](#)

Insurer's demand for additional or corrected proof of loss as waiver or estoppel as to right to assert contractual limitation provision, or as suspending running thereof.[15 ALR2d 955](#)

Time for making autopsy or demand therefor under insurance policy.[30 ALR2d 837](#)

Disability insurance or provision: clause requiring notice of claim within specified time or as soon as reasonably possible, or the like.[17 ALR3d 530](#)

Notice or proof of loss under one policy as notice or proof of loss under another provision of same policy or another policy issued by same insurer.[29 ALR3d 856](#)

Group insurance: Waiver or estoppel on basis of statements in promotional or explanatory literature issued to insureds.[36 ALR3d 541](#)

Validity and effect of choice-of-law provision in group insurance policy.[53 ALR3d](#)

[1095](#)

Payment of premiums by corporation on corporate officer's life insurance policy as affecting right to policy.[56 ALR3d 1086](#)

Group insurance: construction of provision limiting coverage to full-time employees.[57 ALR3d 801](#)

Group Insurance: construction of provision limiting coverage to active employees or to persons working actively in conduct of business.[58 ALR3d 993](#)

Construction of provision in health or accident policy extending coverage to persons "actually in the employ of" the policyholder.[64 ALR3d 1178](#)

Effective date of group life insurance as to individual policies of employees.[66 ALR3d 1175](#)

Medical Care Insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment.[66 ALR3d 1192](#)

Group insurance: binding effects of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds.[6 ALR4th 835](#)

Liability of employer to employee in connection with selection or retention of group insurer.[10 ALR4th 1267](#)

Termination of employee's individual coverage under group policy for nonpayment of premiums.[22 ALR4th 321](#)

Couch on Insurance 2d:

1 Appleman, Insurance Law and Practice, Group Insurance § 46

Texts:

[New York Insurance Law \(Matthew Bender's New York Practice Series\) §§ 1.05\[1b\], \[2a\], 21.02\[4b\], \[d\], 22.05\[6b\], 35.02\[1b\]\[ii\], 35.04\[1ei\]](#)

🚩 Case Notes

- 📌 1. Generally
- 📌 2. Conversion to individual coverage
- 📌 3. --Notice to insured of conversion right
- 📌 4. Maternity care

🚩 1. Generally

CLS [Ins § 3221\(1\)\(6\)\(A\)](#) does not mandate coverage for alcoholism but simply requires group insurers to offer optional added coverage for diagnosis and treatment of alcoholism; thus, self-insured group health benefit plan was not authorized to exclude coverage for alcohol-related illness based on [11 NYCRR § 52.16\(c\)\(2\)](#), which states that "no policy shall limit or exclude coverage by type of illness, accident treatment or medical condition, except...alcoholism...except that coverage must be made available or provided pursuant to section 3221." [Harvey v Members Employees Trust for Retail Outlets \(2001\) 96 NY2d 99, 725 NYS2d 265, 748 NE2d 1061, 26 EBC 1001.](#)

Employment Retirement Income Security Act (ERISA) does not preempt application of CLS [Ins § 3221\(1\)\(6\)\(A\)](#) and [11 NYCRR § 52.16\(c\)](#) to self-insured group health benefit plans, as enforcement of mandated coverage for alcohol-related illness does not conflict with ERISA or congressional objectives in enacting ERISA and thus does not violate Supremacy Clause under express preemption or implied conflict preemption analysis. [Harvey v Members Employees Trust for Retail Outlets \(2001\) 96 NY2d 99, 725 NYS2d 265, 748 NE2d 1061, 26 EBC 1001.](#)

If furnishing of New York tax waiver was condition to payment of benefits under group accidental death policy, insurer had statutory duty to supply such form to beneficiary within 15 days; insurer's failure to do so could not absolve it from liability for interest from date of receipt of proof of loss; if insurer wished to protect itself against possible liability to the state for beneficiary's tax, it could have paid the money into court rather than unjustly retaining use of money by withholding it from beneficiary. [Moody v Continental Casualty Co. \(1975, 4th Dept\) 48 App Div 2d 184, 368 NYS2d 918.](#)

Exclusion, as contained in certificate of insurance, that coverage under credit life policy was excluded for preexisting total disability was not invalid under the Insurance Law on ground that it was not contained in the contract. [Lincoln First Bank v Grabowski \(1975, 4th Dept\) 50 App Div 2d 1074, 376 NYS2d 342.](#)

Provision of Insurance Law that any portion of a group or blanket accident and health policy which purports, by reason of circumstances under which a loss is incurred, to reduce benefit to an amount less than that provided for the same loss occurring under ordinary circumstances is to be printed in the policy and in each certificate issued thereunder in bold face type applies only to the policy and certificate issued thereunder and not to the notice of insurance contained in the contract. [Lincoln First Bank v Grabowski \(1975, 4th Dept\) 50 App Div 2d 1074, 376 NYS2d 342.](#)

Where statute permitted two-year limitation period, it could not be argued that three-year period provided in certificate of insurance was unreasonable or violative of public policy. [Backus v Nationwide Mut. Ins. Co. \(1977, 4th Dept\) 56 App Div 2d 724, 392 NYS2d 765.](#)

Three-year period of limitations, which was provided in certificate of insurance, which was more favorable to former employee than two-year period permitted by the Insurance Law and which was clear, unambiguous and left no room for judicial construction or interpretation, was applicable statute of limitations rather than six-year statute in action brought by former employee of insurance company for specific performance of certificate of insurance after she was denied disability income benefits. [Backus v Nationwide Mut. Ins. Co. \(1977, 4th Dept\) 56 App Div 2d 724, 392 NYS2d 765.](#)

Hospital patient, eligible for medicare as well as benefits under private policy which paid for other medical charges not covered by medicare benefits which were paid to the hospital, was not entitled to recover from his private insurer for the amount that medicare paid directly to hospital even though patient was nominal debtor to hospital in event medicare defaulted in payment, since insurance contract called for insured to pay only those charges for which patient was legally obligated to pay. [Seligman v Guardian Life Ins. Co. \(1977, 1st Dept\) 59 App Div 2d 859, 399 NYS2d 121, app dismd \(1978\) 44 NY2d 646](#) and app dismd [\(1978\) 44 NY2d 838, 406 NYS2d 759, 378 NE2d 122](#) and app dismd without op [\(1978\) 44 NY2d 851.](#)

Insurance company was entitled to summary judgment dismissing action brought by plaintiff to recover under supplemental group insurance policy for injury she sustained while employed at university even though plaintiff, on learning that injury would leave her totally and permanently disabled, reported her condition to university employee responsible for processing claims for benefits, since (1) there was no indication that claims employee was agent of insurer, and even if agency relationship existed, plaintiff failed to allege that she provided requisite written notice under policy, (2) 6-year delay from time of accident to date on which insurer received plaintiff's written notice of claim was clearly not "reasonable," (3) plaintiff's lack of knowledge regarding extent of coverage was not sufficient to raise factual issue as to whether such lengthy delay was reasonable, (4) plaintiff's purported excuse for delay was alleged failures of university, not conduct of insurer, and (5) plaintiff failed to provide adequate explanation as to why she waited over 6 years before seeking further information regarding scope of coverage. [Todd v Bankers Life & Casualty Co. \(1987, 3d Dept\) 135 App Div 2d 1066, 523 NYS2d 206.](#)

Physician was not entitled to additional disability insurance payments where (1) insurance policy provided that maximum period of indemnity was 5 years and that period of total disability which was same as or related to causes of prior period of total disability would be considered to be continuation of prior period, (2) physician suffered hand injury which resulted in disability payments from August 1974 to March 1975, (3) he was permanently incapacitated in August 1981 due to same hand injury, and (4) insurer paid benefits from August 1981 until September 1986 and then terminated payments. [Adrian v Kemper Group \(1990, 3d Dept\) 159 App Div 2d 853, 552 NYS2d 716](#), app den [\(1990\) 76 NY2d 706, 560 NYS2d 988, 561 NE2d 888](#).

Group health insurance policy providing coverage for subscriber's unmarried dependents who are registered students "in full-time attendance" at accredited college until age 25 did not apply, as matter of law, to 21-year old son of plaintiff who, following injury in skiing accident which rendered him permanently and totally disabled, was forced to reduce his full-time attendance at college to one course per semester, even if such course load constituted maximum number of classes he could take due to his disability. [Klein v Empire Blue Cross & Blue Shield \(1991, 3d Dept\) 173 App Div 2d 1006, 569 NYS2d 838](#), app den [\(1991\) 78 NY2d 863, 578 NYS2d 878, 586 NE2d 61](#).

Insurer, which issued group health policy covering employees of certain corporate employer, could not terminate coverage under clause of policy stating that coverage ended when "active employment with the Policyholder ceases" merely because corporate policyholder was taken over in leveraged buyout and, one year later, had its assets seized in foreclosure, resulting in new corporate ownership that continued to operate same business, albeit under new name, with same employees; if there had been any material change in nature of corporation's business, or some risk-enhancing change in insured workforce of corporation, termination of coverage would have been permitted. [Rothstein v Provident Life & Casualty Ins. Co. \(1992, 1st Dept\) 177 App Div 2d 93, 580 NYS2d 746](#), app den [\(1992\) 80 NY2d 752, 587 NYS2d 288, 599 NE2d 692](#).

Plaintiff was entitled to summary judgment in action against her group health insurance company for reimbursement of private duty nursing expenses incurred where private duty nursing was obtained on recommendation by her attending physician, and health insurance policy stated that nursing expenses were considered covered expenses to extent they were recommended by physician and were "essential for necessary care and treatment"; language in policy regarding necessary care and treatment did not give insurance company right to make independent determination as to insured's need for services since policy contained no language reserving such right, no definition of phrase, and no description of criteria on which determination of need was to be based. [Strassberg v Connecticut General Life Ins. Co. \(1992, 3d Dept\) 182 App Div 2d 1055, 583 NYS2d 48](#).

In action against insurance company based on its use of registered nurse to decide which treatments were medically necessary under group medical policy, insurance company was entitled to dismissal of action for punitive damages since plaintiffs did not allege that

insurance company engaged in systematic behavior. [Ackerman v Metropolitan Life Ins. Co. \(1994, 1st Dept\) 204 App Div 2d 88, 611 NYS2d 538.](#)

"Waiver of Premium" provision in disability section of insurance policy pertaining to "any premium which became due under the policy" applied to all parts of policy, including accident and health insurance sections. [Rotblut v Connecticut Gen. Life Ins. Co. \(1996, 2d Dept\) 226 App Div 2d 617, 641 NYS2d 137.](#)

Defendant insurer, which provided health-care coverage through health insurance contract between it and health trust, was not entitled to summary judgment in breach of contract action on basis of shortened limitations period contained in policy of insurance where it was undisputed that insureds were not provided with copy of underlying policy between defendant and health trust and only received benefits booklet, which merely stated that it was intended to provide only general information about policy and that reference should be made to underlying contract which detailed shortened limitations period; under circumstances, fact issue was raised as to whether such direction was sufficient to constitute requisite notice that parties, by written agreement, reduced limitations period for commencement of action against insurer for nonpayment of claims. [New Medico Assocs. ex rel. VanArsdal v Empire Blue Cross & Blue Shield \(1998, 3d Dept\) 249 App Div 2d 760, 671 NYS2d 788.](#)

Insurer, not-for-profit benefit corporation organized and existing under CLS Ins Art 43, was subject to specific notice requirements of CLS [Ins § 3221](#). [New Medico Assocs. ex rel. VanArsdal v Empire Blue Cross & Blue Shield \(1998, 3d Dept\) 249 App Div 2d 760, 671 NYS2d 788.](#)

Preexisting condition exclusion in group long-term disability insurance policy barred coverage of insured's herniated C3-C4 disc where (1) exclusion expressly applied to injury or related injury for which insured consulted with or received advice from licensed medical practitioner during 6 months before effective date of policy, (2) during that period, insured had surgery to remove herniated discs at C4-C5 and C5-C6 levels and to fuse his vertebrae, (3) after effective date of policy, he was diagnosed with herniated C3-C4 disc, (4) before litigation began, his doctor unequivocally stated that C3-C4 herniation was caused by spinal fusion surgery and removal of C4-C5 and C5-C6 discs, (5) after litigation began, same doctor opined that surgery was more than 50 percent responsible for C3-C4 herniation, and (6) term "related" in exclusion would be given its ordinary and accepted meaning. [Sloman v First Fortis Life Ins. Co. \(1999, 2d Dept\) 266 AD2d 370, 698 NYS2d 295.](#)

Preexisting condition exclusion in group long-term disability insurance policy barred coverage of insured's depression where 2 doctors who examined him in connection with his depression concluded that he had preexisting mental condition that was greatly exacerbated by, inter alia, his physical pain and suffering and loss of physical functions directly attributable to his preexisting herniated discs and surgery to remove them and fuse his vertebrae. [Sloman v First Fortis Life Ins. Co. \(1999, 2d Dept\) 266 AD2d 370, 698 NYS2d 295.](#)

Court erred in granting defendant insurer's summary judgment motion, and should have granted summary judgment declaring that insurer was obligated to reimburse plaintiff for medical and hospital bills under medical insurance policy issued by defendant to plaintiff's decedent, despite insurer's disclaimer of coverage on ground that decedent's illness arose from use of alcohol, since CLS [Ins § 3221](#) and its implementing regulations do not allow insurer to exclude coverage for medical conditions which develop as consequence of alcohol use ([11 NYCRR § 52.16\(c\)](#)); further, although insurer provided coverage to decedent under plan under Employee Retirement Income Security Act ([29 USCS § 1001](#) et seq., (ERISA)), requirements of CLS [Ins § 3221](#) and its implementing regulations are not preempted by [ERISA. Harvey v Members Emples. Trust for Retail Outlets \(2000, 2d Dept\) 272 AD2d 575, 708 NYS2d 458](#), app gr [95 NY2d 764, 716 NYS2d 38, 739 NE2d 294](#) and affd [96 NY2d 99, 725 NYS2d 265, 748 NE2d 1061, 26 EBC 1001](#).

Nonparticipating provider physician practicing in Pennsylvania was not intended third-party beneficiary entitled to enforce insurance contract between State of New York and insurer where insurance contract was intended to benefit state employees by providing them and their dependents with medical insurance, policy excluded nonparticipating providers from receiving direct benefits, and nonparticipating providers were to be paid directly by patients and had no relationship with insurer. [Cole v Metropolitan Life Ins. Co. \(2000, 4th Dept\) 273 AD2d 832, 708 NYS2d 789](#).

Patients' assignments of their rights to New York State employees' group medical insurance payments to nonparticipating provider physician practicing in Pennsylvania were void and could not confer standing on physician to sue insurer for such payments where insurance policy contained clear language declaring invalidity of such assignments. [Cole v Metropolitan Life Ins. Co. \(2000, 4th Dept\) 273 AD2d 832, 708 NYS2d 789](#).

Insurer, which reimbursed insured for cost of motorized wheelchair to be used by insured's wife as "medical necessity" under terms of group health insurance plan, was not required to reimburse insured for cost of manually operated wheelchair solely to allow insured and his wife to observe tenets of their Orthodox Jewish faith, which precluded use of motorized vehicle on Sabbath, since needs that arise from individual's religious beliefs must be fulfilled by individual or appropriate religious organization. [Wachtel v Metropolitan Life Ins. Co. \(1988, Dist Ct\) 141 Misc 2d 665, 534 NYS2d 72](#), revd on other grounds (1990, Sup App T) [146 Misc 2d 670, 559 NYS2d 85](#).

Provisions of CLS [Ins § 3221\(a\)\(1\)\(A\)](#) are not applicable to jewelers block policy. [Falcon Crest Diamonds v Dixon \(1996, Sup\) 173 Misc 2d 450, 655 NYS2d 232](#).

As to the contents of a group accident and health insurance policy which insures against disablement, disease, or sickness (excluding disablement which results from accident), N.Y. [Ins. Law § 4235\(b\)](#) mandates that no such policy shall be delivered or issued for delivery in New York unless it conforms to the requirements of N.Y. [Ins. Law § 3221](#).

[Polan v State Ins. Dep't \(2003, App Div, 1st Dept\) 768 NYS2d 441.](#)

Unlike N.Y. [Ins. Law § 4224](#), N.Y. [Ins. Law § 3221](#), entitled "Group or blanket accident and health insurance policies; standard provisions," is aptly included in N.Y. Ins. Law art. 32, entitled "Insurance Contracts-Life, Accident and Health, Annuities," which governs the form and contents of the various types of insurance policies delivered or issued for delivery in [New York. Polan v State Ins. Dep't \(2003, App Div, 1st Dept\) 768 NYS2d 441.](#)

N.Y. Ins. Law § 3221q(1)(b) sets certain minimum requirements for covered policies and prohibits covered insurers from establishing rules for eligibility (including continued eligibility) of any individual or dependent to enroll under a covered policy based upon his or her medical condition (including both physical and mental illnesses); however, nothing in the section prohibits an insurer from offering different terms of coverage for physical or mental illnesses. [Polan v State Ins. Dep't \(2003, App Div, 1st Dept\) 768 NYS2d 441.](#)

There is no requirement that insurance agent request that each insurer participating in its website have electronic version of insurance policies approved by New York if exact language of non-electronic version has already been approved; as to those insurance policies which are subject to filing with and approval by Insurance Department, such as group health insurance policies, statutory and regulatory formatting requirements must be complied with. Insurance Department, Opinions of General Counsel, Opinion Number 00-02-03.

Term "benefits" as used in [11 NYCRR § 52.18\(c\)\(2\)](#) does not include right of member of group insurance plan to receive, from group policyholder, permanent subsidy of his/her health insurance premium. Insurance Department, Opinions of General Counsel, Opinions Number 00-04-01.

New York Insurance Law does not prohibit for-profit insurers that issue accident and health insurance from paying brokers or agents bonuses or other compensation in addition to ordinary commissions paid for facilitating sale of insurance; however, bonuses or other additional compensation to be paid, and criteria established for making such pay ments, must be filed with Insurance Department for Superintendent's approval, in accordance with statutes and regulations relating thereto. Insurance Department, Opinions of General Counsel, Opinion Number 00-10-02.

Provided that conditions contained in [11 NYCRR § 420.3\(e\)\(2\)\(b\)](#) are met, insurer need only provide initial, annual, and revised notices to group policyholder. Insurance Department, Opinions of General Counsel, Opinion Number 01-02-18.

As to nonpublic personal financial information, notice requirements imposed on auto dealer, who was insurer's duly appointed agent and who was also group credit life insurance policyholder, were contained in [11 NYCRR § 420.3\(p\)\(2\)\(i\)](#) and (ii)(c). Insurance Department, Opinions of General Counsel, Opinion Number 01-02-18.

Requirements for insurers and their agents for obtaining authorization for disclosure of nonpublic personal health information are contained in [11 NYCRR § 420.17](#). Insurance Department, Opinions of General Counsel, Opinion Number 01-02-18.

Managed care organization that issues contract in New York is not required to cover court ordered services (i.e. psychological evaluations) for at-risk juvenile beyond limits of its policy or contract. Insurance Department, Opinions of General Counsel, Opinion Number 01-04-02.

Insurance Department does not have jurisdiction to take action against employers who mislead their employees about their health insurance plans. Insurance Department, Opinions of General Counsel, Opinion Number 01-08-03.

Self-funded health benefit plan operated by church organization had to comply with requirements of New York Insurance Law; plan would be considered to be "group policy" under CLS [Ins § 3221](#), but since plan was not health service corporation, it would not be considered to be within purview of CLS [Ins § 4305](#). Insurance Department, Opinions of General Counsel, Opinion Number 01-10-04.

Continuation benefits were among those that self-funded health benefit plan operated by church organization would have to provide under CLS [Ins § 3221\(m\)](#). Insurance Department, Opinions of General Counsel, Opinion Number 01-10-04.

Continuation requirements of CLS [Ins § 3221\(m\)](#) are similar but not identical with those provided under Consolidated Omnibus Budget Reconciliation Act of 1985. Insurance Department, Opinions of General Counsel, Opinion Number 01-10-04.

Self-funded health benefit plan operated by church organization would be exempt from New York Insurance Law if employee contributions were no longer required, and if plan were opt to be subject to Employee Retirement Income Security Act, it would no longer be subject to New York Insurance Law. Insurance Department, Opinions of General Counsel, Opinion Number 01-10-04.

Protections of CLS [Mil § 316](#) do not extend to group health insurance policies; however, group accident and health insurance policies are protected by CLS [Ins §§ 3221](#) and [4305](#). Insurance Department, Opinions of General Counsel, Opinion Number 01-11-08.

Minimum benefits that must be provided in group accident and health insurance policy are set forth in CLS [Ins § 3221\(k\)](#) through (o), further subject to "freedom of choice" requirements under CLS [Ins § 4235\(f\)\(4\)](#). Insurance Department, Opinions of General Counsel, Opinion Number.

New York State Statutory Disability Benefits (DBL) are not included as group coverage for members of Reserves who wish to continue, convert, or suspend their group coverage; DBL coverage is not encompassed within those policies covered by Circular Letter 29 (2001). Insurance Department, Opinions of General Counsel, Opinion Number 01-12-03.

As matter of statutory construction, policies issued to comply with New York Workers' Compensation Law Article 9 are not encompassed within those that are covered by CLS [Ins § 3221\(n\)](#) and (o), and thus Circular Letter 29 (2001). Insurance Department, Opinions of General Counsel, Opinion Number 01-12-03.

Plan administrator, which designs, administers, and implements large "group health self-insured programs," and processes and settles claims, may, under certain circumstances, share its service fee with insurance agent. Insurance Department, Opinions of General Counsel, Opinion Number 02-01-02.

Provided that conditions contained in [11 NYCRR § 420.3\(e\)\(2\)\(v\)\(b\)](#) are met, insurer need only provide initial, annual and revised notices to group policyholder (auto dealer/agent herein); auto dealer/agent's obligations as to meeting notice and opt out requirements are contained in [11 NYCRR § 420.3\(p\)\(2\)\(i\)](#) and (ii)(c). Insurance Department, Privacy Opinions of General Counsel, Opinion Number 01-02-18.

Dental and vision coverages are encompassed within coverage that may be provided to domestic partners of individuals insured under group health insurance policies and contracts. Insurance Department, Opinions of General Counsel, Opinion Number 02-.

There is no conflict between [11 NYCRR § 52.45\(f\)](#) (Regulation 62) and [11 NYCRR § 59.5](#) (Regulation 123) in regards to minimum benefit/loss ratio standard for group and blanket accident and health insurance policies. Insurance Department, Opinions of General Counsel, Opinion Number 02-02-30.

Under both federal and New York State law, employee who is terminated from his or her employment because of reduction in work force is entitled to continuation benefit under former employer's existing group health insurance plan; further, New York law also requires conversion benefit. Insurance Department, Opinions of General Counsel, Opinion Number 02-05-16.

There are no provisions in CLS Pub Health Art 44, [10 NYCRR Part 98](#), or CLS Ins Art 32 mandating time period for participating providers to submit claims to HMOs; any such time limitation should be contained in applicable participating provider contract between provider and HMO. Insurance Department, Opinions of General Counsel, Opinion Number 02-06-21.

There is no provision in CLS Insurance Law permitting physician to submit "revised" claim to HMO for up to 6 years after date of service. Insurance Department, Opinions of General Counsel, Opinion Number 02-06-21.

Regulation 169 ([11 NYCRR §§ 420.0-420.24](#)) would not prohibit licensee from providing group policyholder or policyholder's designated broker with report that lists claim history information, such as date claim was paid and type of provider involved, so long as randomly generated identifier does not identify individual who is subject of

information being disclosed or there is no reasonable basis to believe that such identifier could be used to identify such individual; in such case, under [11 NYCRR § 420.3\(t\)](#), that information would not be "nonpublic personal health information." Insurance Department, Opinions of General Counsel, Opinion Number 02-06-24.

Nothing in either CLS [Ins § 3221](#) or [11 NYCRR § 52](#) (Regulation 62) would prohibit inclusion of provision in group long term disability income policy whereby benefits payable are reduced by amount of Social Security disability benefits payable to certificate holder and his or her spouse and child(ren) as result of insured's disability. Insurance Department, Opinions of General Counsel, Opinion Number 02-06-29.

Disclosure to collection or billing agent retained by health care provider should be treated as any other disclosure to non-affiliated third party. Insurance Department, Opinions of General Counsel, Opinion Number 02-06-06.

"Prudent layperson" standard of CLS [Ins § 4303\(a\)\(2\)](#) would apply to all services rendered in emergency department; however, since statute by its terms only regulates coverage decisions in policies and contracts insuring in-patient hospital care, standard does not serve to provide coverage that would not otherwise exist. Insurance Department, Opinions of General Counsel, Opinion Number 02-07-10.

Whether denial such as "physician build emergency room services are not covered, except for CPR when performed in the emergency room" would be in contravention of Regulation 62 is dependent on coverage provided under policy or contract. Insurance Department, Opinions of General Counsel, Opinion Number 02-07-10.

Assuming that group master policy was subject to approval by New York State Insurance Department, no applicable New York Insurance statute or regulation would prohibit inclusion, in accident and health insurance policy, of provision whereby insurer had right to recover amounts paid to or on behalf of injured party, either from third party tortfeasor or directly from insured, to extent that such amounts were recovered by insured from another source; however, CLS [CPLR § 4545](#) could affect insurer's right to recover in those instances where injured party has had verdict awarding damages for injuries covered under insurance policy. Insurance Department, Opinions of General Counsel, Opinion Number 02-09-07.

Group contract issued by health service corporation must cover annual mammography screening for individuals over age 50, except for contract issued to cover employees employed in more than one state. Insurance Department, Opinions of General Counsel, Opinion Number 02-09-09.

Life insurer would meet its obligation under CLS [Ins § 3221\(a\)\(6\)](#) by issuing electronic version of certificate of insurance to employer (or other group policyholder) where employer has undertaken to deliver certificate of insurance to each group member by placing it on its Intranet and to comply with requirements for disclosure by means of electronic media that are contained in ERISA Regulation ([29 C.F.R. § 2520.104b-1](#)).

Insurance Department, Opinions of General Counsel, Opinion Number 02-10-18.

Employee welfare fund registered with New York Insurance Department in accordance with New York Insurance Law Art 44 is not subject to Women's Health and Wellness Act (Laws 2002, Ch 554). Insurance Department, Opinions of General Counsel, Opinion Number 03-02-24.

Under CLS [Ins §§ 3221\(m\)](#) and [4305\(e\)](#), maximum period of continuation benefits for former employee is 18 months. Insurance Department, Opinions of General Counsel, Opinion Number 03-03-16.

Chiropractic coverage, as mandated under CLS [Ins § 3221\(k\)\(11\)\(A\)](#), may be subject to reasonable deductible, co-payment, and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that such amounts, limits, and review are not more restrictive than those applied to other health professionals and do not function to direct treatment in manner discriminative against chiropractic care. Insurance Department, Opinions of General Counsel, Opinion Number 03-06-05.

Employer may decide to reinstate prescription drug coverage through its insurance policy. Insurance Department, Opinions of General Counsel, Opinion Number 03-06-17.

Insurer may not refuse to add prescription drug coverage; insurer may, under extremely limited circumstances, impose pre-existing condition limitation. Insurance Department, Opinions of General Counsel, Opinion Number 03-06-17.

For most New York residents covered under group health insurance policies and contracts issued out of state, New York does not require that its mandated benefits apply to such insurance policies and contracts. Insurance Department, Opinions of General Counsel, Opinion Number 03-10-23.

New York mandates coverage of numerous specific conditions or procedures by health insurers in CLS [Ins §§ 1118](#), [3221](#), [4235](#), [4303](#), and [4305](#). Insurance Department, Opinions of General Counsel, Opinion Number 04-03-05.

Employer is not obligated to offer continuation of coverage under either group dental insurance policy or group life insurance policy to terminated employee, since dental insurance is not "hospital, surgical or medical expense insurance" under CLS [Ins § 3221\(m\)](#). Insurance Department, Opinions of General Counsel, Opinion Number 04-03-11.

Authorized accident and health insurer may deliver by electronic transmission (i.e., as attachment to e-mail) certificate described in CLS [Ins § 3221\(a\)\(6\)](#) which has been approved by Insurance Department under CLS [Ins § 3201](#) to employer or person in whose name group or blanket accident and health insurance policy has been issued where such employer or person has consented to delivery by electronic transmission. Insurance Department, Opinions of General Counsel, Opinion Number 04-07-02.

Coverage of either in-patient or out-patient hospital care is not necessary condition precedent for imposition of mandated benefits in accident and health insurance policies since there are mandated benefits that do not have such condition, for which see CLS [Ins §§ 3216, 3221](#), and [4235](#). Insurance Department, Opinions of General Counsel, Opinion Number 04-07-09.

✦ 2. Conversion to individual coverage

In a breach of contract action against plaintiff's former employee arising out of the alleged failure to give notice to plaintiff of her right to convert her group insurance coverage to individual coverage, inasmuch as the obligation to notify is statutory and contained in Ins Law § 162 [now § 3221], no cause of action could be maintained for breach of contract. [Jakobsen v Wilfred Laboratories, Inc. \(1984, 2d Dept\) 99 App Div 2d 525, 471 NYS2d 306.](#)

In an action on a group policy, which provided that, on termination of active employment, the policy should automatically terminate unless the employee within 31 days after such termination shall apply for an individual policy, evidence held to show that deceased employee, who had not applied for an individual policy after failing to report for work, quit work because of a strike and not because of illness, and his beneficiary was therefore not entitled to recover on the policy. Under a group policy providing that, on termination of active employment by an insured employee, his insurance shall automatically terminate and the insurer be released from further liability thereon, unless within 31 days of the termination of his employment he applies for and pays the premium on an individual policy, an insured employee is bound to know his rights as respects demanding an individual policy on leaving his employment, and no cancellation by the company is necessary. [Chrosniak v Metropolitan Life Ins. Co. \(1923\) 121 Misc 453, 201 NYS 211, affd \(1924\) 209 App Div 846, 204 NYS 898.](#)

Cases construing [Insurance L § 204](#), subd 3 [now § 3220(a)(8) and § 4216] apply equally to Insurance L § 162, subd 5 [now § 3221(e)]. [Antinora v Nationwide Life Ins. Co. \(1973\) 76 Misc 2d 599, 350 NYS2d 863.](#)

Conversion policy or contract need not provide same benefits as were provided in former group policy or contract. Insurance Department, Opinions of General Counsel, Opinion Number 02-03-16.

While insurer need not provide continuation benefit beyond that mandated by statute, it may, if requested by employer, provide extended continuation period; whether public employer is required to request such continuation from insurer is not governed by Insurance Law or regulations. Insurance Department, Opinions of General Counsel, Opinion Number 02-03-16.

3. --Notice to insured of conversion right

Where decedent, in his lifetime, was issued a certificate of life insurance under a group insurance policy issued to the trustee of a labor union of which he was a member, and stopped working on December 30, 1958, to enter a hospital where he died on May 14, 1959, becoming ineligible for coverage under the insurance policy April 1, 1959, because his employer was thereafter making no contributions toward his insurance, but was not notified of his lack of coverage and conversion rights extending the conversion privilege of such a certificate holder for 90 days after termination of coverage in the absence of notice given to him by the insurer concerning his conversion privileges, the policy was still in effect as to decedent at date of his death. [De Ville v Continental Assurance Co. \(1960\) 8 NY2d 1080, 207 NYS2d 453, 170 NE2d 457.](#)

As to certain types of group insurance, such as policies issued to labor union trustees, the amendments of 1940, 1947, and 1948 of former §§ 161 and 204 of this act practically made obsolete policy provisions which simply grant a 31-day conversion privilege following termination of eligibility of a certificate holder, and an insurer issuing a group policy in this category which fails to notify a member of conversion rights within the stated period for conversion assumes the risk of the certificate holder's death within 90 days. [De Ville v Continental Assurance Co. \(1960, 4th Dept\) 10 App Div 2d 386, 199 NYS2d 876, affd \(1960\) 8 NY2d 1080, 207 NYS2d 453, 170 NE2d 457.](#)

Assuming, without deciding, that group health insurer, on terminating group coverage, was required to notify insured of conversion option for same coverage on direct pay basis under CLS [Ins § 3221\(e\)\(8\)\(A\)](#), no cause of action could be maintained by insured for breach of contract based on absence of such notification since duty is statutory rather than contractual. [Klein v Empire Blue Cross & Blue Shield \(1991, 3d Dept\) 173 App Div 2d 1006, 569 NYS2d 838, app den \(1991\) 78 NY2d 863, 578 NYS2d 878, 586 NE2d 61.](#)

A motion for summary judgment requiring the insurer to pay over proceeds of a group insurance policy was granted as the statute required the employer to give employees knowledge of their right to convert from group insurance to individual life insurance after termination of employment and if the insured failed to give notice, the conversion was extended to 90 days and the policy deemed amended at least to the extent of fixing the conversion privilege period of 90 days so that a notice set two days after the insured's death thereby made the group life policy still effective. [Miller v Metropolitan Life Ins. Co. \(1970\) 64 Misc 2d 658, 315 NYS2d 353.](#)

Under Insurance L § 143 [now § 3103], provisions of Insurance L § 162, subd 5 [now § 3221(e)] applied to group insurance policy, issued to New York resident by Ohio corporation, which stated that Ohio law applied, and which failed to inform insured of his conversion rights. [Antinora v Nationwide Life Ins. Co. \(1973\) 76 Misc 2d 599, 350 NYS2d 863.](#)

Where employer does not have knowledge or is not in control of event triggering employee's conversion rights under group life policy, employer is not in position to notify

employee of his or her rights under policy and thus employer is not liable for its failure to act in absence of such information. [Van Ostrand v National Life Assurance Co. \(1975\) 82 Misc 2d 829, 371 NYS2d 51.](#)

Where other employees' knowledge of employee's divorce and involvement in divorce proceedings was not acquired in scope of their employment nor was it their duty to report such information to employer, fact that other employees had such knowledge was not sufficient notice to justify imposition of liability on employer for its failure to inform employee of her conversion rights under group life policy upon her divorce with respect to policy taken out on life of employee's spouse. [Van Ostrand v National Life Assurance Co. \(1975\) 82 Misc 2d 829, 371 NYS2d 51.](#)

While parties stipulated that group insurance coverage was part of a "compensation package" and not a negotiated fringe benefit, such benefits are commonly a substitute for direct cash wages and cannot be classified as mere gratuity, in determining whether national association of manufacturers and manufacturers' group trust fund who acted for group insurer, were negligent in failing to notify an employee of a member of association of his conversion rights upon expiration of the group insurance. [Reger v National Asso. of Bedding Mfrs. Group Ins. Trust Fund \(1975\) 83 Misc 2d 527, 372 NYS2d 97.](#)

Under New York law, the absence of affirmative notification subsequent to the termination of employment conferred upon deceased the right to convert for 90 days after the termination of coverage, and death before the expiration of 90-day period is deemed the exercise of the right of conversion. [Oakley v National Western Life Ins. Co. \(1968, SD NY\) 294 F Supp 504.](#)

✚ 4. Maternity care

Chapter 843 of the Laws of 1976 [now § 3221(k)(5)], which mandates the inclusion of maternity care coverage in health and accident insurance policies written, altered, amended or renewed after January 1, 1977, may not constitutionally be applied to policies issued before its effective date as "guaranteed renewable policies", i.e., policies renewable at the sole option of the insured, because of the constitutional restrictions on impairment of obligations of contracts. [Health Ins. Asso. v Harnett \(1978\) 44 NY2d 302, 405 NYS2d 634, 376 NE2d 1280.](#)

Chapter 843 of the Laws of 1976 [now § 3221(k)(5)], which mandates the inclusion of maternity care coverage in health and accident insurance policies issued after January 1, 1977, is not unconstitutional as to its substantive provisions, but may not constitutionally require the addition of such coverage to policies in existence before that date and thereafter renewed, if the renewal is at the option of the insured alone without the consent of the insurer. [Health Ins. Asso. v Harnett \(1978\) 44 NY2d 302, 405 NYS2d 634, 376 NE2d 1280.](#)

Insurance carriers and their trade association, challenging the constitutionality of chapter

843 of the Laws of 1976 [now § 3221(k)(5)], which mandates the inclusion of maternity care coverage in health and accident insurance policies issued after January 1, 1977, and which was enacted to remedy the absence of adequate insurance coverage for rapidly rising maternity care costs falling on young families usually of moderate income, have failed to establish that the chapter is unfair, unjust or arbitrary and thus a deprivation of due process; the choice of means to meet the objective of making maternity care coverage widely available was within the legislative prerogative, and, absent an unconstitutional selection, the wisdom of the Legislature in exercising its discriminating authority is beyond the scope of judicial review. [Health Ins. Asso. v Harnett \(1978\) 44 NY2d 302, 405 NYS2d 634, 376 NE2d 1280.](#)

Plaintiff failed to state a cause of action against an insurer for alleged violations of Ins Law § 162-a [now § 3221(k)(5)] on the asserted grounds that a group health insurance policy delivered or issued for delivery to a policy holder outside New York but insuring a New York resident must contain mandated maternity care coverage, since only group health insurance policies "delivered or issued for delivery" in New York must provide such coverage. [Bernstein v Mutual of New York \(1982, Sup\) 115 Misc 2d 591, 454 NYS2d 527.](#)

Full medical insurance benefits under group medical plan would be awarded to employee whose wife became pregnant and entered into agreement with her doctors to pay set fee for treatment throughout pregnancy, including delivery, and who made some, but not all, payments under that agreement prior to time husband left his employment several months before birth; since wife had incurred her costs when she signed agreement with her doctors, and since policy indicated ". . . any claim which is incurred before the major medical expense coverage ends will not be affected [by termination of coverage]," employee was entitled to reimbursement, less normal co-insurance, for doctors' full fee. [Lazer v Metropolitan Life Ins. Co. \(1986, Dist Ct\) 133 Misc 2d 1104, 509 NYS2d 243.](#)

FORMS

Form 1 -- Introductory Allegation in Action Against Insurance Company

Form 2 -- Particular Allegation as to Compliance by Plaintiff With Conditions Precedent in Policy

Form 3 -- Particular Allegations as to Payment of Premiums Other Than First Premium

Form 1

Introductory Allegation in Action Against Insurance Company

Upon information and belief, at all the times hereinafter mentioned, the defendant was and still is a corporation duly organized and existing under and by virtue of the laws of the State of [-----] and duly authorized to carry out on the business of [-----] [particular kind of] insurance in the State of New York, and at all times hereinafter mentioned was engaged in carrying on such business in the City of [-----] .

Form 2

Particular Allegation as to Compliance by Plaintiff With Conditions Precedent in Policy

Plaintiff has duly performed all the conditions of the said policy on his part.

-or-

Plaintiff and the said [-----] [the insured] have duly performed all the conditions of the said policy on their part.

Form 3

Particular Allegations as to Payment of Premiums Other Than First Premium

Said policy of insurance was continued in force by the payment of each annual premium of [-----] dollars by the said [-----] to defendant and by the receipt of the same and the issuance of the regular receipt therefor and a certificate, duly countersigned by a duly authorized representative of the company, each year, continuing said policy in force by defendant up to noon [-----] , 19 [--] .

[n1] There are two paragraphs (11).

[n2] There are two paragraphs (11).

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