

§ 4235. Group accident and health insurance. (a) (1) Any policy of insurance against death or injury resulting from an accident which covers more than one person, except blanket accident insurance policies as defined in section four thousand two hundred thirty-seven of this article and accident and health insurance policies conforming to subsections (a), (b) and (c) of section three thousand two hundred sixteen of this chapter, shall be deemed a group accident insurance policy.

(2) Any policy which insures against disablement, disease or sickness (excluding disablement which results from accident), and which covers more than one person, except blanket health insurance policies as defined in section four thousand two hundred thirty-seven of this article and accident and health insurance policies conforming to subsections (a), (b) and (c) of section three thousand two hundred sixteen of this chapter, shall be deemed a group health insurance policy.

(3) Any policy of insurance which combines the coverage of group accident insurance and of group health insurance shall be deemed a group accident and health insurance policy.

(b) No policy of group accident, group health or group accident and health insurance, and no certificate thereunder, shall be delivered or issued for delivery in this state unless it conforms to the requirements of section three thousand two hundred twenty-one of this chapter and with the exception of a group policy or contract of insurance issued pursuant to article nine of the workers' compensation law, unless it conforms to the requirements of subsection (c) of this section.

(c) (1) No policy of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this state unless it conforms to one of the following descriptions:

(A) A policy issued to an employer or to a trustee or trustees of a fund established by an employer, which employer or trustee or trustees shall be deemed the policyholder, insuring with or without evidence of insurability satisfactory to the insurer, employees of such employer, and insuring, except as hereinafter provided, all of such employees or all of any class or classes thereof determined by conditions pertaining to the employment or a combination of such conditions and conditions pertaining to the family status of the employee, for insurance coverage

on each person insured based upon some plan which will preclude individual selection. However, such a plan may permit a limited number of selections by employees if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable. The premium for the policy shall be paid by the policyholder, either from the employer's funds, or from funds contributed by the insured employees, or from funds contributed jointly by the employer and employees. If all or part of the premium is to be derived from funds contributed by the insured employees, then such policy must insure not less than fifty percent of such eligible employees or, if less, fifty or more of such employees when such policy is providing coverage for group hospital, medical, major medical or similar comprehensive types of expense reimbursed insurance and, for all other types of group accident and health insurance, must insure a minimum of fifty percent or five of such eligible employees, whichever is fewer.

(B) A policy issued to a trustee or trustees of a fund established by, or participated in, by the employer members of a trade association, which trustees shall be deemed the policyholder, for the sole benefit of the employees of such employers, the policy must conform subject to the following requirements:

(i) The policy may be issued only if:

(I) the association has been in existence for at least two years and was formed for purposes principally other than obtaining insurance, and

(II) the participating employers, meaning such employer members whose employees are to be insured, constitute at date of issue at least fifty percent of the total employers eligible to participate, unless the total number of persons covered at date of issue exceeds six hundred, in which event such participating employers must constitute at least twenty-five percent of such total employers, in either case omitting from consideration any employer whose employees are already insured under a similar group accident and health insurance policy.

(ii) The persons eligible for insurance under the policy shall be all of the employees of the participating employers, or all of any class or classes thereof determined by conditions pertaining to their employment.

(iii) The premium for the policy shall be paid by the trustee or trustees either from funds contributed by the employers or by the

employees; or funds contributed jointly by the employers and the employees. A policy on which no part of the premium so payable is to be derived from funds contributed by the insured employees must insure all eligible employees.

(iv) The policy must cover at least fifty employees at date of issue.

(v) The insurance coverage under the policy must be based upon some plan precluding individual selection either by the employees or by the policyholder or the employer. However, such a plan may permit a number of selections by the employer if the selections offered utilize consistent plans of coverage so the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections by employees if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable.

(C) A policy issued to a labor union, which shall be deemed the policyholder, insuring, with or without evidence of insurability satisfactory to the insurer, members of such union and insuring, except as hereinafter provided all of such members or of any class or classes thereof determined by conditions pertaining to their employment or membership in the union or both for amounts of insurance on each person insured based on a plan precluding individual selection, provided however, such a plan may permit a limited number of selections by members if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable, and not less than fifty percent of all eligible union or, if less, fifty or more of such eligible members are insured.

(D) A policy issued to a trustee or trustees of a fund established, or participated in, by two or more employers or by one or more labor unions, or by one or more employers and one or more labor unions, which trustee or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(i) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both.

(ii) The premium for the policy shall be paid by the trustee or trustees either wholly from funds contributed by the employer or employers of the insured person or by the union or unions, or by both, or jointly from such funds and funds contributed by the insured persons specifically for their insurance or from contributions by the insured persons. A policy on which all or part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force only if it insures not less than fifty percent of the then eligible persons, or, if less, fifty or more of such eligible persons excluding any as to whom evidence of individual insurability is not satisfactory to the insurer. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer.

(iii) The policy shall insure at least fifty persons at date of issue, except that if part of the premium is to be derived from funds to be contributed by the insured persons specifically for their insurance the policy shall insure at least one hundred employees or members at date of issue.

(iv) The insurance coverage under the policy shall be based upon some plan precluding individual selection either by the insured persons or by the policyholders, employers, or unions. However, with respect to a policyholder, employer or union, such plan may permit a number of selections by the policyholder, employer or union, if the selections offered utilize consistent plans of coverage so that the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections by insured persons if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable.

(v) With respect to a policy issued to a trustee or trustees of a fund established by one or more labor unions, or by one or more employers and one or more labor unions the proposed insured must submit, and the insurer must obtain, a written certification that a reasonable number of comparative bids have been obtained from different insurers and that such bids have been considered by the trustees before making a decision concerning which bid to accept. Such decision must be made at a

trustees' meeting held on a date certain, and a copy of the minutes of such meeting must be attached to such certification.

(E) A policy issued to a creditor, vendor, (including the parent holding company of such creditor or vendor), trustee, trustees or agent insuring a group of debtors or vendees, (including coverage on the spouse of a debtor or vendee), all as defined and set forth in paragraph three of subsection (b) of section four thousand two hundred sixteen of this article and under the same conditions and limitations and subject to the definitions as specified therein; provided, however, that the amount of indemnity payable with respect to any person insured thereunder shall not at any time exceed:

(i) in all cases except as hereinafter provided the lesser of thirty thousand dollars and the amount of unpaid indebtedness due from or the amount of the purchase price unpaid by such person;

(ii) in the case of a loan commitment pursuant to a program for defraying the cost of attendance of a student at a college or university or at an elementary or secondary school providing education required for minors as described in said paragraph, the lesser of thirty thousand dollars and the total of the unpaid balance of the scheduled periodic payments whether due or not due and the amount of any outstanding loan commitment pursuant to such a program; or

(iii) in the case of a transaction secured by a real estate mortgage, the lesser of the sum of seventy-five thousand dollars and the amount of the indebtedness so secured.

(F) A policy issued to a social services district pursuant to section three hundred sixty-seven-a of the social services law.

(G) A policy issued to the state of New York insuring, with or without evidence of individual insurability satisfactory to the insurer, persons who are managerial or confidential employees, or retired managerial or confidential employees, of governments or public employers for the purposes of article fourteen of the civil service law. The state shall be deemed to be the policyholder. With respect to its employees, the state and each other participating government or public employer shall be deemed to be the employer. The premiums on such policy may be paid by the employer, by the employees, or by the employer and employees jointly. If the premiums are derived from funds contributed wholly by the employer, the policy must insure all eligible employees. If all or

part of the premium is to be derived from funds contributed by insured employees, then such policy must insure not less than forty percent of such employees, the calculation being with respect to each employer individually. The insurance coverage may be based upon a plan which permits a limited number of selections by the employees. The provisions of subsections (d), (h), (i) and (j) hereof shall not apply to a policy issued pursuant to this subparagraph.

(H) A policy issued to an association, or to a trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations, all of whose eligible members have the same profession, trade or occupation, which association or associations have been organized and maintained in good faith for purposes principally other than that of obtaining insurance and have been in active existence for at least two years. The policy shall insure members, or employees of members, of such association or associations for the benefit of persons other than employers and the association or associations, or any officials, representatives, trustees or agents thereof and shall provide for the issuance of a certificate to the persons insured or such beneficiary as evidence of such insurance. The members or employees eligible for the insurance under the policy shall be all the members, or all the members and their employees, or all of any class or classes thereof determined by conditions pertaining to their employment or to association membership or both. The premiums for the policy shall be paid from association or members' funds, or partly from such funds and partly from funds contributed by the insured individuals, or from funds wholly contributed by the insured individuals. A policy on which all or part of the premium is to be derived from funds contributed by the insured individuals specifically for their insurance must insure at least fifty percent of the then eligible individuals or a minimum of two hundred individuals, whichever is less, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer. A policy on which no part of the premium is to be derived from funds contributed by the insured individuals specifically for their insurance must cover all eligible individuals, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer. In every case the policy must cover at least one hundred individuals at date of issue. The insurance coverage on employees insured under the policy

shall be based upon some plan precluding individual selection. However, with respect to such fund, or association or associations, such a plan may permit a number of selections by the fund, association or associations if the selections offered utilize consistent plans of coverage so that the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections offered by employees or members if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable. If a policy dividend is declared or a reduction in rate is made under such a policy, the excess, if any, of the aggregate dividends or rate reductions under the policy over the aggregate expenditure for insurance under such policy made from association or employer funds, including expenditures made in connection with administration of such policy, shall be applied by the policyholder for the sole benefit of the insured individuals. A policy issued pursuant to this subparagraph shall provide a conversion privilege no less favorable than that provided for in subsection (e) of section three thousand two hundred twenty-one of this chapter.

(I) A policy insuring persons employed under 32 U.S.C. § 709, members of the national guard on full-time training duty under title 32 of the United States Code, or on active duty or active duty for training under title 10 of the United States Code, under the full-time manning program, issued to the adjutant general, who shall be deemed the policyholder, or to a trustee or trustees of a fund established, created, or maintained for the benefit of such individuals insured, which trustee or trustees shall be deemed the policyholder, the premium of which is to be paid by the individuals insured either directly or by deduction from wages or salary. The policy must insure at least fifty percent or four hundred of the individuals eligible for such insurance, whichever is less. Such policy shall provide for the payment of benefits, to the individual insured or to some beneficiary or beneficiaries other than to the aforesaid trustees or the adjutant general. The policy shall also provide for the issuance of a certificate of insurance to the individual insured or to such beneficiary, as evidence of such insurance. The insurance coverage may be based upon a plan which permits a limited number of selections by the insured member, if the selections offered utilize consistent plans of coverage so that the resulting plans of

coverage are reasonable.

(J) Under a policy issued by an insurer to a trustee or to the trustees of a trust, established or adopted by two or more individuals who are entitled to a right of conversion, pursuant to subsection (e) of section three thousand two hundred twenty-one of this chapter or under the terms of a contract covering residents of New York, which trustee or trustees shall be deemed to be the policyholder, to insure such individuals, subject to the following requirements:

(i) The policy must cover at least twenty-five individuals during the first policy year.

(ii) The benefits provided under the policy shall be those required by subsection (f), (g) or (h) of section three thousand two hundred twenty-one of this chapter.

(iii) In lieu of the coverage requirements of subsections (k) and (l) of section three thousand two hundred twenty-one of this chapter and subparagraphs (B), (C), (D), (E) and (F) of paragraph four of subsection (f) of this section, the coverage requirements of paragraphs one through ten of subsection (i) and the requirements of subsection (j) of section three thousand two hundred sixteen of this chapter shall be applicable to such policy.

(iv) If a policy dividend is declared or a reduction in rate is made under such a policy, it shall be applied by the policyholder for the sole benefit of the insured individuals.

(K) A policy issued to an association or the trustee or trustees of a trust established, or participated in, by one or more associations, to insure association members, subject to the following:

(i) Each association shall have:

(I) A minimum of two hundred insured members at the policy's date of issue;

(II) Been organized and maintained in good faith for purposes principally other than that of obtaining insurance;

(III) Been in active existence for at least two years; and

(IV) A constitution and by-laws which provide that:

(aa) The association hold regular meetings not less than annually to further the purposes of the association;

(bb) The association collect dues or solicit contributions from members; and

(cc) The members have voting privileges and representation on the governing board and committees.

(ii) The premium for the policy shall be paid by the association or the trustees either wholly from funds contributed by the association or by the insured individuals, or from funds contributed jointly by the association and insured individuals. A policy on which no part of the premium is to be derived from funds contributed by the insured individuals specifically for their insurance must insure all eligible individuals excluding any as to whom evidence of individual insurability is not satisfactory to the insurer.

(iii) The amount of insurance under the policy shall be based upon some plan precluding individual selection either by the insured members or by the association. However, with respect to an association, such a plan may permit a number of selections by the association if the selections offered utilize consistent plans of insurance so that the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections by insured members if the selections offered utilize consistent plans of insurance for individual group members so that the resulting plans of coverage are reasonable.

(iv) Except as provided in subsection (e) of this section, such policy shall provide for the payment of benefits to the person insured or to some beneficiary or beneficiaries other than the association or any officials, representatives, trustees or agents thereof and shall provide for the issuance of a certificate to the association for delivery to the member or such beneficiary, as evidence of such insurance.

(v) The premiums charged must be reasonable in relation to the benefits provided.

(L) A policy issued to any organization, or the trustee or trustees of a trust established, or participated in, by one or more of such organizations, to insure certain persons subject to the following:

(i) The organization must be:

(I) A bank, retailer or other issuer of a credit card, charge card or payment card which can be used to buy goods or services, and the policy must insure holders of that card;

(II) A bank, savings and loan association, credit union, mutual fund, money market fund, stockbroker or other similar financial institution regulated by state or federal law, and the policy must insure the

depositors, account holders or members of that institution.

(ii) Except for a credit union where the premium shall be paid entirely from funds contributed by the credit union, the organization or organizations shall have a minimum of two hundred insured persons at the policy's date of issue.

(iii) The premium for the policy shall be paid by the organization or trustees either wholly from funds contributed by the organization or by the insured individuals, or from funds contributed jointly by the organization and insured individuals. A policy on which no part of the premium is to be derived from funds contributed by the insured individuals specifically for their insurance must cover all eligible individuals excluding any as to whom evidence of individual insurability is not satisfactory to the insurer.

(iv) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the insured persons or by the organization. However, with respect to an organization, such a plan may permit a number of selections by the organization if the selections offered utilize consistent plans of insurance so that the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections by members if the selections offered utilize consistent plans of grading the amounts of insurance for individual group members so that the resulting plans of coverage are reasonable.

(v) Except as provided in subsection (e) of this section, such policy shall provide for the payment of benefits to the person insured or to some beneficiary or beneficiaries other than the organization, or any officials, representatives, trustees or agents thereof, and shall provide for the issuance of a certificate to the persons insured or such beneficiary, as evidence of such insurance.

(vi) The premium charged must be reasonable in relation to the benefits provided.

(M) A policy issued to insure any other group approved by the superintendent upon a finding that: (i) there is a common enterprise or economic or social affinity or relationship; (ii) the premiums charged are reasonable in relation to the benefits provided; and (iii) the issuance of the policy would result in economies of acquisition or administration, would be actuarially sound, and would not be contrary to

the best interest of the public. The superintendent shall promulgate regulations setting forth any such groups that have been accepted as qualifying pursuant to this subparagraph.

(N) A policy issued to a continuing care retirement community covering at least fifty percent of the residents of the community, in conjunction with a continuing care retirement contract described in section four thousand six hundred one of the public health law.

(2) For the purpose of complying with the participation requirements prescribed in subparagraphs (A), (B), (C), (D) and (G) of paragraph one of this subsection, the provisions of this subsection are to be construed as permitting the issuance of more than one policy or contract when offered as alternatives to the eligible employees or members.

(3) (A) Any dividend hereafter apportioned on any participating group insurance policy, or any rate reduction hereafter made or continued on any non-participating group policy for the first or any subsequent year of insurance under any such policy heretofore or hereafter issued under subparagraph (K), (L) or (M) of paragraph one of this subsection, may be applied to reduce the policyholder's part of the cost of such policy, except that the excess, if any, of the insured's aggregate contribution under the policy over the net cost (gross premium less dividends or rate reductions) of the insurance shall be applied at the discretion of the insurer either as a cash payment to the insured or to reduce the insured's premium, unless the insured assigns the dividend or rate reduction to the policyholder. If a dividend or rate reduction is payable upon termination of the policy the insurer shall either make payment to the insured or to the policyholder upon receipt of a certification from the policyholder that the dividend or rate reduction will be distributed by the policyholder to the insureds or applied to reduce the insured's premium.

(B) The provisions of subparagraph (A) of this paragraph shall apply to New York residents insured under a policy issued in any other jurisdiction to a group which is not of the type described in subparagraphs (A) through (J) of paragraph one of this subsection.

(d) (1) In this section, for the purpose of insurance other than for group hospital, medical, major medical or similar comprehensive-types of expense reimbursed insurance hereunder: "employees" includes the officers, managers, employees and retired employees of the employer and

of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners, employees and retired employees of affiliated individuals and firms controlled by the insured employer through stock ownership, contract or otherwise; "employees" may be deemed to include the individual proprietor or partners if the employer is an individual proprietor or a partnership; and "employees" as used in subparagraph (A) of paragraph one of subsection (c) hereof may also include the directors of the employer and of subsidiary or affiliated corporations of a corporate employer.

(2) In this section "employer" may include any municipal corporation, or the proper officers, as such, of any unincorporated municipality, or any department of such corporation or municipality determined by conditions pertaining to the employment.

(3) In this section, for the purpose of group hospital, medical, major medical or similar comprehensive-types of expense reimbursed insurance hereunder:

(A) "employee" shall have the meaning set forth in the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6); and

(B) "full-time employee" means with respect to any month, an employee who is employed on average for at least thirty hours of service per week as set forth in section 4980H(c)(4) of the internal revenue code, 26 U.S.C. § 4980H(c)(4), or any regulations promulgated thereunder.

(e) The benefits payable under the policy shall be payable to the employee or other insured member of the group or to some beneficiary or beneficiaries designated by him, other than the employer or the association or any officer thereof as such; but if there is no designated beneficiary as to all or any part of the insurance benefits at the death of the employee or member, then the benefits payable for which there is no designated beneficiary shall be payable to the estate of the employee or member, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, may be made by the insurer to the hospital or other person or persons furnishing such aid, and the payment of benefits for expenses incurred on account of hospitalization or medical or

surgical aid after the death of an employee or other member of the insured group for such person's spouse, child or children, or other person chiefly dependent upon him for support or maintenance, may be made by the insurer to the surviving spouse or otherwise as the policy may provide. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(f) (1) (A) Any policy of group accident, group health or group accident and health insurance may include provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, medical or surgical care or physical and occupational therapy by licensed physical and occupational therapists upon the prescription or referral of a physician for the employee or other member of the insured group, the employee's or member's spouse, the employee's or member's child or children, or other persons chiefly dependent upon the employee or member for support and maintenance; provided that:

(i) a policy of hospital, medical, surgical, or prescription drug expense insurance that provides coverage for children shall provide such coverage to a married or unmarried child until attainment of age twenty-six, without regard to financial dependence, residency with the employee or member, student status, or employment, except a policy that is a grandfathered health plan may, for plan years beginning before January first, two thousand fourteen, exclude coverage of an adult child under age twenty-six who is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. For purposes of this item, "grandfathered health plan" means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e); and

(ii) a policy under which coverage terminates at a specified age shall not so terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which coverage would otherwise terminate and who is chiefly dependent upon such employee or member for support and maintenance, while the insurance of the employee or member remains in force and the child remains in such

condition, if the insured employee or member has within thirty-one days of such child's attainment of the termination age submitted proof of such child's incapacity as described herein.

(B) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy of hospital, medical or surgical expense insurance pursuant to this section that provides coverage for children, must make available and if requested by the policyholder, extend coverage under the policy to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under any employer health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the insurer. Such coverage shall be made available at the inception of all new policies and with respect to all other policies at any anniversary date. Written notice of the availability of such coverage shall be delivered to the policyholder prior to the inception of such group policy and annually thereafter.

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

within no less than thirty days of the day of birth to make coverage effective from the moment of birth. This election shall not be required in the case of student insurance or where the group's plan does not provide coverage for children.

(3) A policy under which coverage of a dependent spouse or named insured would terminate upon such spouse or named insured attaining the age prescribed in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq. ("Medicare"), as the age of first eligibility for the benefits provided by such law shall not so terminate, if such dependent spouse is not then eligible for all of such benefits for as long as the policy remains in force and such dependent spouse remains ineligible to receive any of such "Medicare" benefits, provided proof of such ineligibility is submitted to the insurer within thirty-one days of the date notice of termination of coverage be sent by first class mail by the insurer to the last known address of the policyholder. Any such policy may provide for the continuation of such benefit provisions, or any part or parts thereof, after the exhaustion of the benefit rights with respect to the employee or other member of the insured group, or after the death of an active or retired employee or other member of the insured group.

(4) Notwithstanding any provisions of a policy of group accident, group health or group accident and health insurance, whenever such policy provides for reimbursement for:

(A) any physical and occupational therapy service which is within the lawful scope of practice of a licensed physical and occupational therapist, a subscriber to such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or licensed physical and occupational therapist pursuant to prescription or referral by a physician;

(B) any podiatric service which is within the lawful scope of practice of a licensed podiatrist, a subscriber to such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or licensed podiatrist and when such policy or any certificate issued thereunder is delivered or issued for delivery without this state by an authorized insurer, covered persons residing in this state shall be entitled to reimbursement for podiatric services as herein provided;

(C) any optometric service which is within the lawful scope of practice of a licensed optometrist, a subscriber to such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or licensed optometrist and when such policy or any certificate issued thereunder or delivered or issued for delivery without the state by an authorized insurer so provides, covered persons residing in this state shall be entitled to reimbursement for that service which may be rendered by an optometrist as herein provided. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, and/or appurtenances thereto;

(D) any dental service which is within the lawful scope of practice of a licensed dentist, a subscriber to such policy shall be entitled to reimbursement for such service whether the said service is performed by a physician or licensed dentist and when such policy or any certificate issued thereunder or delivered or issued for delivery without the state by an authorized insurer so provides, covered persons residing in this state shall be entitled to reimbursement for dental services as herein provided;

(E) The services of licensed health professionals who can bill for services, a subscriber to such policy shall be entitled to reimbursement for such service provided pursuant to a clinical practice plan established pursuant to subdivision fourteen of section two hundred six of the public health law;

(F) any speech-language pathology or audiology service which is within the lawful scope of practice of a duly licensed speech-language pathologist or audiologist, a subscriber to such policy shall be entitled to reimbursement for such service whether the said service is performed by a physician or duly licensed speech-language pathologist or audiologist, provided however, that nothing contained herein shall be construed to impair any terms of such policy which may require said service to be performed pursuant to a medical order, or a similar or related service of a physician, in which case coverage need not be provided for any tests, evaluations or diagnoses if such tests, evaluations or diagnoses have already been provided by or through a physician within twelve months of the referral or order from the physician. However, nothing herein shall be construed as preventing an

insurer from covering more than one test or evaluation provided by a speech-language pathologist or audiologist within a twelve-month period where such test or evaluation is ordered by a physician as medically necessary. Nor shall anything herein be construed as prohibiting the limitation of such services, where covered, to specified settings other than offices, such as hospitals or to services provided by such professionals as part of a home care agency's services; and when such policy or any certificate issued thereunder is delivered or issued for delivery without the state by an authorized insurer, covered persons residing in this state shall be entitled to reimbursement for speech-language pathology or audiology service as herein provided.

(G) psychiatric or psychological services or for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments, however defined in such policy, a subscriber to such policy shall be entitled to reimbursement for such psychiatric or psychological services or diagnosis or treatment whether performed by a physician, psychiatrist or a certified and registered psychologist when the services rendered are within the lawful scope of their practice, and when such policy or any certificate issued thereunder is delivered or issued for delivery without this state by an authorized insurer, covered persons residing in this state shall be entitled to reimbursement for such diagnosis and treatment by a physician, psychiatrist or a certified and registered psychologist as hereinabove provided; and

(H) any service which is within the lawful scope of practice of a licensed chiropractor, a subscriber to such policy shall be entitled to reimbursement for such service when such service is performed by a licensed chiropractor.

(g) (1) No domestic insurer and no foreign or alien insurer doing business in this state shall hereafter issue, within or without this state, any policy of group accident, group health or group accident and health insurance, other than a policy issued pursuant to subparagraph (J) of paragraph one of subsection (c) hereof, which shall not appear to be self-supporting on reasonable assumptions as to morbidity or other appropriate claim rate, interest and expense.

(2) The superintendent may require all such insurers to file with him, either directly or through such agency as he may approve, at such times and in such manner and for such forms of insurance as he prescribes,

their experience under such forms and such other information as the superintendent may deem necessary or expedient for the administration of this section and such experience and other information shall be compiled and analyzed as the superintendent prescribes.

(h) (1) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state. A group accident and health insurance policy providing disability and family leave benefits pursuant to article nine of the workers' compensation law shall be subject to the requirements of subsection (n) of this section.

(2) An insurer may revise such schedules from time to time, and shall file such revised schedules with the superintendent.

(3) No insurer shall issue any policy of group accident, group health or group accident and health insurance the premium rate under which for the first policy year is less than that determined by the schedules of such insurer as then on file with the superintendent; nor shall it pay to the agent or agents or to a broker or brokers for the solicitation or sale of such policy or for any other purpose related to such policy any commission, compensation or other fees or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent; nor shall such insurer pay for services pertaining to the service or administration thereof to any individual, firm or corporation any fees, commissions or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent or for such services not rendered in behalf of such insurer; provided, however, that nothing contained herein shall apply to or affect the computation of dividends or experience rating credits.

(4) Nothing herein shall prohibit the state insurance fund from taking

into account peculiar hazards of individual risks in establishing higher premium rates to be charged for insurance providing for the payment of disability and family leave benefits in accordance with article nine of the workers' compensation law.

(i) (1) Whenever the superintendent determines, after notice to all insurers doing the business of group accident, group health or group accident and health insurance in this state and a hearing at which such insurers may present pertinent statistics and other available data, that it is advisable in the administration of this section to adopt a schedule of minimum premium rates for any type of benefit provided under policies of group accident, group health or group accident and health insurance, the superintendent shall thereupon file in his office such a schedule which shall include a description of the benefit or benefits for which minimum premium rates are being prescribed and of the minimum premium rates applicable thereto.

(2) Such schedule may be revised by the superintendent from time to time or withdrawn, after a similar notice and hearing.

(3) The effective date of such schedule, or of any such revision or withdrawal thereof, shall be specified by the superintendent. After the effective date of the first schedule no domestic insurer and no foreign or alien insurer doing business in this state shall issue, within or without this state, any policy of group accident, group health or group accident and health insurance providing any benefit to which the schedule of minimum premium rates then in effect applies, unless the premium for such benefit for the first policy year shall be at least equal to that determined on the basis of such schedule.

(4) If an insurer desires to provide a benefit of the same general type as, but not identical with, one described in said schedule, it shall before issuing any policy providing for such different benefit obtain the superintendent's approval of the premium proposed to be charged therefor. The superintendent shall grant such approval if he is satisfied that the proposed premium is not less than that which would have to be charged consistent with the schedule of minimum premium rates then in effect.

(j) (1) Anything in this chapter to the contrary notwithstanding, any policy of group accident, group health or group accident and health insurance may provide for readjustment of the rate of premium based on

the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder, and such readjustment may be made retroactive only for such policy year.

(2) Any such rate readjustment shall be computed on a basis which is equitable to all group accident, group health or group accident and health insurance policies.

(3) Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under such policies may be used to reduce the employer's contribution to group insurance for the employees of the employer, and the excess over such contribution by the employer shall be applied by the employer for the sole benefit of the employees.

(k) Whenever an insurer elects to terminate any policy as described in this section, such insurer shall include in his notification of intent to terminate such policy reference to the policyholder's responsibilities under section two hundred seventeen of the labor law. Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholder's responsibilities under section two hundred seventeen of the labor law.

(l) The superintendent shall promulgate rules and regulations concerning the method, manner and time for a policyholder to provide written notice of termination to the certificate holders as required by subdivision three of section two hundred seventeen of the labor law.

(m) This section shall not apply to any contract issued by any article forty-three corporation except as provided in section four thousand three hundred five of this chapter.

(n)(1) On or before June first, two thousand seventeen, the superintendent of financial services by regulation, in consultation with the chair of the workers' compensation board of this state, shall determine whether the family leave benefit coverage of a group accident and health insurance policy providing disability and family leave benefits pursuant to article nine of the workers' compensation law, including policies issued by the state insurance fund, shall be experience rated or community rated, which may include subjecting the family leave benefit coverage of the policy to a risk adjustment

mechanism. Notwithstanding any law to the contrary, the superintendent shall establish the rates for any community rated family leave benefit coverage and shall apply commonly accepted actuarial principles to establish community rated family leave benefit coverage rates that are not excessive, inadequate or unfairly discriminatory. On June first, two thousand seventeen and on September first of each year thereafter the superintendent shall publish all community rated family leave benefit rates for the policy period beginning on the following January first.

(2) If the policy is subjected to a risk adjustment mechanism, the superintendent of financial services shall promulgate regulations necessary for the implementation of this subsection in consultation with the chair of the workers' compensation board of this state. Any such risk adjustment mechanism shall be administered directly by the superintendent of financial services of this state, in consultation with the chair of the workers' compensation board of this state, or by a third party vendor selected by the superintendent of financial services in consultation with the chair of the workers' compensation board.

(3) "Risk adjustment mechanism" as used in this subsection means the process used to equalize the per member per month claim amounts among insurers in order to protect insurers from disproportionate adverse risks.

(o) (1) No contract or agreement between a health plan subject to this article and a health care provider, other than a residential health care facility as defined by section twenty-eight hundred one of the public health law, shall include a provision that:

(A) contains a most-favored-nation provision; or

(B) restricts the ability of a corporation, an entity that contracts with a corporation for a provider network, or a health care provider to disclose: (i) actual claims costs; or (ii) price or quality information required to be disclosed under federal law, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations, including, but not limited to, patient cost-sharing covered by the provider contract to any subscriber, enrollee, group, or other entity receiving health care services pursuant to the contract, or to any public compilation of reimbursement data such as the New York all payer database required by law or regulation, provided that no disclosure shall include protected health information

or other information covered by statutory or other privilege.

(2) For purposes of this subsection, the term "health plan" shall include: (A) an insurer licensed pursuant to this chapter or a health maintenance organization certified pursuant to article forty-four of the public health law; and

(B) a third-party administrator, affiliated with an insurer or health maintenance organization, who administers a health benefit plan.