CHAPTER 28 OF THE CONSOLIDATED LAWS

INSURANCE LAW

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ARTICLE 1

GENERAL PROVISIONS

Section 101. Short title.
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§ 101. Short title. This chapter shall be known and may be cited as the "insurance law".

§ 102. Declaration. The legislature hereby declares that the purpose

of this chapter is to recodify, without substantive change, the insurance law in effect immediately prior to the effective date of this chapter.

§ 103. Explanation of order of provisions. In this recodification of the insurance law, the provisions have been divided in descending order of application, with illustrations, as follows:

Article 1

Section 101
Subsection (a)
Paragraph (1)
Subparagraph (A)
Item (i)
Clause (I)
Subitem (aa)
Subclause (aaa)

§ 104. Continuation of existing offices, licenses, approvals and proceedings.

(a) All persons who, at the effective date of this chapter, held any office in the department shall continue to hold such office under and subject to this chapter.

(b) Every license of an insurer, insurance agent, insurance broker, public adjuster, reinsurance intermediary, insurance consultant or other licensee in force immediately prior to the effective date of this chapter shall continue in force until its date of expiration or until terminated pursuant to this chapter.

(c) Every insurer doing business in this state as an authorized insurer at the effective date of this chapter may continue to transact the kind or kinds of insurance business it was licensed to transact on such date until the date of expiration of its license or until the license is terminated pursuant to this chapter.

(d) Every form of policy, contract, certificate, application, rider or endorsement in use immediately prior to the effective date of this

chapter which was approved by the superintendent pursuant to any law herein repealed may, unless he prescribes otherwise, continue to be issued in accordance with the approval:

(1) following such effective date, if the form complies with this chapter and did comply with the repealed law, or

(2) for six months following such effective date, if it does not comply with this chapter but did comply with the repealed law.

(e) No action or proceeding commenced before the effective date of this chapter, and no violation of any provision of law hereby repealed, shall be affected by such repeal, but all procedure hereafter taken in reference thereto shall conform to the provisions of this chapter as far as practicable.

§ 106. Construction of references. (a) In this chapter, unless otherwise stated or required by the context:

(1) All references to a part, title, article or section number or letter refer to the part, title, article or section so numbered or lettered in this chapter, and all references in any section of this chapter to a numbered or lettered subsection, paragraph, subparagraph, item or clause refer to the subsection, paragraph, subparagraph, item or clause so numbered or lettered in such section.

(2) All references to former provisions of chapter twenty-eight of the consolidated laws refer to provisions of the former insurance law enacted by chapter eight hundred eighty-two of the laws of nineteen hundred thirty-nine.

(b) In other laws of this state, references to the former insurance law repealed by this chapter, and to any article, section or other provision thereof, refer to this chapter and its provisions which correspond to the repealed article, section or other provision.

§ 107. Definitions of terms of general use in this chapter. (a) In this chapter, unless the context otherwise requires:

(1) "Accident and health insurance company", means any corporation having power to do the kinds of insurance business specified in item (i) of paragraph three of subsection (a) of section one thousand one hundred

thirteen of this chapter or items (i) and (ii) of such paragraph, provided such company does not have power to do any other kind or kinds of insurance business.

(2) "Accredited reinsurer" means an assuming insurer not authorized to do an insurance business in this state but which (i) presents satisfactory evidence to the superintendent that it meets the applicable standards of solvency required in this state, (ii) is in compliance with the conditions prescribed by regulation under which a ceding insurer may be allowed credit for reinsurance recoverable from an insurer not authorized in this state, and (iii) has received a certificate of recognition as an accredited reinsurer issued by the superintendent pursuant to such regulation; provided that no insurer shall be an accredited reinsurer with respect to any kind of insurance not provided for in such certificate.

(3) "Admitted assets" means assets of an insurer which conform to the requirements of section one thousand three hundred one of this chapter.

(4) "Affiliate" means a corporation a majority of whose shares is owned or controlled by shareholders, directors or officers of another corporation, who own or control a majority of the shares of the other corporation.

(5) "Alien insurer" means any insurer incorporated or organized under the laws of any foreign nation, or of any province or territory not included under the definition of foreign insurer.

(6) "American institution" means an institution created or existing under the laws of the United States of America or of any state, district or territory thereof.

(7) "Articles of association", when used in reference to an unincorporated association, means the basic instrument prescribing the powers, purposes and organization of the association.

(8) "Assuming insurer" means an insurer which, under a contract of reinsurance, incurs to another insurer, called the ceding insurer, an obligation the performance of which is contingent upon the ceding insurer's incurring liability or loss under its contract or contracts of insurance, guaranty or suretyship made with third persons.

(9) "At last year-end" means the end of the next preceding calendar year.

(10) "Authorized insurer" means an insurer authorized as such to do an

insurance business in this state in compliance with this chapter, by reason of a license so to do issued and in force pursuant to the laws of this state or of a corporate charter granted and in force pursuant to the laws of this state, but not including any insurer herein exempted from compliance with the requirement that it obtain a license to do business.

(11) "Board of directors" means the body having power and responsibility for management and control of a corporation and the advisory committee or similar body having such power in reference to a reciprocal insurer or Lloyds underwriters.

(12) "Capital", when used in reference to a stock insurance company, means the aggregate par value of all classes of shares of capital stock issued and outstanding.

(13) "Ceding insurer" means the insurer to which an assuming insurer is obligated.

(14) "Charter" means the basic instrument, by whatever name called, prescribing the powers, purposes and organization of a corporation.

(15) "Company" means a corporation.

(16) "Control". Except for the purposes of article fifteen of this chapter, "control", including the terms "controlling", "controlled by" and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an institution, whether through the ownership of voting securities, by contract or otherwise.

(17) "Department" means the department of financial services of this state.

(18) "Deputy" means a deputy superintendent of financial services of this state.

(19) "Domestic insurer" means any authorized insurer incorporated or organized under any law of this state.

(20) "Firm" means a partnership, limited or unlimited, general or special.

(21) "Foreign insurer" means any insurer incorporated or organized under the laws of any state, as herein defined, other than this state.

(22) "Fraternal benefit society" has the meaning ascribed to it by subsection (a) of section four thousand five hundred one of this chapter.

(23) "Independent insurance agent" has the meaning ascribed to it by section two thousand one hundred one of this chapter.

(24) "Institution" means a corporation, a joint-stock company, an association, a trust, a business partnership, a business joint venture or any similar entity.

(25) "Insurance agent" has the meaning ascribed to it by section two thousand one hundred one of this chapter.

(26) "Insurance broker" has the meaning ascribed to it by section two thousand one hundred one of this chapter.

(27) "Insurance contract" has the meaning ascribed to it by section one thousand one hundred one of this chapter.

(28) "Life insurance company" means any corporation having power to do either one or both of the kinds of insurance business specified in paragraphs one and two of subsection (a) of section one thousand one hundred thirteen of this chapter.

(29) "Lloyds underwriters" means any aggregation of individuals, who under a common name engage in the business of insurance for profit through an attorney-in-fact having authority to obligate the underwriters severally, within such limits as may be lawfully specified in the power of attorney, on contracts of insurance made or issued by such attorney-in-fact, in the name of such aggregation of individuals, to and with any person or persons insured.

(30) "Minimum surplus" means the minimum amount by which the admitted assets of an insurer without capital stock must exceed its liabilities in order to be permitted to do business in this state.

(31) "Minor" or "infant" means a person who has not attained the age of eighteen years.

(32) "Mortgage" includes a deed of trust.

(33) "Obligations" includes bonds, debentures, notes and other evidences of indebtedness (whether or not liability for payment extends beyond the security therefor) as well as participation interests in any of the foregoing.

(34) "Officer" means any person charged with active management and control, in an executive capacity, of the affairs of a corporation, including the president, vice-president, secretary, assistant secretary, treasurer, assistant treasurer, general counsel, actuary, comptroller and any other person appointed or elected by the board of directors to

exercise similar powers, and including the manager, attorney-in-fact, or other person appointed or elected by the board of directors to exercise similar powers, of a United States branch of an alien insurer, and the attorney-in-fact of a reciprocal insurer or Lloyds underwriters, and in case such manager or attorney-in-fact is a corporation, including the officers of such corporation.

(35) "Parent corporation" has the meaning assigned to it in the definition of subsidiary.

(36) "Property/casualty insurance company" means any company having power to write any one or more of the basic kinds of insurance specified in subsection (a) of section four thousand one hundred one of this chapter.

(37) "Reciprocal insurer" means any aggregation of persons, firms or corporations or, in the alternative, New York counties, towns, cities, villages, district corporations (as defined in paragraph three of section 2.00 of the local finance law), or school districts and boards of cooperative educational services, called "subscribers" in article sixty-one of this chapter, who or which under a common name engage in the business of inter-insurance or exchanging contracts of insurance on the reciprocal plan through an attorney-in-fact having authority to obligate the subscribers severally, within such limits as may lawfully be specified in the subscriber's agreement, on contracts of insurance made with any subscriber as a policyholder through such attorney-in-fact acting on behalf of all other subscribers. Such term includes any reciprocal or inter-insurance exchange, by whatever name known, and any reference thereto as an insurer shall be deemed to mean any such aggregation of inter-insurers operating through an attorney-in-fact individually and collectively as an insurance organization for the benefit of its policyholders.

(38) "Renewal license" means a license which becomes effective immediately following the expiration of a license previously issued and in force, and which differs from such previous license only as to the date of expiration.

(39) "State" means any state of the United States, the commonwealth of Puerto Rico and the District of Columbia.

(40) "Subsidiary" means an institution controlled, directly or indirectly, by another institution or by a retirement system. "Parent

corporation" means an institution or a retirement system that, directly or indirectly, controls another institution. For the purposes of the definitions in this subsection:

(A) an institution is conclusively presumed to be controlled by an institution or retirement system that, directly or indirectly, with power to vote, owns, controls or holds a majority of the outstanding voting securities of such institution;

(B) no presumption, either of control or of absence of control, arises if such ownership, control or holding of voting securities is less than a majority but more than five percent;

(C) absence of control is presumed if such ownership, control or holding of voting securities is five percent or less; and

(D) in determining control, voting securities held in separate accounts of an institution or retirement system shall be deemed to be owned by the institution or retirement system, but voting securities in an investment advisory account that are not owned by an institution but are held in an account as to which the institution is an investment adviser shall not be deemed to be controlled or held by such institution.

(41) "Superintendent" means the superintendent of financial services of this state.

(42) "Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, which is the sum of all capital and surplus accounts minus any impairment thereof.

(43) "United States". Except for the purposes of article fourteen of this chapter, when used to signify place, means only the states of the United States, the commonwealth of Puerto Rico and the District of Columbia.

(44) "United States branch" means, as the context may require, the business unit through which business is transacted within the United States by an alien insurer, or the assets and liabilities of such insurer within the United States pertaining to such business or the management powers pertaining to such business and to such assets and liabilities or any combination of these three.

(45) "Voting securities" means securities of any class or any ownership interest having voting power for the election of directors, trustees or management of an institution, other than securities having

such power only by reason of the happening of a contingency.

(46) "Doing an insurance business" has the meaning ascribed to it by section one thousand one hundred one of this chapter.

(47) "Commercial risk insurance" means insurance not subject to section three thousand four hundred twenty-five of this chapter issued or issued for delivery in this state, on a risk located in this state, insuring any of the following contingencies:

(A) loss of or damage to real property;

(B) loss of or damage to personal property;

(C) losses or liabilities arising out of the ownership, operation or use of a motor vehicle;

(D) liabilities of persons acting as officers or directors; or

(E) other liabilities, including product liability, for loss of, damage to, or injury to persons or property.

(48) "Product liability" means liability of the insured for damages for personal injury, death or property damage, where liability is based upon negligence, implied warranty or strict liability, arising out of a design, inspection, testing or manufacturing defect, or any other defect in a product, or is based upon any failure to warn, or to properly instruct in the use of a product or for any liability for any damage arising out of the handling or use of any product manufactured, sold, handled or distributed by the insured or work completed by or on behalf of the insured.

(49) "Professional liability insurance" means insurance covering liability arising out of the practice of any profession for which a license is required by a governmental authority of this state or, with respect to treatment of patients, arising out of the operation of a duly certified hospital.

(50) "Public entity insurance" means commercial risk insurance issued to a public entity.

(51) "Public entity" means:

(A) the state of New York;

(B) a county, city, town, village or any other political subdivision or civil department or division of the state;

(C) a school district, board of cooperative educational services or any other governmental entity or combination or association of governmental entities operating a public school, college, community

college or university;

(D) a fire district, fire company, volunteer fire department, or any other entity that contracts with a municipality or other political subdivision to provide fire protection;

(E) a public library, as defined in section two hundred fifty-three of the education law, authorized to operate in this state;

(F) a public corporation, including a municipal corporation, district corporation or public benefit corporation;

(G) an improvement district, special district or other district authorized by the village law, town law, county law or any other law;

(H) a public corporation, public authority, commission, agency, municipal or other public housing authority, or project organized pursuant to article two of the private housing finance law; or

(I) any other governmental instrumentality or unit in the state of New York.

(52) "Gap amount" means:

(A) in the case of a lease of personal property, the difference, if any, between:

(i) the amount owed by the lessee, under the early termination provision of the lease, as of the date of a total loss of the leased property caused by its theft or physical damage, or the amount which would have been owed by the lessee had the lessor not waived such obligations; and

(ii) the sum of: (I) any unpaid rental payments and other unpaid charges, arising from the failure of the lessee to fulfill the lessee's obligations under the lease, that had accrued prior to the date of the loss; and (II) the actual cash value of the personal property as of the date of the loss. If the lessee is required under the lease agreement to maintain a physical damage insurance policy on the personal property which is the subject of the lease agreement, and that policy is in effect on the date of the loss, then "actual cash value" shall have the same meaning as under the physical damage insurance policy.

(B) In the case of a loan or other credit transaction on the purchase of personal property, the difference, if any, between:

(i) the amount owed by the debtor under the loan or other credit transaction as of the date of a total loss of the personal property which is the subject of the loan or other credit transaction agreement

caused by its theft or physical damage, or the amount that would have been owed by the debtor had the creditor not waived such obligation; and

(ii) the sum of: (I) any unpaid payments and other unpaid charges, arising from the failure of the debtor to fulfill the obligations under the loan or other credit transaction agreement, that had accrued prior to the date of the loss; and (II) the actual cash value of the personal property as of the date of the loss. If the debtor is required under the loan or other credit transaction agreement to maintain a physical damage insurance policy on the personal property which is the subject of the loan or other credit transaction agreement, and that policy is in effect on the date of the loss, then "actual cash value" shall have the same meaning as under the physical damage insurance policy.

(53) "Nonprofit property/casualty insurance company" means an insurer organized pursuant to section six thousand seven hundred three of this chapter and that is subject to the provisions of article sixty-seven of this chapter.

(54) "Title insurance agent" shall be deemed to have the same meaning as paragraph one of subsection (y) of section two thousand one hundred one of this chapter.

(55) "Medically fragile child" means an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria: (1) is technologically dependent for life or health sustaining functions; (2) requires a complex medication regimen or medical interventions to maintain or to improve their health status; or (3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. The term "medically fragile child" shall also include traumatic brain injury, the nature of which typically require care in a specialty care center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions of this subsection. Notwithstanding the definitions set forth in this subsection, any patient which has received prior approval from an

insurer for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child at least until discharge from that facility occurs.

(b) Whenever the terms "include", "including" or terms of similar import appear in this chapter, unless the context requires otherwise, such terms shall not be construed to imply the exclusion of any person, class or thing not specifically included.

(c) A reference in this chapter to any other law or statute of this state, or of any other jurisdiction, means such law or statute as amended to the effective date of this chapter and, unless the context otherwise requires, as amended thereafter.

§ 108. Applicability of business corporation law to insurers. (a) The business corporation law applies to every corporation heretofore or hereafter formed under:

(1) this chapter, except corporations subject to section one thousand one hundred ten or article forty-three, forty-five, forty-six or sixty-seven of this chapter, or a captive insurance company formed in accordance with the not-for-profit corporation law, or

(2) any other statute of this state, or any other law, if the corporation's purposes include a purpose for which a corporation may be formed under this chapter.

(b) (1) If any provision of the business corporation law conflicts with any provision of this chapter, the provision of this chapter shall prevail, and the conflicting provision of the business corporation law shall not apply.

(2) If any provision of this chapter relates to a matter embraced in the business corporation law but is not in conflict therewith, both provisions shall apply.

(c) The following provisions of the business corporation law shall not apply to a domestic stock insurer or an authorized stock insurer: section one hundred six, subsection (a) of section two hundred one, sections five hundred ten, five hundred eleven, five hundred seventeen, five hundred eighteen, seven hundred nineteen, nine hundred eight, articles three, ten and twelve.

(d) The following provisions of the business corporation law shall not

apply to a domestic incorporated mutual insurer or an authorized incorporated mutual insurer: section one hundred six, subsection (a) of section two hundred one, sections seven hundred nine, and seven hundred nineteen, articles three, five, six (except section six hundred nineteen), nine, ten and twelve.

(e) The following provisions of the business corporation law, in addition to those referred to in subsections (c) and (d) hereof, do not apply to an incorporated foreign insurer or an incorporated alien insurer: sections thirteen hundred one, thirteen hundred two, sections thirteen hundred four through thirteen hundred six inclusive, sections thirteen hundred eight through thirteen hundred eleven inclusive, sections thirteen hundred fifteen, thirteen hundred sixteen and thirteen hundred eighteen.

(f) A provision of the business corporation law which is referred to in section thirteen hundred seventeen or thirteen hundred nineteen thereof is not applicable to an incorporated foreign insurer or an incorporated alien insurer if such provision of the business corporation law is made inapplicable to such insurer under subsection (b), (c) or (d) hereof.

(g) In applying the business corporation law to any corporation pursuant to this section, unless the context otherwise requires, the following terms in such law have the following respective meanings:

(1) "Secretary of state" means "superintendent of financial services".

(2) "Department of state" means "department of financial services".

(3) "Corporation" and "domestic corporation" mean an incorporated "domestic insurer" as defined in section one hundred seven of this article.

(4) "Foreign corporation" means both an incorporated "foreign insurer" and an incorporated "alien insurer", as defined in section one hundred seven of this article.

(5) "Stated capital" means "capital" as defined in section one hundred seven of this article.

(h) A member of a domestic mutual insurer shall have the rights given to a "shareholder" in section six hundred nineteen of the business corporation law.

§ 109. Penalties; civil actions. (a) Every violation of any provision of this chapter shall, unless the same constitutes a felony, be a misdemeanor.

(b) Every penalty imposed by this section shall be in addition to any penalty or forfeiture otherwise provided by law.

(c) (1) If the superintendent finds after notice and hearing that any authorized insurer, representative of the insurer, licensed insurance agent, licensed insurance broker, licensed adjuster, or any other person or entity licensed, certified, registered, or authorized pursuant to this chapter, has willfully violated the provisions of this chapter or any regulation promulgated thereunder or with respect to accident and health insurance, any provision of titles one or two of division BB of the Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260), as may be amended from time-to-time, and any regulations promulgated thereunder, then the superintendent may order the person or entity to pay to the people of this state a penalty in a sum not exceeding one thousand dollars for each offense.

(2) Failure to pay such penalty within thirty days after the order, unless it is suspended by an order of a court of competent jurisdiction, shall constitute a further violation of the provisions of this chapter.

(3) No penalty shall be imposed pursuant to this subsection if a monetary penalty is otherwise provided in this chapter.

(d) The superintendent may maintain a civil action in the name of the people of the state to recover a judgment for a money penalty imposed by law for the violation of any provision of this chapter.

§ 110. Cooperation with other regulatory agencies. (a) In order to assist in the performance of the superintendent's duties under this chapter, the superintendent:

(1) may share documents, materials or other information, including confidential, privileged, and trade secret documents, materials or information with other local, state, federal, and international regulatory agencies, with the New York Liquidation Bureau, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, with any third-party consultant designated by the superintendent, with local, state, federal, and international law

enforcement authorities, including members of any supervisory college described in section three hundred two of this chapter, provided that the recipient has the authority and agrees to maintain the confidentiality and privileged status of the document, material or other information and has verified in writing the legal authority to maintain confidentiality; provided, however, that this paragraph shall not be construed as limiting access to records pursuant to article six of the public officers law, except as provided in paragraph three of subsection (b) of this section;

(2) may receive documents, materials or information, including otherwise confidential, privileged, and trade secret documents, materials or information, from the New York Liquidation Bureau, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, from regulatory and law enforcement officials of other foreign or domestic jurisdictions, including members of any supervisory college described in section three hundred two of this chapter, and from any other entity designated by the superintendent in a regulation, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) may enter into agreements governing sharing and use of documents, materials or information consistent with this subsection.

(b) (1) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in this section.

(2) The sharing of documents, materials, or information by the superintendent pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the superintendent is solely responsible for the administration, execution, and enforcement of the provisions of this section.

(3) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or third-party consultants pursuant to this section shall be confidential by law and privileged, shall not be subject to article six of the public officers law, shall not be subject to subpoena, and shall not be subject

to discovery or admissible in evidence in any private civil action.

§ 111. Investigation by the superintendent with respect to prescription drugs. (a) Whenever it shall appear to the superintendent, either upon complaint or otherwise, that in the advertisement, purchase or sale within this state of any prescription drug, which is contemplated to be paid by a policy approved by the department for offering within the state, has increased over the course of any twelve months by more than fifty percent to an amount greater than five dollars per unit and if it is suspected that any person, partnership, corporation, company, trust or association, or any agent or employee thereof, shall have employed, or employs, or is about to employ any device, scheme or artifice to defraud or for obtaining money or property by means of any false pretense, representation or promise, or that any person, partnership, corporation, company, trust or association, or any agent or employee thereof, shall have made, makes or attempts to make within or from this state or shall have engaged in or engages in or is about to engage in any practice or transaction or course of business relating to the purchase, exchange, or sale of prescription drugs which is fraudulent or in violation of law and which has operated or which would operate as a fraud upon the purchaser, or that any agent or employee thereof, has sold or offered for sale or is attempting to sell or is offering for sale any prescription drug for which the price has increased fifty percent over the prior calendar year to an amount greater than five dollars per unit, and the superintendent believes it to be in the public interest that an investigation be made, he or she may in their sole discretion either require or permit such person, partnership, corporation, company, trust or association, or any agent or employee thereof, to file with the department a statement in writing under oath or otherwise as to all the facts and circumstances concerning the price increase which he or she believes it to be in the public interest to investigate, and for that purpose may prescribe forms upon which such statements shall be made. The superintendent may also require such other data and information as he or she may deem relevant and may make such special and independent investigations as he or she may deem necessary in connection with the matter.

(b) In addition to any other power granted by law, the superintendent, his or her deputy or other officer designated by the superintendent is empowered to subpoena witnesses, compel their attendance, examine them under oath and require the production of any books or papers which he or she deems relevant or material to the inquiry. Such power of subpoena shall be enforced as though the subpoena were issued under section three hundred six of the financial services law.

(c) If any person, partnership, corporation, company, trust or association, fails to submit a written statement required by the superintendent under subsection (a) of this section or fails to comply with a subpoena issued pursuant to subsection (b) of this section, the superintendent may, after notice and a hearing, levy a civil penalty not to exceed to one thousand dollars per day that the failure continues.

(d) Notwithstanding any law to the contrary, any information obtained in an investigation under this section shall be confidential and shall not be subject to disclosure by the department except to the drug accountability board, which may review the information and, as necessary, include any such information in its report. The superintendent may also disclose any such information necessary to protect the public, but such disclosures shall to the greatest extent possible not identify a specific manufacturer or prices charged for drugs by such manufacturer.

§ 111-a. Notification of prescription drug price increases by manufacturers. (a) This section shall apply to a manufacturer of a prescription drug that is purchased or reimbursed in this state by any of the following:

(1) An insurance company authorized in this state to write accident and health insurance, a company organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an organization certified pursuant to article forty-four of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of this chapter, or the New York state health insurance plan established pursuant to article eleven of the civil service law; or

(2) A pharmacy benefit manager, including an entity that directly or through an intermediary, manages the prescription drug coverage provided by a health insurer under a contract or policy delivered or issued for delivery in this state or a health plan subject to section three hundred sixty-four-j of the social services law, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

(b) (1) A manufacturer of a prescription drug with a wholesale acquisition cost of more than forty dollars for a course of therapy shall notify the superintendent, his or her deputy or other officer designated by the superintendent, if the increase in the wholesale acquisition cost of such prescription drug is more than sixteen percent, including the proposed increase and the cumulative increases that occurred within the previous twenty-four months prior to the planned effective date of the increase. For purposes of this section, a "course of therapy" is defined as either of the following:

(i) the recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for thirty days; or

(ii) the recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for a normal course of treatment that is less than thirty days.

(2) (i) The notice required by paragraph one of this subsection shall be provided in writing to the superintendent at least sixty days prior to the planned effective date of the increase and shall include the proposed increase and the cumulative increases that occurred within the previous twenty-four months.

(ii) The superintendent shall forthwith publish the notice required by paragraph one of this subsection on the department of financial services website within five days of its receipt.

(3) (i) The notice required by paragraph one of this subsection shall include the date of the increase, the current wholesale acquisition cost of the prescription drug, and the dollar amount of the future increase

in the wholesale acquisition cost of the prescription drug.

(ii) The notice required by paragraph one of this subsection shall include a statement regarding whether a change or improvement in the drug necessitates the price increase. If so, the manufacturer shall describe the change or improvement.

(4) Information supplied by a manufacturer pursuant to this section that the manufacturer has reasonably designated as a trade secret shall be considered confidential and a trade secret, shall be exempt from public disclosure and copying under article six of the public officers law and shall not be disclosed directly or indirectly by the superintendent. Notwithstanding the foregoing sentence, the superintendent shall be permitted to disclose information in an aggregated format if such aggregate information cannot directly or indirectly be used to identify trade secret information related to a specific manufacturer or the manufacturer's prescription drug, including but not limited to any information related to pricing for the manufacturer's prescription drug that has been reasonably designated as a trade secret.

(5) In the event that a manufacturer of a prescription drug subject to this section does not report the information required in paragraph one of this subsection, the superintendent is authorized to impose any penalty or remedy authorized by this chapter, after notice and a hearing, against such manufacturer of up to five thousand dollars per day for every day after the reporting period described in this section that the required information is not reported.

ARTICLE 2

ORGANIZATION OF THE DEPARTMENT OF FINANCIAL SERVICES

Section 201. State insurance advisory board.
202. Drug accountability board.
205. Gratuities; prohibited payments to department personnel.
208. Transfer or destruction of records.
210. Annual consumer guide of health insurers, and entities certified pursuant to article forty-four of the public health law.
213. New York state health care quality and cost containment

commission.
214. Report on insurance agent licensing examinations.

§ 201. State insurance advisory board. (a) There shall be a state insurance advisory board to work with the superintendent in encouraging and promoting the growth of the insurance industry in the state, and further the goals of the department's mission as it relates to the insurance industry. There shall be ten members of the advisory board who shall be appointed by the superintendent. The membership shall consist of seven representatives of domestic insurance companies that, to the extent practicable, reflect a range of size and geographical location within the state. The membership shall also include one insurance producer and two representatives of consumers. The superintendent shall make rules to govern the method by which insurers may nominate persons to the board and the process for selecting such members, provided that the representative of consumers shall be selected by the superintendent. The term of each member of such advisory board shall be three years, or until a successor is appointed and vacancies shall be filled for the unexpired term only. The board shall meet at least annually pursuant to the call of the superintendent. Such meetings may be presided over by a designee of the superintendent and may be held by means of a conference telephone or similar communications equipment that would allow all persons participating in the meeting to hear each other at the same time. The members of the advisory board shall receive no compensation nor reimbursement for expenses. The advisory board may:

(1) consider and recommend ways, consistent with the protection of consumers and the financial condition of insurers, to encourage, promote, and assist insurance institutions to effectively and productively locate, operate, employ, grow, remain, and expand in New York state;

(2) consider and recommend ways, consistent with the protection of consumers and the financial condition of insurers, to promote the prudent and continued availability of insurance products and services at affordable costs throughout the state;

(3) recommend to the superintendent the establishment of such laws as may be deemed necessary, and the amendment or repeal thereof;

(4) recommend to the superintendent the promulgation of any guidance and regulations, not inconsistent with the law, as may be deemed necessary, and the amendment or repeal thereof;

(5) report within thirty days after receipt, on any proposed regulations, amendments thereto, or repeal thereof, consistent with the protection of consumers and the financial condition of insurers, at the request of the superintendent; and

(6) consider all other matters determined by the superintendent to further the department's mission in relation to the insurance industry.

(b) The advisory board shall have no executive, administrative or appointive powers or duties.

§ 202. Drug accountability board. (a) A nine member drug accountability board is hereby created in the department.

(b) The members of the board shall be appointed by the superintendent, provided however that one member shall be appointed at the suggestion of the temporary president of the senate and one member shall be appointed at the suggestion of the speaker of the assembly, and shall serve a three-year term. Members may be reappointed upon the completion of other terms. In making appointments to the board the superintendent shall give consideration to persons:

(1) licensed and actively engaged in the practice of medicine in the state;

(2) licensed and actively practicing in pharmacy in the state;

(3) with expertise in drug utilization review who are health care professionals licensed under title eight of the education law and who are pharmacologists;

(4) that are consumers or consumer representatives of organizations with a regional or statewide constituency and who have been involved in activities related to health care consumer advocacy;

(5) who are health care economists;

(6) who are actuaries; and

(7) who are experts from the department of health.

(c) The superintendent shall designate a person from the department to serve as chairperson of the board.

(d) Members of the board and all its agents shall be deemed to be an

"employee" for purposes of section seventeen of the public officers law.

(e) (1) The department shall have authority on all fiscal matters relating to the board.

(2) The board may utilize or request assistance of any state agency or authority subject to the approval of the superintendent.

(f) (1) Whenever the superintendent determines it would aid an investigation under section one hundred eleven of this chapter, the superintendent shall refer a drug to the board for a report thereon to be prepared.

(2) If a drug is referred to the board under paragraph one of this subsection the board shall determine:

(A) the drug's impact on the premium costs for commercial insurance in this state, and the drug's affordability and value to the public;

(B) whether increases in the price of the drug over time were significant and unjustified;

(C) whether the drug may be priced disproportionately to its therapeutic benefits; and

(D) any other question the superintendent may certify to the board in aid of an investigation under section one hundred eleven of this chapter.

(3) In formulating its determinations, the board may consider:

(A) publicly available information relevant to the pricing of the drug;

(B) information supplied by the department relevant to the pricing of the drug;

(C) information relating to value-based pricing;

(D) the seriousness and prevalence of the disease or condition that is treated by the drug;

(E) the extent of utilization of the drug;

(F) the effectiveness of the drug in treating the conditions for which it is prescribed, or in improving a patient's health, quality of life, or overall health outcomes;

(G) the likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(H) the average wholesale price, wholesale acquisition cost, retail price of the drug, and the cost of the drug to the Medicaid program minus rebates received by the state;

(I) in the case of generic drugs, the number of pharmaceutical manufacturers that produce the drug;

(J) whether there are pharmaceutical equivalents to the drug;

(K) information supplied by the manufacturer, if any, explaining the relationship between the pricing of the drug and the cost of development of the drug and/or the therapeutic benefit of the drug, or that is otherwise pertinent to the manufacturer's pricing decision; any such information provided shall be considered confidential and shall not be disclosed by the drug utilization review board in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer; and

(L) information from the department of health, including from the drug utilization review board.

(4) Following its review, the board shall report its findings to the superintendent. Such report shall include the determinations required by paragraph two of this subsection and any other information required by the superintendent.

(g) Notwithstanding any law to the contrary, the papers and information considered by the board and any report thereof shall be confidential and not subject to disclosure. The superintendent, in his or her sole discretion, may determine that the release of the board's report would not harm an ongoing investigation and would be in the public interest, and thereafter may release the report or any portion thereof to the public.

(h) The superintendent may call a public hearing on the determinations of the board, notice of such hearing shall be given to the manufacturer of the drug and shall be published on the website of the department for not less than fifteen days before the hearing.

§ 205. Gratuities; prohibited payments to department personnel. (a) No insurer or other person subject to this chapter, nor any other insurer or person shall directly or indirectly confer, or offer to confer, any money or other valuable benefit, whether in the form of payment, loan, credit, or otherwise, upon the superintendent, any deputy, or any employee of the department, by way of gratuity or for service or pretended service. Neither the superintendent, any deputy, nor any

employee of the department shall accept, or offer to accept, any such money or benefit.

(b) Subsection (a) hereof shall not prohibit the payment of compensation to any stenographer for transcripts of hearings or conferences, except that the superintendent may prescribe, by regulation, the conditions under which such transcripts may be furnished and the compensation therefor.

§ 208. Transfer or destruction of records. The superintendent may, in accordance with the provisions of section one hundred eighty-six of the state finance law, effect the transfer, or destruction, of any records made, acquired, or received by the department, if such records are, in his judgment, of no further material value to the state; but, subject to the provisions of section 57.29 of the arts and cultural affairs law, no records or other data required to be filed with the department during his administration, pursuant to any provision of this chapter, may be so destroyed.

§ 210. Annual consumer guide of health insurers, and entities certified pursuant to article forty-four of the public health law.

(a) The superintendent shall annually publish on or before September first, nineteen hundred ninety-nine, and annually thereafter, a consumer guide to insurers providing managed care products, individual accident and health insurance or group or blanket accident and health insurance and entities licensed pursuant to article forty-four of the public health law providing comprehensive health service plans which includes, in detail, a ranking from best to worst based upon each company's claim processing or medical payments record during the preceding calendar year using criteria available to the department, adjusted for volume of coverage provided. Such ranking shall also take into consideration the corresponding total number or percentage of claims denied which were reversed or compromised after intervention by the department and the department of health, consumer complaints to the department and the department of health, violations of section three thousand two hundred twenty-four-a of this chapter and other pertinent data which would

permit the department to objectively determine a company's performance. The department in publishing such consumer guide shall publish one state-wide guide or no more than five regional guides so as to facilitate comparisons among individual insurers and entities within a service market area. Such rankings shall be printed in a format which ranks all health insurers and all entities certified pursuant to article forty-four of the public health law in one combined list.

(b) The superintendent shall include in such guide annually, and insurers and entities certified pursuant to article forty-four of the public health law shall provide to the superintendent the information required for such guide in a timely fashion, the following information:

(1) The number of grievances filed pursuant to section forty-four hundred eight-a of the public health law, section three thousand two hundred seventeen-d of this chapter, section four thousand three hundred six-c of this chapter, or article forty-eight of this chapter and the number of such grievances in which an adverse determination of the insurer or entity was reversed in whole or in part versus the number of such determinations which were upheld;

(2) Beginning September first, two thousand twenty-seven, the number of approvals and the number of adverse determinations in whole or part issued by utilization review agents pursuant to section forty-nine hundred three of the public health law or section four thousand nine hundred three of this chapter; and

(3) The number of appeals to utilization review determinations that were filed pursuant to section forty-nine hundred four of the public health law and section four thousand nine hundred four of this chapter and the number of such determinations that were reversed in whole or in part versus the number of such determinations that were upheld.

(c) Beginning September first, nineteen hundred ninety-nine and annually thereafter, in addition to the information required in subsections (a) and (b) of this section, the superintendent, in conjunction with the commissioner of health, in consultation with the National Committee on Quality Assurance or a similar national organization, shall include in such guide the following additional information, for the most recent year in which such information is available and where applicable, for health insurers, health insurers providing managed care products and entities certified under article

forty-four of the public health law providing comprehensive health service plans pursuant to such article:

(1) the percentage of physicians who are either board certified or board eligible;

(2) the percentage of primary care physicians who remained participating providers, provided however, that such percentage shall exclude voluntary terminations due to physician retirement, relocation or other similar reasons;

(3) the percentage of enrollees aged twenty-three to thirty-nine and forty to sixty-four who had one or more visits to a health plan practitioner during the three years of their continual enrollment.

(4) the methods used to compensate primary care physicians and other providers, provided however, that nothing in this section shall be construed to require disclosure of the specific details of any financial arrangement between the insurer or entity and an individual provider or practice;

(5) the national accreditation status of insurers and entities, where applicable;

(6) indices of the quality of care provided, such as the rates of mammography, prostate, and cervical cancer screening, prenatal care, well-child care, immunization and such other information collected by the commissioner of health through the health plan employer data and information set (HEDIS); or through the quality assurance reporting requirements for entities not otherwise required to collect and report health plan employer data and information set (HEDIS) data;

(7) the results of a consumer satisfaction survey among enrollees of the various health insurers and entities, which shall be conducted by the superintendent and commissioner of health, in consultation with the National Committee on Quality Assurance or a similar national organization;

(8) a toll-free telephone number for each health insurer or plan;

(9) toll-free telephone numbers at the department and the department of health to which consumers can make complaints about insurers or entities; and

(10) except as required in paragraph seven of this subsection, health insurers and entities certified pursuant to article forty-four of the public health law shall report the information required under this

subdivision to the commissioner of health, and the commissioner shall provide such information to the superintendent for inclusion in the annual consumer guide.

(d) Beginning September first, two thousand twenty-seven and annually thereafter, in addition to the information required in subsections (a), (b), and (c) of this section, the superintendent shall include in such guide, and insurers and entities certified pursuant to article forty-four of the public health law shall provide to the superintendent, in a form and manner specified by the superintendent, the information required for such guide in a timely fashion, the following information regarding pre-authorization requests under article forty-nine of the public health law or article forty-nine of this chapter:

(1) the number of pre-authorization requests received under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter;

(2) the number of pre-authorization requests for which an authorization was issued under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter;

(3) the number of pre-authorization requests for which an adverse determination was issued in whole or part under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter;

(4) the number of pre-authorization requests for which an adverse determination was appealed under section forty-nine hundred four of the public health law and section four thousand nine hundred four of this chapter;

(5) the number of pre-authorization requests for which an adverse determination was reversed on appeal in whole or part under section forty-nine hundred four of the public health law and section four thousand nine hundred four of this chapter;

(6) the number of pre-authorization requests for which an adverse determination was upheld under section forty-nine hundred four of the public health law and section four thousand nine hundred four of this chapter;

(7) the twenty-five current procedural terminology codes with the highest number of pre-authorization requests and the percentage of

authorizations for each of these current procedural terminology codes under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter;

(8) the twenty-five current procedural terminology codes with the highest number of pre-authorization requests for which an authorization was issued under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter;

(9) the twenty-five current procedural terminology codes with the highest number of pre-authorization requests under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter for which an adverse determination was issued in whole or part but that was reversed by an appeal, in whole or part, under section forty-nine hundred four of the public health law and section four thousand nine hundred four of this chapter; and

(10) the twenty-five current procedural terminology codes with the highest number of pre-authorization requests for which an adverse determination was issued in whole or part under section forty-nine hundred three of the public health law and section four thousand nine hundred three of this chapter.

(e) Health insurers and entities certified pursuant to article forty-four of the public health law shall provide annually to the superintendent and the commissioner of health, and the commissioner of health shall provide to the superintendent by March first of each year, all of the information necessary for the superintendent to produce the annual consumer guide. In compiling the guide, the superintendent shall make every effort to ensure that the information is presented in a clear, understandable fashion that facilitates comparisons among individual insurers and entities, and in a format that lends itself to the widest possible distribution to consumers. The superintendent shall either include the information from the annual consumer guide in the consumer shopping guide required by subsection (a) of section four thousand three hundred twenty-three of this chapter or combine the two guides as long as consumers in the individual market are provided with the information required by subsection (a) of section four thousand three hundred twenty-three of this chapter.

(f) The superintendent shall contract with a national organization for the purposes of drafting and designing the guide, including the

preparation of relevant explanatory material. Such organization shall have actual experience in preparing a similar guide for at least one other state. The superintendent, in consultation with the commissioner of health, may also contract with one or more national organizations to assist such commissioner in the collection of data and the analysis and auditing of the clinical measurers. Such organizations shall consult periodically with associations representing health insurers and health maintenance organizations as well as with consumer representatives in New York in preparing the consumer guide.

§ 213. New York state health care quality and cost containment commission. (a) There is hereby established within the department a commission, to be known as the "New York state health care quality and cost containment commission". The commission shall consist of thirteen members appointed by the governor, one of whom shall be the superintendent, one of whom shall be the commissioner of health, and six of whom shall be appointed on the recommendation of the legislative leaders, two on the recommendation of the temporary president of the senate, two on the recommendation of the speaker of the assembly, one on the recommendation of the minority leader of the senate, and one on the recommendation of the minority leader of the assembly. All members shall serve at the pleasure of the governor, and vacancies shall be appointed in the same manner as original appointments. Members of the commission shall serve without compensation, but shall be reimbursed for reasonable travel expenses. In making appointments to the commission, the governor shall ensure that the interests of health care consumers, small businesses, the medical community and health plans are represented on the commission.

(b)(1) The purpose of the commission shall be to analyze the impact on health insurance costs and quality of proposed legislation which would mandate that health benefits be offered or made available in individual and group health insurance policies, contracts and comprehensive health service plans, including legislation that affects the delivery of health benefits or services or the reimbursement of health care providers.

(2) The governor, the chair of the senate insurance committee and the chair of the assembly insurance committee may request in writing that

the commission evaluate a proposed mandated benefit. Upon receiving such a request, the commission may, by a majority vote of its members, undertake an evaluation of such proposed mandated benefit.

(3) In evaluating a proposed mandated benefit, the commission shall:

(A) investigate the current practices of health plans with regard to the proposed mandated benefit, and, to the extent possible, self-funded health benefit plans;

(B) investigate the potential premium impact of the proposed mandated benefits on all segments of the insurance market, as well as the potential for avoided costs through early detection and treatment of conditions, or more cost-effective delivery of medical services; and

(C) analyze the most current medical literature regarding the proposed mandated benefit to determine its impact on health care quality.

(4) In evaluating a proposed mandated benefit, the commission may hold one or more public hearings, and shall strive to obtain independent and verifiable information from diverse sources within the healthcare industry, medical community and among health care consumers with regard to the proposed mandated benefit.

(c) To assist the commission in its duties, and upon the direction of the commission, the superintendent is authorized to enter into one or more contracts with independent entities and organizations with demonstrable expertise in health care quality, finance, utilization and actuarial services. For the purposes of this section, the superintendent shall not enter into contracts with health plans, entities or organizations owned or controlled by health plans, or with significant business relationships with health plans.

(d) Upon completion of its evaluation of a proposed mandated benefit pursuant to this section, the commission shall deliver a written report of its findings to the chair of the assembly insurance committee and the chair of the senate insurance committee.

§ 214. Report on insurance agent licensing examinations. The superintendent shall perform a study of the insurance agent licensure examinations required pursuant to section two thousand one hundred three of this chapter. The study shall, at a minimum, include the total number of examinees, the passing rate of all examinees, and the mean scores on

the examination. Additionally, the study shall examine the correlation between these statistics and the applicants' native language, level of education, gender, race and ethnicity. The study shall be completed by March fifteenth, two thousand twelve, and annually thereafter.

ARTICLE 3

ADMINISTRATIVE AND PROCEDURAL PROVISIONS

Section 301. Regulations by superintendent.
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306. Immunity from prosecution.
307. Annual statements; audited financial statements.
308. Special reports.
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310. Examinations; how conducted.
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317. Compliance with reporting requirements of the financial security act.
318. Reports of fire losses; availability of information.
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320. Records to be made available by organizations subject to the provisions of this chapter.
321. Medical information exchange centers.
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330. Rating services available to other states.
331. Superintendent to maintain index of tax districts; insurers' requirements.

333. Assessments to defray expenses of Committee on Valuation of Securities of the National Association of Insurance Commissioners.
335. Implementation of hospital reimbursement methodology.
336. War risk exclusion; notification.
337. Annual consumer guide on automobile insurance.
339. Colorectal cancer screening notification.
340. Report of claims that may result in a monetary award.
341. Notification regarding qualified health insurance plans.
342. Public awareness to finance long term care.
343. Mental health and substance-related and addictive disorder services parity report.
344. Mental health and substance-related and addictive disorder parity compliance programs.
345. Health care claims reports.
346. Annual report on insurance for multi-family buildings.

§ 301. Regulations by superintendent. The superintendent shall have the power to prescribe and from time to time withdraw or amend, in writing, regulations, not inconsistent with the provisions of this chapter:

(a) governing the duties assigned to the members of the staff of the department;

(b) effectuating any power, given to him under the provisions of this chapter to prescribe forms or otherwise make regulations;

(c) interpreting the provisions of this chapter; and

(d) governing the procedures to be followed in the practice of the department.

§ 302. Supervisory colleges. (a) The superintendent may participate in a supervisory college in order to determine compliance with this chapter with respect to an insurer that is registered under article fifteen, sixteen, or seventeen of this chapter and has international operations. The powers of the superintendent with respect to supervisory colleges include:

(1) initiating the establishment of a supervisory college;

(2) clarifying the membership and participation of other supervisors in the supervisory college;

(3) clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) establishing a crisis management plan.

(b) Each insurer registered under article fifteen, sixteen, or seventeen of this chapter that is subject to a supervisory college shall be liable for and shall pay the reasonable expenses of the superintendent's participation in a supervisory college, including reasonable travel expenses. A supervisory college may be convened as either a temporary or permanent forum for the communication and cooperation between the regulators charged with the supervision of the insurer or its parent, affiliates, or subsidiaries. The superintendent may establish a regular assessment to the insurer for the payment of these expenses.

(c) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers, the superintendent may participate in a supervisory college with other regulators charged with supervision of the insurer or its parent, affiliates, or subsidiaries, including other state, federal, and international regulatory agencies. The superintendent may enter into agreements pursuant to section one hundred ten of this chapter providing the basis for cooperation between the superintendent and other regulatory agencies and for the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the superintendent's authority to regulate or supervise the insurer or its parent, affiliates, or subsidiaries within the superintendent's jurisdiction.

§ 306. Immunity from prosecution. (a) At any hearing conducted

pursuant to this chapter or in any cause or proceeding instituted by the superintendent pursuant to this chapter, the superintendent, or his deputy or other officer conducting the hearing, cause or proceeding may confer immunity in accordance with the provisions of section 50.20 of the criminal procedure law.

(b) No person compelled in accordance with the provisions of section 50.20 of the criminal procedure law to give answer or produce evidence of any other kind at any such hearing, cause or proceeding shall be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to this chapter. Any person testifying at any such hearing, cause or proceeding may execute, acknowledge and file in the office of the superintendent a statement expressly waiving his immunity or privilege against self-incrimination in respect to any transaction, matter or thing specified in such statement and thereupon the answers given or evidence produced by such person in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such person shall not be entitled to any immunity or privilege on account of any answers he may so give or evidence he may so produce.

§ 307. Annual statements; audited financial statements. (a) (1) Every insurer and every fraternal benefit society that is authorized to do an insurance business in this state, and every pension fund, retirement system or state fund that is required, by any law of this state, to report to the superintendent or is subject to the superintendent's examination, shall file in the office of the superintendent, annually on or before the first day of March, a statement, to be known as its annual statement, executed in duplicate, verified by the oath of at least two of its principal officers, showing its condition at last year-end or, in the case of a pension fund or retirement system, on such date in the year next preceding as the superintendent may approve. Such statement shall be in such form and shall contain such matters as the superintendent shall prescribe. The superintendent may accept an electronic filing of a foreign insurer's annual statement that does not contain the signatures or verification of the officers provided that the

foreign insurer has filed, in its state of domicile, an annual statement verified by the oath of at least two of its principal officers. In such a situation, the officers of the foreign insurer shall be deemed to have given their oath in this state.

(2) The superintendent shall from time to time prescribe the form of such annual statement, which may be a printed document and/or electronic media, and which may be varied as to different types of insurers, corporations, societies, pension funds and retirement systems, as shall seem to him best adapted to elicit a true exhibit of the condition of each such entity, in respect to every matter which he may deem material. For every annual statement form which differs from or is in addition to those adopted from time to time by the national association of insurance commissioners, the superintendent shall cause to be prepared and furnished to every insurer, pension fund or retirement system required by law to report to him, printed forms of the statements and schedules required by him.

(3) The annual statement of an alien insurer may be verified by the oath of the manager or assistant manager thereof within the United States, or by any other official of such insurer authorized by it to sign and verify its annual statements, if such authorization shall be proved by filing with the superintendent such evidence as he may require. The annual statement of an alien insurer, excepting a fraternal benefit society, shall be a separate statement, to be known as its general form of statement, of the business done within the United States and of the assets held by or for it within the United States for the protection of policyholders and creditors within the United States and of the liabilities incurred against such assets, and shall not contain any statement in regard to its assets and business elsewhere. But the superintendent may require any such alien insurer to give such additional information as to its total business or assets or any portion thereof as he may determine.

(4) Every insurer and every fraternal benefit society which is authorized to do an insurance business in this state, and every pension fund, retirement system or state fund which is required by any law of this state to report to the superintendent, which willfully fails to file an annual statement as required in this section, or willfully fails to reply within thirty days to a written inquiry by the superintendent

in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to two hundred fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

(b) (1) Every licensed insurer, except an assessment co-operative property/casualty insurance company having direct premiums written in this state of less than two hundred fifty thousand dollars in any calendar year and having less than five hundred policyholders at the end of such calendar year, shall be required to file within five months of the end of such calendar year, an annual financial statement (including an annual financial statement of any subsidiary of the type described in paragraph nine of subsection (a) of section one thousand four hundred four or subparagraph (B) of paragraph four of subsection (a) of section one thousand four hundred seven of this chapter) together with an opinion thereon of an independent certified public accountant on the financial statement of such insurer and any such subsidiary, which statement and opinion shall be available for public inspection at the office of the superintendent and the principal office of the insurer. Each such insurer shall furnish the superintendent with an evaluation by such accountant of the accounting procedures and internal control systems of the insurer that are necessary to the furnishing of the opinion. Each such insurer shall require the accountant to make available for review by the superintendent the work papers and any communications between the accountant and the insurer relating to the examination of the insurer. Any such work papers and communications made available to the superintendent shall be kept confidential, shall not be subject to subpoena and shall not be made public unless, after notice and opportunity to be heard, the superintendent determines that the interests of policyholders, stockholders or the public will be served by the publication thereof. Each such insurer shall require the accountant to notify the superintendent if the accountant has determined that the insurer has materially misstated its financial condition as reported to the superintendent or that the insurer does not meet minimum capital or surplus to policyholder requirements.

(2) If the insurer is part of a group of insurance companies which utilizes a pooling agreement or one hundred percent reinsurance

agreement that affects the solvency and integrity of such insurer's reserves and such insurer cedes all of its direct and assumed business to the pool, then such insurer may file audited consolidated or combined financial statements in lieu of separate annual audited financial statements provided that a consolidating or combining exhibit be filed that clearly reconciles amounts in the audited financial statement to the individual company annual statements. In addition, an insurer may comply by filing statements prepared in accordance with generally accepted accounting principles, provided that appropriate reconciliation is made of the differences between net income and capital and surplus reported on that basis and that reported in the annual statutory statement filed with the superintendent.

(3) In lieu of the requirements of this subsection, the superintendent may accept copies of filings of audited financial statements required by another state where they are found to be substantially similar to the requirements herein. Upon written application of any insurer, extensions of the filing date and exemptions from the filing requirements may be granted by the superintendent, if the superintendent finds, upon review of the application, that compliance would constitute a financial or organizational hardship upon the insurer.

§ 308. Special reports. (a) (1) The superintendent may also address to any health maintenance organization, life settlement provider, life settlement intermediary or its officers, or any authorized insurer or rate service organization, or officers thereof, any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of a corporation, as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(2) In the event any corporation or person does not provide a good faith response to an inquiry from the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance or health maintenance organization coverage or with respect to life settlements, within a time period specified by the

superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such corporation or person not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response, but in no event shall such penalty exceed seven thousand five hundred dollars.

(b) In addition to the other reports required by this article, the superintendent may also require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe.

(c) The superintendent shall ensure that any contracts entered into, modified, extended or in any way made or continued with an organization or administrator to receive, distribute and otherwise administer funds for the pools specified in section eighteen of chapter two hundred twenty-six of the laws of nineteen hundred eighty-six and sections three thousand two hundred thirty-three, four thousand three hundred twenty-one-a and four thousand three hundred twenty-seven of this chapter, shall require such organization or pool administrator to submit the reports required pursuant to section two hundred six of the public health law at the time and in the format and manner specified in such section.

§ 309. Examinations of insurers; when authorized or required. (a) The superintendent may make an examination into the affairs of any insurance corporation or other insurer doing or authorized to do any insurance business in this state or, of any pension fund, retirement system or other organization which is required by law to make reports to, or is subject to examination by, the department as often as he deems it expedient for the protection of the interests of the people of this state, in addition to examinations authorized by other provisions of this chapter.

(b) The superintendent shall make an examination into the affairs:

(1) of every authorized domestic fraternal benefit society and every domestic property/casualty insurance company, at least once in every three years; except that the superintendent may extend the three year interval to not more than five years with respect to a property/casualty

insurance company, upon determining that the three year requirement is not necessary to safeguard the interests of the public or policyholders;

(2) of every domestic life insurance company, at least once in every five years; and

(3) of every other authorized domestic insurer and every rate service organization which makes or files rates, whether or not advisory, at least once in every five years.

* (c) As part of an examination, the superintendent shall review determinations of coverage for substance use disorder treatment and shall ensure that such determinations are issued in compliance with sections three thousand two hundred sixteen, three thousand two hundred twenty-one, four thousand three hundred three, and title one of article forty-nine of this chapter.

* NB Effective until January 1, 2027

* (c) As part of an examination, the superintendent shall review determinations of coverage for substance-related and addictive disorder services and shall ensure that such determinations are issued in compliance with sections three thousand two hundred sixteen, three thousand two hundred twenty-one, four thousand three hundred three, and title one of article forty-nine of this chapter.

* NB Effective January 1, 2027

§ 310. Examinations; how conducted. (a) (1) Whenever pursuant to any provision of this chapter, the superintendent shall determine to examine the affairs of any insurer or other person, he shall make an order indicating the scope of the examination and may appoint as examiners one or more persons not employed by any insurer or interested in any insurer except as a policyholder. A copy of such order shall upon demand be exhibited to the insurer or person whose affairs are to be examined before the examination begins.

(2) Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person, including those of any affiliated or subsidiary companies thereof, which are relevant to the examination, and shall have power to administer oaths and to examine under oath any officer or agent of such insurer or

other person, and any other person having custody or control of such documents, regarding any matter relevant to the examination.

(3) The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so.

(4) The refusal of any insurer to submit to examination shall be ground for revocation or refusal of a license or renewal license.

(5) The examiner or examiners in charge of such examination shall make a true report of every examination made by them, verified under oath, which shall comprise only facts appearing upon the books, records, or other documents of such insurer or other person or as ascertained from the sworn testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as may reasonably be warranted from such facts.

(b) In connection with any such examination the superintendent may appoint one or more competent persons as appraisers with authority to appraise the real property of such insurer or other person or any real property on which it holds security. The report of such appraisers shall be a supplement to the report of the examiner or examiners in charge, and shall be subject to notice and hearing as provided in section three hundred eleven of this article.

§ 311. Filing of report on examination. (a) Except as hereinafter provided the superintendent may withhold from public inspection for such time as he deems proper any report on examination made pursuant to section three hundred ten of this article.

(b) (1) Before adopting any such report and filing it for public inspection, the superintendent shall notify the insurer or other person examined of its contents and shall afford such insurer or other person a reasonable opportunity to obtain further details and to demand a hearing with reference to facts, conclusions or recommendations therein contained.

(2) If a hearing is requested within ten days after the giving of such notice, the superintendent shall give notice and a hearing in accordance with the provisions of this article. Such hearing shall be held before the superintendent or a deputy superintendent.

(c) The report on examination, with modifications thereof, if any, shall be accepted by the superintendent and filed for public inspection within six months after final hearing thereon and if he deems it in the public interest to do so, he may publish any such report or any excerpt therefrom or summary thereof, in one or more newspapers in the state.

(d) In any action or proceeding in the name of the people against the insurer or other person examined, or any officer or agent thereof, such report, if adopted by the superintendent and filed for public inspection, shall be admissible in evidence and shall be presumptive evidence of the facts stated therein.

(e) Nothing herein contained shall preclude the superintendent from instituting any proceeding under article seventy-four of this chapter at any time or from using as proof in such proceeding any report on examination or part thereof, whether or not such report has been adopted and filed.

§ 312. Report on examination to be forwarded. (a) The superintendent shall forward to every insurer or other person examined a copy of the report on examination as filed for public inspection, together with any recommendations or statements relating thereto which he may deem proper.

(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report. The superintendent may require that a copy of the report shall also be furnished by such insurer to the supervising insurance official of each state in the United States in which such insurer is authorized to do an insurance business.

§ 314. Public retirement and pension systems. (a) In this section, "system" means an actuarily funded public retirement or pension system of the state of New York or of a municipality thereof.

(b) Notwithstanding any other provision of law to the contrary, the superintendent shall have, in addition to any other powers conferred upon him by law, the following authority with respect to any system:

(1) to require the administrative head or trustees of a system as may be appropriate to file an annual report pursuant to the provisions of section three hundred seven of this article in such form and containing such matters as the superintendent shall prescribe, and to respond in such form as the superintendent may require to any inquiry in relation to transactions or condition of the system or any matter connected therewith pursuant to the provisions of section three hundred eight of this article;

(2) to promulgate and amend from time to time, after consultation with the administrative heads of systems and after a public hearing, standards with respect to actuarial assumptions, accounting practices, administrative efficiency, discharge of fiduciary responsibilities, investment policies and financial soundness; and

(3) to make an examination into the affairs of every system, including compliance with the standards established pursuant to paragraph two of this section, at least once in every five years in accordance with the provisions of sections three hundred ten, three hundred eleven and three hundred twelve of this article and to recover the expenses of such examination from such system in accordance with the provisions of subsection (f) of section two hundred six of the financial services law. A copy of each report on examination as filed for public inspection shall be forwarded to the governor, state comptroller and legislature and, in the case of systems of the city of New York, to the mayor, city comptroller and president of the city council.

§ 315. Professional malpractice or misconduct; reporting requirements. (a) Every organization or person authorized to issue professional liability insurance policies in this state shall report any disposition, whether by judgment or settlement, of any claim made against an individual licensed pursuant to the provisions of title eight of the education law where the claim was based upon fraud, incompetence or negligence except that reports for physicians, physician's assistants and specialist's assistants shall be reported pursuant to the provisions of subsection (b) hereof.

(b) (1) Each insurance company engaged in issuing professional medical malpractice insurance in this state the medical malpractice insurance

association shall file with the superintendent and with the commissioner of health quarterly reports on all claims for medical malpractice made against any of its insureds and received by it during the preceding three month period, a report of any surcharge or merit-rating adjustment made on an insured's premium and the reason for the surcharge or merit-rating adjustment and a report of any cancellation, including voluntary cancellation by the insured and the reason for the cancellation, of its insureds professional medical liability insurance for reasons other than non-payment of premiums during the preceding three month period.

(2) Each hospital, as defined in article twenty-eight of the public health law, which, and each health care practitioner licensed, certified or registered pursuant to the provisions of title eight of the education law who, is self-insured for professional medical malpractice or is insured for professional medical malpractice with an insurance company not licensed to do business in this state shall also file quarterly reports with the superintendent and the commissioner of health on all claims for medical malpractice made against him, her, or it during the preceding three month period. For purposes of this section, a hospital which, or individual who, is self-insured for professional medical malpractice shall mean a hospital which, or individual who, is not insured for professional medical malpractice with either an insurance company engaged in issuing professional medical malpractice insurance in this state or the medical malpractice insurance association or an insurance company not licensed to do business in this state.

(c) Reports required by this section shall contain the following information:

(1) the name and address of the professional licensee against whom such claim is made, including the name and address of the hospital, other person or institution if the report is made pursuant to subsection (b) hereof;

(2) the name, address and age of the claimant or plaintiff;

(3) the nature and substance of the claim;

(4) the date and place in which the claim arose;

(5) within three months after final disposition of the claim, the amounts paid, if any, and the date and manner of disposition (by judgment, settlement or otherwise);

(6) the reasons for the cancellation of professional liability insurance for reasons other than non-payment of premiums; and

(7) such additional information as the superintendent or the commissioner of education shall require for reports required by subsection (a) hereof and as the superintendent and commissioner of health shall require for reports required by subsection (b) hereof.

(d)(1) Reports required by subsection (a) hereof shall be in writing on a form prescribed by the superintendent and commissioner of education and shall be submitted to the department of education within sixty days of the date of any settlement or judgment.

(2) Reports required by subsection (b) hereof shall be in writing on a form prescribed by the superintendent and commissioner of health and shall be submitted to them not less than quarterly on dates jointly determined by them and shall contain information received during the preceding three month period concerning claims received, additional required data not previously reported and disposition of claims.

(e) Written reports and other documentation compiled pursuant to subsection (a) hereof shall be admissible in evidence in any administrative or judicial action or proceeding.

(f) Any report or information furnished or compiled pursuant to this section shall be deemed to be a confidential communication. Reports required by subsection (a) hereof shall not be subject to inspection or disclosure in any manner except upon written request by a duly authorized public agency or pursuant to a judicial subpoena issued in a pending action or proceeding. Reports required by subsection (b) hereof shall not be open for review or be subject to subpoena except by a public agency or authority of this state.

(g) Malpractice insurance compliance reporting requirements. The failure to make any report required by this section shall constitute a misdemeanor. The department of health shall oversee the enforcement of this subdivision, and on or before June thirtieth of each calendar year provide a report to the governor and the legislature regarding industry compliance. Such report shall include a recommendation from the department regarding changes in the applicable penalties for noncompliance, which are necessary to ensure the integrity of the reporting system. The department shall further study the necessity of assessing penalties for false reporting by physicians, hospitals, or

health care plans for purposes of collecting and disseminating data required to be disclosed pursuant to title one of article twenty-nine-d of the public health law.

§ 316. Electronic filings. Notwithstanding subdivision one of section three hundred five of the state technology law, the superintendent may promulgate regulations to require an insurer or other person or entity making a filing or submission with the superintendent pursuant to this chapter to submit the filing or submission to the superintendent by electronic means. Should the superintendent require that a filing or submission be made by electronic means, an insurer or other person or entity affected thereby may submit a request to the superintendent for an exemption from the electronic filing requirement upon a demonstration of undue hardship, impracticability, or good cause, subject to the approval of the superintendent.

§ 317. Compliance with reporting requirements of the financial security act. Insurers licensed to write personal injury liability insurance in connection with the ownership, maintenance or use of motor vehicles, as authorized pursuant to paragraph thirteen of subsection (a) of section one thousand one hundred thirteen of this chapter, shall fully comply with the reporting requirements of article six of the vehicle and traffic law. In the event that an insurer fails to timely and properly report any of the information required by such article or the regulations of the commissioner of motor vehicles promulgated thereunder, the superintendent, upon notice and an opportunity to be heard, is authorized to impose a fine on such insurer in an amount not to exceed five hundred dollars for each failure to timely and properly report. In the event of a persistent and willful violation of the reporting requirements, the superintendent, upon notice and an opportunity to be heard, is authorized to impose a fine on such insurer, in an amount not to exceed five thousand dollars per day for each day such violation continues.

§ 318. Reports of fire losses; availability of information. (a) Insurers shall report all fire losses in excess of five hundred dollars or such larger amount as prescribed by the superintendent, arising under policies covering property located in this state to a central organization engaged in property loss registration, as designated by the superintendent, in accordance with regulations promulgated by the superintendent.

(b) The information contained in such reports shall, in accordance with such regulations, be available to law enforcement agencies, to tax districts which have, pursuant to the provisions of section twenty-two of the general municipal law, filed with the superintendent a notice of intention to claim against the proceeds of a policy of fire insurance, to the office of fire prevention and control and to appropriate governmental agencies charged with the responsibility for demolition of structures.

§ 319. Release of information resulting from insurers' investigation of fires. (a) In this section, "authorized law enforcement agency" means:

(1) any official of any agency authorized to investigate a fire at the place where the fire occurred;

(2) the district attorney responsible for the prosecution in the county where the fire occurred; and

(3) solely for the purpose of subsections (b) and (c) hereof, the Federal Bureau of Investigation or any other federal agency, and the United States attorney's office when authorized or charged with investigation or prosecution of the fire in question.

(b) Each insurer authorized to issue policies covering losses incurred to personal or real property through fire shall contact the appropriate authorized law enforcement agency and release information in its possession resulting from an investigation conducted by it pertaining to any such fire loss, should the insurer be of the opinion that the fire was caused by other than accidental means. The notification to a single authorized agency shall be sufficient for purposes of this section, provided, however, that in cities with a population over one million, notification to the appropriate fire protection agency shall be

sufficient for the purposes of this section.

(c) Any authorized law enforcement agency may, in writing, require the insurer to release, to that agency, any relevant information or evidence deemed important to the authorized law enforcement agency that the insurer may have in its possession relating to the fire loss in question. Relevant information shall include, but shall not be limited to:

(1) pertinent insurance policy information relevant to a fire loss under investigation and any application for such a policy;

(2) policy premium payment records that are available;

(3) history of previous claims made by the insured; and

(4) material relating to the investigation of the loss, including statements of any person, proof of loss, and any other evidence relevant to the investigation.

(d) Any insurer providing information to an authorized law enforcement agency or agencies concerning a particular fire loss for which the insurer has provided information pursuant to this section shall have the right to request relevant information and to receive within a reasonable time, not to exceed thirty days after the receipt of such request, the information requested, provided that the information is not subject to the provisions of paragraphs (a), (e) and (f) of subdivision two of section eighty-seven of the public officers law. This subsection shall confer no substantive or procedural rights on a defendant in a criminal action, proceeding or prosecution.

(e) The authorized agency provided with information pursuant to subsection (c) hereof, in furtherance of its own purposes, may release or provide such information to any other authorized law enforcement agency.

(f) Any information or evidence furnished pursuant to this section shall be held in confidence by the appropriate agency until such information is required to be released pursuant to a criminal proceeding, or if such agency shall be served a summons or subpoena to testify as to any information or evidence in its possession regarding such fire loss in any civil action where an insured or other person is seeking recovery under a policy against an insurer for fire damage to real or personal property.

§ 320. Records to be made available by organizations subject to the provisions of this chapter. (a) Every insurer shall, upon request of the state department of social services or of a local social services district for any records, or any information contained in such records, pertaining to the coverage of any individual for such individual's medical costs under any individual or group policy or other obligation made by such organizations, or the medical benefits paid by or claims made to such organizations pursuant to such policy or other obligation in accordance with the limitations of subsection (c) hereof, make the requested records or information available upon a certification by the department of social services or the social services district that such individual is an applicant for or recipient of medical assistance, or is a person who is legally responsible for such an applicant or recipient, pursuant to the social services law.

(b) The superintendent and the commissioner of the state department of social services shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of records, which procedures shall include financial arrangements as may be necessary to reimburse insurers for necessary costs incurred in furnishing requested information, and the time and manner such procedures are to become effective. Such procedures may be added to a new cooperative agreement which shall supersede the agreement currently in existence between the superintendent and the commissioner of social services.

(c) The department of social services or a local social services district shall request only that information necessary to determine whether any insurance benefits have been or should have been claimed and paid with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subsection (b) hereof become effective, the superintendent shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer, is used only for the purpose of

identifying the records or information requested in such manner so as not to violate the confidentiality provisions of the social services law.

(e) (1) Every insurer shall, upon request of an authorized representative of the state office of temporary and disability assistance, or a social services district child support enforcement unit established pursuant to section one hundred eleven-c of the social services law, enter into an agreement with the state office of temporary and disability assistance or a social services district to develop and operate a data match system, using automated data exchanges to the maximum extent feasible, in which each such insurer, pension fund, retirement system or other organization shall provide for each calendar quarter the name, record address, social security number or other taxpayer identification number, and other identifying information for each individual who maintains a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account at such institution and who owes past-due support, as identified by the state office of temporary and disability assistance or a social services district child support enforcement unit by name and social security number or other taxpayer identification number. Nothing herein shall be deemed to limit the authority of a local social services district support collection unit pursuant to section one hundred eleven-h of the social services law.

(2) No insurer which discloses information pursuant to paragraph one of this subsection, or discloses any financial record to the state office of temporary and disability assistance or a social services district child support enforcement unit for the purpose of enforcing a child support obligation of such person, shall be liable under any law to any person for such disclosure, or for any other action taken in good faith to comply with paragraph one of this subsection.

(f) "Insurer", as used in this section, means:

(1) (i) an insurer required to be licensed to do an insurance business in this state under this chapter, including a corporation subject to article forty-three or forty-seven of this chapter;

(ii) a pension fund, retirement system or other organization required by law to make reports to, or which is subject to examination by, the superintendent;

(iii) a health maintenance organization subject to article forty-four of the public health law; or

(iv) a self-funded plan or any other insurer with respect to any medical claim or benefit of a resident of this State; and

(2) any person or other entity acting on behalf of an insurer as described in paragraph one of this subsection with respect to any medical claim or benefit of a resident of this State.

§ 321. Medical information exchange centers. (a) Whenever any insurance company (which is a member of a medical information exchange center or which otherwise may transmit medical information in whatever manner to any other similar facility including but not limited to an electronic data facility used by two or more insurance companies to determine or aid in determining the insurability of applicants) requests medical information from any applicant for personal insurance, it shall not transmit, nor be considered to have obtained the applicant's informed consent to transmit, the information to any such facility unless such company furnishes such applicant with a clear and conspicuous notice disclosing:

(1) a description of such facility and its operations, including its name, address and telephone number where it may be contacted to request disclosure of any medical information transmitted to it;

(2) the circumstances under which such facility may release such medical information to other persons; and

(3) such applicant's rights to request such facility to arrange disclosure of the nature and substance of any information in its files pertaining to him, and to seek correction of any inaccuracies or incompleteness of such information.

(b) Such notice shall be given to all applicants when any application for personal insurance is completed.

(c) No such facility shall release, transmit or otherwise communicate any medical information it may have to any other person unless such other person shall have in its possession a written instrument signed by the person who is the subject of medical information (or by a parent or guardian if such subject is a minor) specifically naming such facility and authorizing such other person to obtain such medical information

from such facility.

(d) No such facility shall maintain information about HIV related test results pertaining to any individual unless such test results are included within a general code, which code is not designated solely for HIV related test results, and concerning which code no member of such facility may request from such facility details sufficient to determine whether the code was used to maintain information about HIV related test results.

For purposes of this subsection, an "HIV related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.

§ 322. Prohibited referral payment to licensees by motor vehicle repairers. No licensed insurance agent, licensed insurance broker, licensed adjuster, authorized insurer or representative of such insurer shall directly or indirectly request, procure or accept any payment from a motor vehicle repairer for referring any motor vehicle repair business to such repairer.

§ 325. Records of domestic insurers. (a) Every domestic insurer and every licensed United States branch of an alien insurer entered through this state shall, except as hereinafter provided, keep and maintain at its principal office in this state its charter and by-laws (in the case of a United States branch a copy thereof) and its books of account, and if a domestic stock corporation a record containing the names and addresses of its shareholders, the number and class of shares held by each and the dates when they respectively became the owners of record thereof, and if a domestic corporation the minutes of any meetings of its shareholders, policyholders, board of directors and committees thereof. If any such records are kept in a language other than English, they shall be accompanied by accurate translations thereof. An insurer may satisfy the requirements of this subsection by storing the aforementioned books and records on servers that are accessible through

the internet, on an internal server hosted by the insurer or one of its affiliates, or externally with a third-party service provider if they are easily accessible from the insurer's principal office in this state and the insurer complies with all applicable state and federal laws and regulations.

(b) A domestic insurer and a licensed United States branch of an alien insurer entered through this state may keep and maintain its books of account without this state if, in accordance with a plan adopted by its board of directors and approved by the superintendent, it maintains in this state suitable records in lieu thereof; provided, however, that the superintendent may after notice and hearing direct such insurer to return all or any of its books of account to this state if such return is reasonably necessary to protect the interests of the people of this state or to permit their inspection in this state by a director, a shareholder, or, in the case of a mutual insurer, a policyholder, who has shown to the satisfaction of the superintendent that he has made an application to such insurer for inspection of such books in good faith and for a necessary and legitimate purpose, and that such insurer has either declined to permit such inspection without this state or to agree to pay any additional expenses reasonably to be incurred by the applicant or his agent or attorney in connection with the inspection of such books as a result of their maintenance without this state. If in the judgment of the superintendent delay in the return of any or all books of account of such insurer may be hazardous, or may cause irreparable injury, to the people of this state or to the policyholders of such insurer he may direct the return thereof without notice and hearing.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section, any licensed United States branch of an alien insurer entered through this state which keeps and maintains its books of account without this state on April first, nineteen hundred eighty-seven may continue to do so, unless the superintendent determines, after notice and hearing, that the return of such books to this state is reasonably necessary to protect the interests of the people of this state.

§ 329. Certificates as evidence; affirmation of documents and

testimony. (a) Every certificate, assignment, conveyance or other paper executed by the superintendent or one of his deputies pursuant to law and sealed with the official seal of the department shall be received as evidence in any judicial or other proceeding and may be recorded in the proper recording offices.

(b) Any charter, or any certificate or other instrument supplemental to or amendatory of the charter, of an insurer filed in the office of the superintendent and containing statements of fact required or permitted by law to be contained therein, shall be received in all courts, public offices and official bodies as prima facie evidence of such facts and of the execution of such instrument.

(c) Whenever by the laws of any jurisdiction other than this state, any certificate by any officer in such jurisdiction or a copy of any instruments certified or exemplified by any such officer, may be received as prima facie evidence of the incorporation, existence or capacity of any corporation incorporated in such jurisdiction, or claiming so to be, such certificate when exemplified, or such copy of such instrument when exemplified shall be received in all courts, public offices and official bodies of this state, as prima facie evidence with the same force as in such jurisdiction. Such certificate or certified copy of such instrument shall be so received, without being exemplified, if it is certified by the secretary of state, or official performing the equivalent function as to corporate records of such jurisdiction.

(d) Notwithstanding any provision of this chapter requiring an oath as to the proof of a document or the truth of testimony, the affiant may, if his religious beliefs cause him to object to giving an oath, affirm the document or his testimony.

§ 330. Rating services available to other states. (a) The superintendent shall have authority to contract with the insurance supervisory officials of other states to make available the services of the rating and statistics sections of the department for the purpose of examining and reviewing rate filings made with such officials and to render such other advisory assistance in connection therewith as said officials may request. The provisions of section one hundred twelve of the state finance law shall be applicable to such contracts.

(b) All expenses, including the compensation of officers and employees of the department made pursuant to any such contract, shall be paid in the first instance out of the state treasury on the certificate of the superintendent upon audit and warrant of the comptroller and shall be presented in the form of an itemized bill therefor to such insurance supervisory officials. The state treasury shall be reimbursed by payments thereto by the superintendent of amounts collected by him in accordance with the provisions of this section.

§ 331. Superintendent to maintain index of tax districts; insurers' requirements. (a) The superintendent shall maintain a suitable index of tax districts which, pursuant to the provisions of section twenty-two of the general municipal law, file with him a notice of intention to claim against the proceeds of a policy of fire insurance insuring the interest of an owner in any premises located therein against which a lien, as defined by such section exists.

(b) Such index shall be kept current on a daily basis and shall be available for public inspection during regular business hours. It shall contain such information as the superintendent deems appropriate.

(c) Every such notice received by the superintendent shall become effective on the date of entry thereof in such index and shall constitute constructive notice to each insurer of the tax district's claim against any proceeds payable pursuant to the provisions of any insurance policy subject to the provisions of section three thousand four hundred ten of this chapter.

(d) Upon a final determination of an insurer's obligation to pay any proceeds of a policy of insurance for damages caused by fire to real property, as such term is defined in section twenty-two of the general municipal law, and prior to payment of such proceeds, each insurer or, in the case of a policy purchased from an unauthorized insurer pursuant to section two thousand one hundred five of this chapter, each insurer or its adjusting representative, shall notify the enforcing officer of each tax district in which the property is located and which is entered in the index that a loss has been sustained and demand in writing by registered or certified mail that such officer's certificate indicating the amount of all liens of the district against the property, including

interest and penalties to the date of the certificate, be served, at a specified address, in person or by registered or certified mail, upon the insurer, or, in the case of a policy purchased from an unauthorized insurer pursuant to section two thousand one hundred five of this chapter, upon the insurer or its adjusting representative, within twenty days from the date of receipt of such demand.

(e) Upon the failure of the enforcing officer to serve the certificate of lien in accordance with subsection (d) hereof, the right of the tax district to claim against any such proceeds shall terminate. Within ten days of receipt of such certificate of lien the insurer shall pay to the enforcing officer from such proceeds the amounts specified in the certificate.

§ 333. Assessments to defray expenses of Committee on Valuation of Securities of the National Association of Insurance Commissioners. (a) The purpose of this section is to provide a means of making funds available, not in excess of two hundred fifty thousand dollars in any one year, to the Committee on Valuation of Securities of the National Association of Insurance Commissioners to defray the expenses of such committee, in the investigation, analyses and valuation of securities and the determination of the amortizability of bonds, owned by insurers, for the purpose of furnishing to the several states on a uniform basis information needed in the supervision of insurers licensed to transact business in the several states.

(b) The superintendent shall have authority to contract with such committee to make available to the department the analyses, reports and information developed by the committee and, after taking into consideration similar payments which may be made by other states, for the department to make payment to such committee, to the extent authorized in subsection (a) hereof on account of the expenses of the committee, from funds obtained through assessments for such purpose under this section.

(c) The superintendent shall periodically obtain from the committee a verified budget estimate of receipts and expenses to be incurred by the committee for a stated period, not exceeding one year, with appropriate explanations of the estimates therein contained.

(d) (1) If the superintendent shall be satisfied as to the reasonableness of such budget estimate, he shall determine the portion of the funds required by the estimate, to be assessed as hereinafter provided, by deducting from the estimate or from the sum of two hundred fifty thousand dollars, whichever is less, any amounts received or receivable by the committee from other states whose laws do not substantially conform to the method of assessment herein provided and applying to the remainder the proportion which the total investments in securities of domestic life insurers bear to the total investments in securities of life insurers domiciled in this and other states whose laws authorize and require assessments on substantially the same bases as herein provided.

(2) The superintendent shall thereafter as soon as convenient, by notice stating the method of computation thereof, assess the amount to be paid on account of such expenses, pro rata upon all domestic life insurers in the proportion which the total investments in securities of each domestic life insurer shall bear to the total investments in securities of all such insurers. The total investments in securities of any life insurer for purposes of this section shall be the total admitted value of stocks and bonds reported as such in its annual statement last filed prior to such assessment with the department of financial services or with the supervisory official of its state of domicile. Upon receipt of such notice each such insurer shall within thirty days pay said assessment to the superintendent.

(3) The superintendent shall deposit all moneys collected by him pursuant to this section in an account entitled "Superintendent of Financial Services, Security Valuation Expense Account", in a bank or trust company in the city of Albany designated by the comptroller. Such moneys shall be paid by the superintendent to the Committee on Valuation of Securities of the National Association of Insurance Commissioners after audit by the comptroller.

(e) The superintendent shall annually require of such committee, and at such other times as he may deem it necessary or advisable, a duly certified audit of receipts and disbursements and statement of assets and liabilities, showing the details of its financial operations.

§ 335. Implementation of hospital reimbursement methodology. The superintendent shall have the power to prescribe rules and regulations governing insurer procedures and subscriber contract provisions necessary to implement a hospital reimbursement methodology established in accordance with the provisions of article twenty-eight of the public health law, and insurer procedures and subscriber contract provisions necessary to implement a hospital inpatient discharge review program established in accordance with the provisions of section twenty-eight hundred three-i of the public health law, and to establish standards, criteria and procedures for evaluation of insurer performance in offering contracts for hospital and medical benefits on an open enrollment basis necessary for a determination of the hospital payment rate conversion factor in accordance with the provisions of paragraph (i) of subdivision eleven of section twenty-eight hundred seven-c of the public health law.

The superintendent shall periodically report his findings and conclusions to the commissioner of health and to the chairman and vice-chairman of the council on health care financing concerning insurer performance in offering contracts for hospital and medical benefits on an open enrollment basis.

§ 336. War risk exclusion; notification. Prior to a life insurer commencing the issuance of life insurance policies which contain any provision that restricts or excludes payment of the life insurance death benefit in the event of death as the result of war or the special hazards incident to service as defined in subsection (c) of section three thousand two hundred three of this chapter such insurer shall notify the superintendent specifying how, when, where and to which class of persons such provision will apply and shall also notify the superintendent when it ceases issuing such policies. The superintendent shall make such information known to the public in such manner and at such times as shall be determined by the superintendent.

§ 337. Annual consumer guide on automobile insurance. (a) The

superintendent shall issue and update, as necessary, a consumer guide on private passenger automobile insurance that shall contain comprehensive information written in plain language in a clear and understandable format, including the following:

(1) an annual ranking of automobile insurers: (A) including an analysis of private passenger insurers in the state which provides, in detail, a ranking of such insurers from best to worst based on each insurer's record of consumer complaints during the preceding calendar year, using criteria available to the department, adjusted for volume of insurance written; and (B) taking into consideration the corresponding total of claims improperly denied in whole or in part, consumer complaints found to be valid in whole or in part, and any other pertinent data which would permit the department to objectively determine an insurer's performance; and (C) the superintendent may note, to the extent relevant, actions taken by the department against an insurer for violating any law or regulation;

(2) a list of makes and models of automobiles that generally do not meet underwriting guidelines of automobile insurers or in regard to which consumers can expect to pay higher premiums as a result of an automobile's style, model type or other distinguishing features, except that specific insurers shall not be identified for purposes of such list;

(3) an explanation of all types of automobile insurance required by law and available as optional coverage, including policyholders' rights under these types of coverage and when making claims;

(4) an explanation of and information on the automobile insurance plan established pursuant to article fifty-three of this chapter, including how motorists in such plan should proceed in attempting to obtain insurance in the voluntary market;

(5) recommendations as to how best to shop for and compare prices, service and quality of automobile insurance coverage;

(6) an explanation of prohibited discriminatory practices applying to insurance companies, agents and brokers; and

(7) a department toll free consumer hot-line through which consumers may initiate complaints, and request general information, about automobile insurance.

(b) The requirements set forth in subsection (a) of this section may

be satisfied by separate or supplemental publications and updates.

(c) The superintendent shall post the consumer guide on automobile insurance on the department's website.

§ 339. Colorectal cancer screening notification. The superintendent shall require an insurer authorized to write accident and health insurance in this state, a corporation organized pursuant to article forty-three of this chapter, and a health maintenance organization certified pursuant to article forty-four of the public health law to notify insureds and enrollees at least annually of colorectal cancer screenings covered by such insureds' or enrollees' health insurance policy or contract, and of the most recently published guidelines of the American Cancer Society for colorectal cancer screenings that are covered by such insureds' or enrollees' health insurance policy or contract. The notice shall be delivered by United States postal mail unless the insured or enrollee consents to another method of notification, including electronic notification.

§ 340. Report of claims that may result in a monetary award. (a) Definition; for the purposes of this section:

"Central reporting organization" shall mean any entity which receives from, assimilates or disseminates information to insurers or the department of social services regarding bodily injury, wrongful death and death benefits.

(b) Insurers shall report within a reasonable period of time to a central reporting organization of its choosing all claims filed for bodily injury, wrongful death and death benefits under any policy which provides coverage for liability for injury to person, except claims for medical malpractice, workers' compensation or other similar insurance required by law, and comprehensive motor vehicle insurance reparations benefits. The central reporting organization shall in turn report this information to the department of social services.

(c) An insurer shall be deemed to be in compliance with this section if such information was reported within a reasonable period of time to the central reporting organization with which the insurer contracts.

(d) In the absence of fraud or bad faith for failure to make or file any report pursuant to this section, no person subject to this section or acting under authority of this section shall be subject to civil liability, and no civil cause of action shall arise against such person for the furnishing of any information pursuant to this section. Nothing herein shall abrogate or modify in any way an immunity privilege, provided in statute or by common law.

(e) No person making any report pursuant to this section shall be compelled to provide such information, or any report thereof, to the superintendent.

(f) Insurers or central reporting organizations complying with this section shall have immunity in accordance with provisions of section 50.20 of the criminal procedure law.

(g) Personally identifying information about applicants and recipients of public assistance obtained through the establishment or operation of any reporting program established by this section by the department of social services, social services districts or by a contractor shall be kept confidential in accordance with section one hundred thirty-six of the social services law and the regulations of the department of social services.

§ 341. Notification regarding qualified health insurance plans. Within fifteen days of the effective date of this section, the superintendent shall notify the centers for Medicare and Medicaid services that New York state elects to have policies issued pursuant to sections four thousand three hundred twenty-one, four thousand three hundred twenty-two and four thousand three hundred twenty-six of this chapter as "qualified health insurance" for the purpose of assistance under the federal Trade Adjustment Assistance Reform Act of 2002.

§ 342. Public awareness to finance long term care. The department, department of health, office for the aging and department of taxation and finance may jointly establish and conduct a public awareness program on the availability and coverage provided by life insurance and health insurance plans for long term care, and the provisions of various tax

credits therefor.

*** § 343. Mental health and substance use disorder parity report.** (a) Beginning July first, two thousand nineteen and every two years thereafter, each insurer providing managed care products, individual comprehensive accident and health insurance or group or blanket comprehensive accident and health insurance, each corporation organized pursuant to article forty-three of this chapter providing comprehensive health insurance and each entity licensed pursuant to article forty-four of the public health law providing comprehensive health service plans shall submit to the superintendent, in a form and manner prescribed by the superintendent, a report detailing the entity's compliance with federal and state mental health and substance use disorder parity laws based on the entity's record during the preceding two calendar years. The superintendent shall publish on the department's website on or before October first, two thousand nineteen, and every two years thereafter, the reports submitted pursuant to this section.

(b) Each person required to submit a report under this section shall include in the report the following information:

(1) Rates of utilization review for mental health and substance use disorder claims as compared to medical and surgical claims, including rates of approval and denial, categorized by benefits provided under the following classifications: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs;

(2) The number of prior or concurrent authorization requests for mental health services and for substance use disorder services and the number of denials for such requests, compared with the number of prior or concurrent authorization requests for medical and surgical services and the number of denials for such requests, categorized by the same classifications identified in paragraph one of this subsection;

(3) The rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for mental health claims and substance use disorder claims compared with the rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for medical and surgical claims;

(4) The percentage of claims paid for in-network mental health services and for substance use disorder services compared with the percentage of claims paid for in-network medical and surgical services and the percentage of claims paid for out-of-network mental health services and substance use disorder services compared with the percentage of claims paid for out-of-network medical and surgical services;

(5) The number of behavioral health advocates, pursuant to an agreement with the office of the attorney general if applicable, or staff available to assist policyholders with mental health benefits and substance use disorder benefits;

(6) A comparison of the cost sharing requirements including but not limited to co-pays and coinsurance, and the benefit limitations including limitations on the scope and duration of coverage, for medical and surgical services, and mental health services and substance use disorder services for coverage in the individual, small group, and large group markets, provided that the comparison captures at least seventy-five percent of a company's enrollees in each market;

(7) The number by type of providers licensed to practice in this state that provide services for the treatment and diagnosis of substance use disorder who are in-network, and the number by type of providers licensed to practice in this state that provide services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who are in-network;

(8) The percentage of providers of services for the treatment and diagnosis of substance use disorder who remained participating providers, and the percentage of providers of services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who remained participating providers; and

(9) Any other data, information, or metric the superintendent deems necessary or useful to measure compliance with mental health and substance use disorder parity including, but not limited to an evaluation and assessment of: (i) the adequacy of the company's in-network mental health services and substance use disorder provider panels pursuant to provisions of the insurance law and public health law; and (ii) the company's reimbursement for in-network and

out-of-network mental health services and substance use disorder services as compared to the reimbursement for in-network and out-of-network medical and surgical services.

* NB Effective until January 1, 2027

* § 343. Mental health and substance-related and addictive disorder services parity report. (a) Beginning July first, two thousand nineteen and every two years thereafter, each insurer providing managed care products, individual comprehensive accident and health insurance or group or blanket comprehensive accident and health insurance, each corporation organized pursuant to article forty-three of this chapter providing comprehensive health insurance and each entity licensed pursuant to article forty-four of the public health law providing comprehensive health service plans shall submit to the superintendent, in a form and manner prescribed by the superintendent, a report detailing the entity's compliance with federal and state mental health and substance-related and addictive disorder services parity laws based on the entity's record during the preceding two calendar years. The superintendent shall publish on the department's website on or before October first, two thousand nineteen, and every two years thereafter, the reports submitted pursuant to this section.

(b) Each person required to submit a report under this section shall include in the report the following information:

(1) Rates of utilization review for mental health and substance-related and addictive disorder claims as compared to medical and surgical claims, including rates of approval and denial, categorized by benefits provided under the following classifications: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs;

(2) The number of prior or concurrent authorization requests for mental health services and for substance-related and addictive disorder services and the number of denials for such requests, compared with the number of prior or concurrent authorization requests for medical and surgical services and the number of denials for such requests, categorized by the same classifications identified in paragraph one of this subsection;

(3) The rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for mental health

claims and substance-related and addictive disorder claims compared with the rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for medical and surgical claims;

(4) The percentage of claims paid for in-network mental health services and for substance-related and addictive disorder services compared with the percentage of claims paid for in-network medical and surgical services and the percentage of claims paid for out-of-network mental health services and substance-related and addictive disorder services compared with the percentage of claims paid for out-of-network medical and surgical services;

(5) The number of behavioral health advocates, pursuant to an agreement with the office of the attorney general if applicable, or staff available to assist policyholders with mental health benefits and substance-related and addictive disorder benefits;

(6) A comparison of the cost sharing requirements including but not limited to co-pays and coinsurance, and the benefit limitations including limitations on the scope and duration of coverage, for medical and surgical services, and mental health services and substance-related and addictive disorder services for coverage in the individual, small group, and large group markets, provided that the comparison captures at least seventy-five percent of a company's enrollees in each market;

(7) The number by type of providers licensed to practice in this state that provide services for the treatment and diagnosis of substance-related and addictive disorder who are in-network, and the number by type of providers licensed to practice in this state that provide services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who are in-network;

(8) The percentage of providers of services for the treatment and diagnosis of substance-related and addictive disorder who remained participating providers, and the percentage of providers of services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who remained participating providers; and

(9) Any other data, information, or metric the superintendent deems necessary or useful to measure compliance with mental health and

substance-related and addictive disorder parity including, but not limited to an evaluation and assessment of: (i) the adequacy of the company's in-network mental health services and substance-related and addictive disorder provider panels pursuant to provisions of the insurance law and public health law; and (ii) the company's reimbursement for in-network and out-of-network mental health services and substance-related and addictive disorder services as compared to the reimbursement for in-network and out-of-network medical and surgical services.

* NB Effective January 1, 2027

*** § 344. Mental health and substance use disorder parity compliance programs.** Penalties collected for violations of section three thousand two hundred sixteen, three thousand two hundred twenty-one and four thousand three hundred three of this chapter related to mental health and substance use disorder parity compliance shall be deposited in a fund established pursuant to section ninety-nine-hh of the state finance law.

* NB Effective until January 1, 2027

* § 344. Mental health and substance-related and addictive disorder parity compliance programs. Penalties collected for violations of section three thousand two hundred sixteen, three thousand two hundred twenty-one and four thousand three hundred three of this chapter related to mental health and substance-related and addictive disorder parity compliance shall be deposited in a fund established pursuant to section ninety-nine-hh of the state finance law.

* NB Effective January 1, 2027

§ 345. Health care claims reports. An insurer authorized to write accident and health insurance in the state, a corporation organized pursuant to article forty-three of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law shall report to the superintendent quarterly and annually on health care claims payment performance with respect to comprehensive health insurance coverage. The reports shall be submitted in the manner

and form prescribed by the superintendent after consultation with representatives of insurers and health care providers but at minimum shall include the number and dollar value of health care claims by major line of business and categorized as follows: health care claims received, health care claims paid, health care claims pended and health care claims denied during the respective quarter or year. The data shall be provided in the aggregate and by major category of health care provider. The reports should address any patterns or suspected areas of revenue maximization that may have contributed to the number of denials. The reports shall be due to the superintendent no later than forty-five days after the end of the respective quarter or year and shall be made publicly available including on the department's website. The superintendent, in conjunction with the commissioner of health, may promulgate regulations requiring additional reporting requirements on insurers, corporations, or health maintenance organizations or health care providers to assess the effectiveness of the payment policies set forth in this section, which may be informed by the administrative simplification workgroup authorized by subsection (k) of section three thousand two hundred twenty-four-a of this chapter.

§ 346. Annual report on insurance for multi-family buildings. An authorized insurer that issues or delivers in this state a policy that insures loss of or damage to real property used predominantly for residential purposes and that consists of two or more dwelling units, other than hotels and motels, shall file a report with the superintendent by March first of each year, in a form prescribed by the superintendent, that includes information on such policies for the preceding calendar year, including premiums collected, claims paid, and such other information as the superintendent shall deem necessary, in consultation with the commissioner of housing and community renewal. The superintendent shall publish on the department's website the reports required by this section.

ARTICLE 4
INSURANCE FRAUDS PREVENTION

Section 401. Title; legislative declaration and purpose.
403. Prohibitions.
404. Procedures.
405. Reports.
407. Other law enforcement authority, powers and duties not affected or impaired.
409. Fraud prevention plans and special investigations units.
411. Life settlements fraud prevention plans.

§ 401. Title; legislative declaration and purpose. This article shall be known and may be cited as the "insurance frauds prevention act".

(a) The legislature finds and declares that the business of insurance directly and indirectly affects all sectors of the public, business and government. It further finds that the business of insurance, including organization and licensing, the issuance of policies, and the adjustment and payment of claims and losses, involve many transactions which have potential for abuse and illegal activities.

(b) Arson for insurance fraud is a particularly damaging crime against society, destroying lives, property and neighborhoods. Insurance losses resulting from arson are reflected in higher premiums charged to residents of this state.

(c) This article establishes a framework within which the superintendent and the department can more effectively assist in the elimination of arson for insurance fraud. That increased capacity, together with a more effective monitoring of fire loss claims and payments by the insurance industry through centralized reporting and oversight, is intended to make it more difficult to perpetrate the crime of insurance fraud by arson.

§ 403. Prohibitions. (a) In this article, "fraudulent insurance act" means insurance fraud as defined in section 176.05 of the penal law; and the terms "personal insurance" and "commercial insurance" shall have the same meaning ascribed to them by section 176.00 of such law.

(b) For the purpose of section one hundred nine of this chapter, it is a violation of this chapter for any individual, firm, association or

corporation subject to the provisions of this chapter to commit a fraudulent insurance act or a fraudulent life settlement act.

(c) In addition to any criminal liability arising under the provisions of this section, the superintendent shall be empowered to levy a civil penalty not exceeding five thousand dollars and the amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this chapter, who is found to have: (i) committed a fraudulent insurance act, fraudulent life settlement act or otherwise violates the provisions of this section; or (ii) knowingly and with intent to defraud files, makes, or assists, solicits or conspires with another to file or make an application for a premium reduction, pursuant to subsection (a) of section two thousand three hundred thirty-six of this chapter, containing any materially false information or which, for the purpose of misleading, conceals information concerning any fact material thereto.

(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms, except as provided for in subsection (e) of this section, shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

(e) All applications for automobile insurance and all claim forms shall contain a notice, in a form approved by the superintendent, that clearly states in substance the following:

"Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each

violation."

(f) In this article, "fraudulent life settlement act" means a fraud as defined in section 176.40 of the penal law.

§ 404. Procedures. (a) If the superintendent has reason to believe that a person has engaged in, or is engaging in, an act defined in section 155.05 of the penal law, with respect to personal or commercial insurance transactions, the business of life settlements, section 176.05 or section 176.40 of such law, the superintendent may make such investigation within or without this state as the superintendent deems necessary to aid in the enforcement of this chapter or to determine whether any person has violated or is about to violate any such provision of the penal law.

(b) A person having material located outside the state and requested by the superintendent may make it available to the superintendent or his representative to be examined at the place where it is located. The superintendent may designate representatives, including officials of the state in which the material is located, to inspect the material on his behalf, and he may respond to similar requests from officials of other states.

§ 405. Reports. (a) Any person licensed or registered pursuant to the provisions of this chapter, and any person engaged in the business of insurance or life settlement in this state who is exempted from compliance with the licensing requirements of this chapter, including the state insurance fund of this state, who has reason to believe that an insurance transaction or life settlement act may be fraudulent, or has knowledge that a fraudulent insurance transaction or fraudulent life settlement act is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the superintendent on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require. The superintendent shall accept reports of suspected fraudulent

insurance transactions or fraudulent life settlement acts from any self insurer, including but not limited to self insurers providing health insurance coverage or those defined in section fifty of the workers' compensation law, and shall treat such reports as any other received pursuant to this section.

(b) The superintendent shall review each report and undertake such further investigation as the superintendent deems necessary and proper to determine the validity of the allegations.

§ 407. Other law enforcement authority, powers and duties not affected or impaired. This article shall not:

(a) Preempt the authority or relieve the duty of other law enforcement agencies to investigate and prosecute suspected violations of law.

(b) Prevent or prohibit a person from voluntarily disclosing any information concerning violations of this article to any law enforcement agency.

(c) Limit any of the powers granted elsewhere in this chapter and other laws to the superintendent or the department to investigate possible violations of this chapter and take appropriate action against wrongdoers.

§ 409. Fraud prevention plans and special investigations units. (a) Every insurer writing private or commercial automobile insurance, workers' compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, except for insurers that write less than three thousand of such policies, issued or issued for delivery in this state annually, and every entity licensed pursuant to article forty-four of the public health law except those entities with an enrolled population of less than sixty thousand persons in the aggregate and, except those entities licensed pursuant to sections forty-four hundred three-a, forty-four hundred three-c, forty-four hundred-d, forty-four hundred three-f and forty-four hundred eight-a of the public health law shall, within one hundred twenty days of the effective date of this amended section to be promulgated by the superintendent to implement this section, file with

the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state. The superintendent may accept programs and processes implemented pursuant to section forty-four hundred fourteen of the public health law as satisfying the obligations of this section and regulations promulgated thereunder.

(b) (1) The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigations unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. An insurer shall include in such plan staffing levels and allocations of resources in such full-time special investigations unit as may be necessary and appropriate for the proper implementation of the plan and approval of such plan pursuant to subsection (d) of this section.

(2) In lieu of a special investigations unit, an insurer may contract with a provider of services related to the investigation of information on or cases of suspected fraudulent activities; provided, however, that an insurer which opts for contracting with a separate provider of services, shall provide to the superintendent a detailed plan therefor, pursuant to requirements set forth in regulation by the superintendent.

(3) Persons employed by special investigations units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education or experience which shall include an associate's or bachelor's degree in criminal justice or related field, or five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies, or seven years of professional investigation experience involving economic or insurance related matters. For the purposes of evaluation of medical related claims insurers may employ or retain duly licensed or authorized medical professionals. Notwithstanding these minimum requirements anyone employed as an investigator in a special investigation unit or by a provider of investigative services under

contract to an insurer as of the effective date of this paragraph and who was also so employed on or before September tenth, nineteen hundred ninety-six may continue in such employment provided the insurer identifies such person in writing to the superintendent giving the date such employment began and a description of the person's qualifications, employment history and current job duties.

(c) The plan shall provide for the following:

(1) interface of special investigation unit personnel with law enforcement and prosecutorial agencies and with the financial frauds and consumer protection unit of the department of financial services;

(2) reporting of fraud data to a central organization approved by the superintendent;

(3) in-service education and training for underwriting and claims personnel in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities;

(4) coordination with other units of an insurer for the investigation and initiation of civil actions based upon information received by or through the special investigation unit;

(5) public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud;

(6) development and use of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity; and

(7) the time and manner in which such plan shall be implemented and a demonstration that the fraud prevention and reduction measures outlined in the plan will be fully implemented.

(d) (1) A fraud detection and prevention plan filed by an insurer with the superintendent pursuant to this section shall be deemed approved by the superintendent if not returned by the superintendent for revision within one hundred twenty days of the date of filing. If the superintendent returns a plan for revision, the superintendent shall state the points of objection with such plan, and any amendments as the superintendent may require consistent with the provisions of this section, including, but not limited to, staffing levels, resource allocation, or other policy or operational considerations. An amended plan reflecting the changes shall be filed with the superintendent within forty-five days from the date of return.

(2) If the superintendent has returned a plan for revision more than

one time, the insurer shall be entitled to a hearing pursuant to the provisions of article three of this chapter and regulations promulgated thereunder.

(3) If an insurer fails to submit a final plan within thirty days after a determination of the superintendent after the hearing held pursuant to paragraph two of this subsection, or otherwise fails to submit a plan, or fails to implement the provisions of a plan in a time and manner provided for in such plan, or otherwise refuses to comply with the provisions of this section, the superintendent may: (i) impose a fine of not more than two thousand dollars per day for such failure by an insurer until the superintendent deems the insurer to be in compliance; or (ii) impose upon the insurer a fraud detection and prevention plan deemed to be appropriate by the superintendent which shall be implemented by the insurer; or (iii) impose the provisions of both subparagraphs (i) and (ii) of this paragraph.

(e) Any plan, the information contained therein, or correspondence related thereto, or any other information furnished pursuant to this section shall be deemed to be a confidential communication and shall not be open for review or be subject to a subpoena except by a court order or by request from any law enforcement agency or authority.

(f) For purposes of this section, the term "policies" shall refer to individuals covered if coverage is issued on a group basis.

(g) Every insurer required to file a fraud prevention plan shall report to the superintendent on an annual basis, no later than March fifteenth, describing the insurer's experience, performance and cost effectiveness in implementing the plan, utilizing such forms as the superintendent may prescribe. Upon consideration of such reports, the superintendent may require amendments to the insurer's fraud prevention plan as deemed necessary.

§ 411. Life settlements fraud prevention plans. (a) Every life settlement provider shall file with the superintendent a plan for the detection, investigation and prevention of fraudulent life settlement acts in this state and those fraudulent life settlement acts affecting life settlement contracts in this state.

(1) The plan shall provide the time and manner in which such plan

shall be implemented, including provisions for a special investigations unit and staffing levels within such unit. Such investigators shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. A life settlement provider shall include in such plan staffing levels and allocations of resources of such special investigations unit that shall be sufficient and appropriate for the proper implementation of the plan and approval of such plan pursuant to subsection (c) of this section.

(2) In lieu of a special investigations unit, a life settlement provider may contract with a provider of services related to the investigation of information on or cases of suspected fraudulent activities; provided, however, that a life settlement provider that opts for contracting with a separate provider of services, shall provide to the superintendent a detailed plan therefor, pursuant to requirements set forth in regulation by the superintendent.

(3) A person employed by a special investigations unit or an independent provider of investigative services under contract with a life settlement provider shall be qualified by education or experience to act in such capacity, subject to requirements established by the superintendent in a regulation.

(b) The plan shall provide for the following:

(1) interface of special investigations unit personnel with law enforcement and prosecutorial agencies, including the financial frauds and consumer protection unit in the department;

(2) reporting of fraud data to a central organization approved by the superintendent;

(3) in-service education and training for personnel in identifying and evaluating instances of suspected fraudulent activity;

(4) coordination with other units of a life settlement provider for the investigation and initiation of civil actions based upon information received by or through the special investigation unit;

(5) public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud;

(6) development and use of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity; and

(7) the time and manner in which such plan shall be implemented and a demonstration that the fraud prevention and reduction measures outlined in the plan will be fully implemented.

(c)(1) A fraud detection and prevention plan filed by a life settlement provider with the superintendent pursuant to this section shall be deemed approved by the superintendent if not returned by the superintendent for revision within one hundred twenty days of the date of filing. If the superintendent returns a plan for revision, the superintendent shall state the points of objection with such plan, and any amendments as the superintendent may require consistent with the provisions of this section, including staffing levels, resource allocation, or other policy or operational considerations. An amended plan reflecting the changes shall be filed with the superintendent within forty-five days from the date of return.

(2) If the superintendent has returned a plan for revision more than one time, then the life settlement provider shall be entitled to a hearing pursuant to the provisions of article three of this chapter and regulations promulgated thereunder.

(3) If a life settlement provider fails to submit a final plan within thirty days after a determination of the superintendent after the hearing held pursuant to paragraph two of this subsection, or otherwise fails to submit a plan, or fails to implement the provisions of a plan in a time and manner provided for in such plan, or otherwise refuses to comply with the provisions of this section, the superintendent may impose:

(A) a fine of not more than two thousand dollars per day for such failure by a life settlement provider until the superintendent deems the life settlement provider to be in compliance;

(B) upon the life settlement provider a fraud detection and prevention plan deemed to be appropriate by the superintendent, which shall be implemented by the life settlement provider; or

(C) both a fine and a fraud detection and prevention plan pursuant to subparagraphs (A) and (B) of this paragraph.

(d) Any plan, the information contained therein, or correspondence related thereto, or any other information furnished pursuant to this section shall be deemed to be a confidential communication and shall not be open for review or be subject to a subpoena except by a court order

or by request from any law enforcement agency or authority.

(e) Every life settlement provider required to file a fraud prevention plan shall report to the superintendent on an annual basis, no later than March fifteenth, describing the provider's experience, performance and cost effectiveness in implementing the plan, utilizing such forms as the superintendent may prescribe. Upon consideration of such reports, the superintendent may require amendments to the provider's fraud detection and prevention plan as deemed necessary.

ARTICLE 5
CERTIFICATES OF INSURANCE

Section 501. Definitions.
502. Prohibitions.
503. Enforcement.
504. Rules and regulations.

§ 501. Definitions. For purposes of this article:

(a) "Certificate" or "certificate of insurance" means any document or instrument, or addendum thereto no matter how titled or described, prepared or issued by an insurer or insurance producer as evidence of property/casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance or an insurance binder.

(b) "Certificate holder" means any person, other than a policyholder, that is identified on the certificate as a certificate holder.

(c) "Insurance producer" has the meaning ascribed to it by subsection (k) of section two thousand one hundred one of this chapter.

(d) "Insurer" means any person "doing an insurance business" within the meaning of this chapter.

(e) "Person" means any individual, partnership, corporation, association, or other entity, but shall not include any governmental entity, or any agency, board, bureau, commission, department, division, institution, office, or public authority of a state, federal or foreign government.

(f) "Governmental entity" means any public entity as defined in

paragraph fifty-one of subsection (a) of section one hundred seven of this chapter, any state authority as defined in subdivision one of section two of the public authorities law, any local authority as defined in subdivision two of section two of the public authorities law, and any interstate or international authority as defined in subdivision three of section two of the public authorities law and any individual acting in his or her capacity as an employee, officer, or elected official of any such governmental entity.

(g) "Policyholder" means a person who has contracted with an insurer for property/casualty insurance coverage.

(h) "Property/casualty insurance" means a kind of insurance that is either a basic kind of insurance or a non-basic kind of insurance, as such terms are defined in section four thousand one hundred one of this chapter, but shall not include a kind of insurance specified under paragraph three or thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter.

§ 502. Prohibitions. In this state:

(a) With respect to a certificate of insurance evidencing that a policy provides personal injury liability insurance or property damage liability insurance, as defined in paragraphs thirteen and fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter, no person or governmental entity shall wilfully require, as a condition of awarding a contract for work, or if a contract has already been awarded as a condition for work to commence or continue under the contract, or if the contract has been performed or partially performed as a condition for payment to be made under the contract, the issuance of a certificate of insurance unless the certificate is:

(1) a form promulgated by the insurer issuing the policy referenced in the certificate of insurance; or

(2) a standard certificate of insurance form issued by an industry standard-setting organization and approved for use by the superintendent or any other form approved for use by the superintendent.

(b) No person or governmental entity shall wilfully require the inclusion of terms, conditions or language of any kind, including warranties or guarantees, that the insurance policy provides coverage or

otherwise sets forth terms and conditions in a certificate of insurance, if the insurance policy referenced by such certificate of insurance does not expressly include such terms, conditions, or language. This subsection shall not prohibit any person or governmental entity from including minimum insurance requirements, coverage limits, terms, or other conditions in the solicitation of bids as part of a competitive process, and it shall not prohibit any person or governmental entity from requesting, or an insurer or insurance producer from responding to such a request with, clarification regarding the terms of the policy, or endorsement thereto.

(c) A certificate of insurance shall not amend, extend, or alter the coverage provided by the insurance policy to which the certificate of insurance makes reference. A certificate of insurance shall further not confer to any person any rights beyond those expressly provided by the policy of insurance referenced therein.

§ 503. Enforcement. If the superintendent finds, after notice and hearing, that any person, other than a governmental entity, has wilfully violated this article, then the superintendent may order the person to pay to the people of this state a penalty in a sum of one thousand dollars for the first violation and two thousand dollars for each subsequent violation.

§ 504. Rules and regulations. The superintendent may adopt rules or regulations as the superintendent considers appropriate to carry out the provisions of this article.

ARTICLE 11

LICENSING OF INSURERS

Section 1101. Definitions; doing an insurance business.
1102. Insurer's license required; issuance.
1103. Duration of licenses.
1104. Revocation or suspension of license; restriction of license authority or limitation on premiums written.

1105. Voluntarily ceasing to maintain license.
1106. Additional requirements for foreign or alien insurer's license.
1107. Licenses for unincorporated insurers.
1108. Insurers exempt from licensing and other requirements.
1109. Limited exemption for health maintenance organizations.
1110. Charitable annuity societies exempt; special permits.
1111. Compulsory insurance; bonds of surety companies; certificates of qualification.
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1112-a. Reports.
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1121. Voucher insurance program.
1122. New York state health insurance continuation assistance demonstration project.
1123. Immigration bail business.
1124. Institutions of higher education exempt; certificate of authority.
1124*2. Managed care health savings account.

§ 1101. Definitions; doing an insurance business. (a) In this article: (1) "Insurance contract" means any agreement or other transaction whereby one party, the "insurer", is obligated to confer benefit of pecuniary value upon another party, the "insured" or "beneficiary", dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such

happening, a material interest which will be adversely affected by the happening of such event.

(2) "Fortuitous event" means any occurrence or failure to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party.

(3) "Contract of warranty, guaranty or suretyship" means an insurance contract only if made by a warrantor, guarantor or surety who or which, as such, is doing an insurance business.

(b) (1) Except as otherwise provided in this subsection, any of the following acts in this state, effected by mail from outside this state or otherwise, by any person, firm, association, corporation or joint-stock company shall constitute doing an insurance business in this state and shall constitute doing business in the state within the meaning of section three hundred two of the civil practice law and rules:

(A) making, or proposing to make, as insurer, any insurance contract, including either issuance or delivery of a policy or contract of insurance to a resident of this state or to any firm, association, or corporation authorized to do business herein, or solicitation of applications for any such policies or contracts;

(B) making, or proposing to make, as warrantor, guarantor or surety, any contract of warranty, guaranty or suretyship as a vocation and not as merely incidental to any other legitimate business or activity of the warrantor, guarantor or surety;

(C) collecting any premium, membership fee, assessment or other consideration for any policy or contract of insurance;

(D) doing any kind of business, including a reinsurance business, specifically recognized as constituting the doing of an insurance business within the meaning of this chapter; or

(E) doing or proposing to do any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this chapter.

(2) Notwithstanding the foregoing, the following acts or transactions, if effected by mail from outside this state by an unauthorized foreign or alien insurer duly licensed to transact the business of insurance in and by the laws of its domicile, shall not constitute doing an insurance business in this state, but section one thousand two hundred thirteen of

this chapter shall nevertheless be applicable to such insurers:

(A) transactions by any life insurance company organized and operated, without profit to any private shareholder or individual, exclusively for the purpose of aiding any charitable, religious, educational or scientific institution organized and operated, without profit to any private shareholder or individual, by issuing insurance or annuity contracts directly from its home office, without agents or representatives in this state, only to or for the benefit of such institutions and to individuals engaged in their service;

(B) transactions with respect to group life, group annuity, group accident and health or blanket accident and health insurance (other than any transaction with respect to a group annuity contract funding individual retirement accounts or individual retirement annuities, as defined in section four hundred eight of the Internal Revenue Code, funding annuities in accordance with subdivision (b) of section four hundred three of such code or providing a plan of retirement annuities under which the payments are derived wholly from funds contributed by the persons covered):

(i) where such groups conform to the definitions of eligibility contained in;

(I) the following paragraphs of subsection (b) of section four thousand two hundred sixteen of this chapter:

(aa) paragraph (1) or (2);

(bb) paragraph (3), if, with respect to those credit transactions entered into in this state, the policy fully conforms with the requirements of sections three thousand two hundred one, three thousand two hundred twenty and four thousand two hundred sixteen of this chapter;

(cc) paragraphs (4), (5), (6), (7), (8), (9) and (10).

(II) the following subparagraphs of paragraph (1) of subsection (c) of section four thousand two hundred thirty-five of this chapter:

(aa) subparagraph (A), (B), (C) or (D);

(bb) subparagraph (E), if, with respect to those credit transactions entered into in this state, the policy fully conforms with the requirements of sections three thousand two hundred one, three thousand two hundred twenty-one and four thousand two hundred thirty-five of this chapter;

(cc) subparagraphs (F), (G) and (H).

(III) section four thousand two hundred thirty-seven (except subparagraph (F) of paragraph three of subsection (a) thereof) or four thousand two hundred thirty-eight (except paragraphs six and seven of subsection (b) thereof) of this chapter; and

(ii) where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business;

(C) transactions involving the continuance or servicing of life or accident and health insurance policies or annuity contracts lawfully issued or delivered in this state by an authorized insurer and occurring subsequent to the termination of such insurer's authority to do an insurance business in this state. Notwithstanding the foregoing, the superintendent's approval granted pursuant to section one thousand one hundred five of this article may authorize transactions involving the continuance or servicing of life insurance policies or annuity contracts to be effected from outside this state by telephone, video call, facsimile, web portal, electronic transfer of funds, or by any other electronic means approved by the superintendent, provided that the insurer shall not have any other contact or interaction with a person in this state other than as specified and in the manner provided in this paragraph;

(D) transactions with respect to policies or annuity contracts lawfully issued without this state occurring subsequent to issue, if, at the time of issue, such policies or contracts covered subjects of insurance or risks not resident or located in this state. Notwithstanding the foregoing, transactions described in this subparagraph involving the continuance or servicing of life insurance policies or annuity contracts may be effected from outside this state by telephone, video call, facsimile, web portal, electronic transfer of funds, or by any other electronic means approved by the superintendent, provided that the insurer shall not have any other contact or interaction with a person in this state other than as specified and in the manner provided in this paragraph;

(E) transactions with respect to policies of insurance on risks located or resident within or without this state (except master policies or contracts of group insurance which are subject to the requirements of

subparagraph (B) hereof), which policies are principally negotiated, issued and delivered without this state in a jurisdiction in which the insurer is authorized to do an insurance business;

(F) transactions authorized by section two thousand one hundred five of this chapter with respect to excess lines insurance;

(G) transactions with respect to the reinsurance of risks of authorized insurers to the extent that such reinsurance is permitted by this chapter;

(H) transactions with respect to insurance contracts negotiated or placed pursuant or otherwise subject to subsection (b), (c), (j) or (k) of section two thousand one hundred seventeen of this chapter;

(I) transactions with respect to any policy of insurance or annuity contract issued prior to September first, nineteen hundred seventy.

(3) Notwithstanding the foregoing, the making of an agreement pursuant to which a lessor of personal property, a creditor making a loan or other credit transaction on personal property or, in the absence of a waiver by the lessor or creditor, the lessor's or creditor's assignee waives the obligation of the lessee or debtor for the gap amount, as such term is defined in paragraph fifty-two of subsection (a) of section one hundred seven of this chapter, shall not constitute, or be deemed to constitute, the doing of an insurance business if:

(i) the lessor or creditor or, in the absence of a waiver by the lessor or creditor, the assignee waives any and all obligations of the lessee or debtor for the gap amount and the lessee or debtor is discharged from any and all further obligation to pay the gap amount;

(ii) the waiver applies only in the event of a total loss of the personal property occasioned by its theft or physical damage;

(iii) in the event the lessor, creditor or assignee purchases lessor or creditor gap insurance, the charge to the lessee or debtor for the waiver does not exceed the cost of the lessor or creditor gap insurance coverage; provided, however, that nothing contained herein shall be construed to prohibit the lessor from including the charge for the waiver in the capitalized cost as that term is defined in subdivision eleven of section three hundred thirty-one of the personal property law.

(3-a) Notwithstanding the foregoing, the marketing, sale, offer for sale, issuance, making, proposing to make or administration of a service contract pursuant to article seventy-nine of this chapter or warranty,

service contract or maintenance agreement conditioned upon or otherwise associated with the sale or supply of heating fuel shall not constitute doing an insurance business in this state.

(4) In the application of this chapter, the fact that no profit is derived from the making of insurance contracts, agreements or transactions, or that no separate or direct consideration is received therefor, shall not be deemed conclusively to show that the making thereof does not constitute the doing of an insurance business.

(5) Notwithstanding the foregoing, an unauthorized insurer, which (A) is affiliated with an insurer licensed in this state, and (B) has satisfied all applicable requirements for placements by excess line brokers as set forth in section two thousand one hundred eighteen of this chapter, may provide from an office within the state, services to support its insurance business. Such services shall not be deemed under this chapter as doing an insurance business in this state. For the purposes of this section these services include, but are not limited to, computer operations, clerical and staffing support, underwriting, negotiating contract terms, quoting premiums, binding coverage, drafting and issuing policies and claims handling, investigation and payment, among other incidental services. Such services shall not include the marketing, soliciting or advertising by the unauthorized insurer directly to policyholders. Notwithstanding paragraph two of subsection (a) of section two thousand one hundred twenty-two of this chapter, such unauthorized insurers shall be permitted to advertise to, and market and solicit through, excess line brokers licensed pursuant to section two thousand one hundred five of this chapter. All obligations of such a licensee under article twenty-one of this chapter shall remain in full force and effect. Any document issued by the unauthorized insurer that indicates any location within this state in which it conducts its operations shall include a prominent notice that the insurer is not licensed by the state of New York, in no smaller than 10 point type, in accordance with regulations as may be promulgated by the superintendent.

(6) Notwithstanding the foregoing, the election by the president of the civil service commission to provide health benefits directly to New York state health benefit plan participants shall not constitute the doing of insurance business within the meaning of article eleven of the insurance law.

(7)(A) Notwithstanding the foregoing, the making of a swap shall not constitute doing an insurance business in this state.

(B) For the purposes of this paragraph, "swap" shall have the meaning set forth in 7 U.S.C. § 1a.

(8) Notwithstanding the foregoing, the maintenance of a website outside the state by an unauthorized foreign or alien insurer duly licensed to transact the business of insurance in and by the laws of its domicile, by which a member of a group may self-enroll, through an automated process, in a group life, group annuity, or group accident and health insurance policy or contract, as defined in paragraphs one, two, and three of subsection (a) of section one thousand one hundred thirteen of this article, shall not constitute doing an insurance business in this state, but section one thousand two hundred thirteen of this chapter nevertheless shall apply to the insurer; provided that:

(A) the group conforms to the definition of eligibility contained in:

(i) paragraph one, two, four (with respect to a policy issued to a trustee or trustees of a fund established or participated in by two or more employers, one or more labor unions, or by one or more employers or labor unions, provided that all such employers or labor unions are in the same industry), or five of subsection (b) of section four thousand two hundred sixteen of this chapter;

(ii) subparagraph (A), (B), (C), or (D) (with respect to a policy issued to a trustee or trustees of a fund established or participated in by two or more employers, one or more labor unions, or by one or more employers or labor unions, provided that all such employers or labor unions are in the same industry) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter; or

(iii) paragraphs one, two, three or four of subsection (b) of section four thousand two hundred thirty-eight of this chapter, but not including a group annuity contract: (I) funding individual retirement accounts or individual retirement annuities, as defined in section four hundred eight of the Internal Revenue Code; (II) funding annuities in accordance with subdivision (b) of section four hundred three of such code; or (III) providing a plan of retirement annuities under which the payments are derived wholly from funds contributed by the persons covered.

(B) the insurer lawfully issued the master policy or contract without

this state in a jurisdiction where the insurer was authorized to do an insurance business;

(C) the insurer's website clearly states that the insurer is not authorized to transact the business of insurance in this state; and

(D) the insurer does not have any other contact or interaction with the member other than as specified and in the manner provided in paragraph two of this subsection.

§ 1102. Insurer's license required; issuance. (a) No person, firm, association, corporation or joint-stock company shall do an insurance business in this state unless authorized by a license in force pursuant to the provisions of this chapter, or exempted by the provisions of this chapter from such requirement. Any person, firm, association, corporation or joint-stock company which transacts any insurance business in this state while not authorized to do so by a license issued and in force pursuant to this chapter, or exempted by this chapter from the requirement of having such license, shall, in addition to any other penalty provided by law, forfeit to the people of this state the sum of one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation.

(b) No corporation organized under any law of this state shall do an insurance business outside this state unless so authorized pursuant to the provisions of this chapter or exempted by the provisions of this chapter from such requirement.

(c) Every insurer organized prior to the first day of October, eighteen hundred ninety-two, as an insurer under any general or special law of this state which was doing an insurance business in this state immediately prior to the first day of January, nineteen hundred forty in compliance with the insurance law then in force and not as an organization exempted therefrom, shall be deemed licensed to do an insurance business in this state, subject to this chapter.

(d) Except as otherwise provided in subsection (h) hereof, the superintendent may issue a license to any insurer to do in this state the kinds of insurance business for which such insurer is qualified under the provisions of this chapter and under its charter. Every such license shall contain the name of the licensee, its home office address,

the state or country under whose laws it was organized, the kinds of insurance business, as defined in this chapter, which it is authorized to do in this state, and the term of such license. The superintendent may refuse to issue or renew any such license if in his judgment such refusal will best promote the interests of the people of this state.

(e) (1) Before licensing any such corporation organized under section one thousand two hundred one of this chapter, to do any insurance business, the superintendent shall:

(A) If such corporation be a stock corporation, cause an examination to be made into its affairs in accordance with the provisions of this chapter; and if it appears from the report upon such examination that the amount of capital and surplus required by law has been paid in and is possessed by the corporation in cash or in investments permitted by this chapter as minimum capital or minimum surplus to policyholder investments under section one thousand four hundred two of this chapter, the superintendent shall file such report in his office and notify the corporation thereof;

(B) If such corporation be a mutual corporation, require proof (by statements of at least three incorporators subscribed and affirmed by such incorporators as true under the penalties of perjury, and by such investigation or examination of the affairs of such corporation as he may deem it expedient to make pursuant to the provisions of this chapter) that:

(i) the corporation has fully complied with the applicable provisions of this chapter,

(ii) it has the required initial surplus in cash or investments as prescribed in this chapter,

(iii) it has the required number and amount of bona fide applications for insurance as prescribed in this chapter,

(iv) the membership list is genuine, and

(v) every member has paid in cash the required premium on the insurance applied for and will take the policies as agreed within sixty days after a license has been issued to such corporation.

If the superintendent finds such proof of the foregoing facts to be sufficient, he shall file it in his office and notify the corporation thereof;

(C) Upon payment of the appropriate fees by such corporation, cause a

copy of its declaration and charter, certified by him, to be filed and recorded in the office of the clerk of the county in which such corporation has its principal office.

(2) The superintendent may refuse a license to any such corporation if he finds, after notice and hearing, that any proposed incorporator or director of a stock corporation, or any director of a mutual corporation, has been convicted of any crime involving fraud, dishonesty, or like moral turpitude, or is an untrustworthy person. As a part of such determination, the superintendent is authorized to fingerprint applicants for licensure. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check.

(3) The corporation, on receiving notice from the superintendent that it has complied with this subsection, shall thereupon deposit with the superintendent such monies or securities as may be required by law.

(4) Upon compliance with this section and any other lawful prerequisites for the issuance of an insurer's license, the superintendent may, pursuant to this section, issue a license to such corporation to do the kind or kinds of business specified in its charter; provided that this subsection shall not apply to co-operative fire insurance companies, fraternal benefit societies, or corporations organized under article forty-three of this chapter.

(f) Except as may be otherwise provided in this chapter, every license to do an insurance business shall be issued to a single licensee, who shall be either an individual or corporation.

(g) (1) No license to do an insurance business, or to act as an insurance agent, agency or broker, shall be granted to any person, firm, association, corporation, or joint-stock company proposing to do business under a name identical with, or so similar to as to be likely to deceive or mislead the public, the name of any insurer then licensed or authorized to do any kind of insurance business within this state, or of any proposed domestic insurance corporation whose name has been approved pursuant to section one thousand two hundred one of this chapter within six months preceding the application for such license, or

of any domestic corporation, organized but not yet licensed, which has not forfeited its charter because of non-use; provided, the superintendent may, in his discretion, upon satisfactory proof of an appropriate resolution of any insurance corporation's board of directors, grant a license to do any different kind of insurance business to another person, firm, association, joint-stock company, insurance agent, agency or broker, or insurance corporation, having a similar, but not identical, name. Notwithstanding any other provision of this article, the superintendent may refuse to grant a license to do an insurance business, or to act as an insurance agent, agency or broker, to any person, firm, association, corporation or joint-stock company proposing to do business under a name which is likely to deceive or mislead the public in this state.

(2) The provisions of this subsection shall not apply to a license renewal for a foreign or alien insurer, or to any corporation formed as part of a plan, approved by the superintendent and by the court, for rehabilitation of a domestic insurance corporation pursuant to article seventy-four of this chapter. A domestic corporation, formed by reincorporation, reorganization or consolidation of other corporations, or upon the sale of the property or franchises of another corporation, or a corporation acquiring or becoming possessed of all of the estate, property, rights, privileges and franchises of any other corporation or corporations by merger, may have a name identical with, or similar to, that of any corporation to whose franchises it has succeeded, if such other corporation was then licensed to do the business of insurance in this state.

(h) No license to transact any kind of insurance business in this state shall be issued or renewed to any foreign or alien insurer or issued or continued in effect to any domestic insurer which is controlled by another state of the United States or by a foreign government or by any political subdivision of either, or which is an agency of any such state, government or subdivision, unless: (1) such insurer was so controlled or constituted, and was authorized to do business in this state, on or prior to January first, nineteen hundred fifty-six; or (2) such insurer is not authorized to transact the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this article and the

superintendent determines that:

(A) such insurer does not receive a subsidy or other competitive advantage, as a result of such control or status, that would enable it to compete unfairly with similarly situated authorized insurers which are not so controlled or constituted;

(B) such insurer is not entitled to claim sovereign immunity as a result of such control or status, or has waived the sovereign immunity;

(C) the use of such insurer would not be detrimental to the interests of the people of this state; and

(D) such insurer otherwise satisfies all applicable requirements for the issuance or renewal of such license.

§ 1103. Duration of licenses. (a) Every license issued to a domestic insurer shall be for an indefinite term and shall expire with the expiration or termination of its corporate existence.

(b) Every license, including every renewal license, issued to a foreign or alien insurer shall be for a term expiring on June thirtieth following the date of issuance, except that at any time after a licensed foreign or alien insurer has filed its annual statement pursuant to section three hundred seven of this chapter the superintendent may issue to such insurer a renewal license for the next year.

§ 1104. Revocation or suspension of license; restriction of license authority or limitation on premiums written. (a) The superintendent may revoke any license issued to any foreign or alien insurer to do an insurance business in this state if, after notice to and hearing, he finds that such insurer has failed to comply with any requirement imposed upon it by the provisions of this chapter and if in his judgment such revocation is reasonably necessary to protect the interests of the people of this state. The superintendent may in his discretion reinstate any such license if he finds that a ground for such revocation no longer exists.

(b) The superintendent shall revoke the certificate of authority of any corporation or agent convicted of violating section two thousand six hundred three of this chapter.

(c) The superintendent may suspend the license, restrict the license authority, or limit the amount of premiums written in this state of any accident and health insurance company, property/casualty insurance company, co-operative property/casualty insurance company, title insurance company, mortgage guaranty insurance company, reciprocal insurer, Lloyds underwriters or nonprofit property/casualty insurance company, except those insurers subject to the provisions of subsection (c) of section two thousand three hundred forty-three of this chapter, if after a hearing on a record, unless waived by the affected insurer, the superintendent determines that such insurer's surplus to policyholders is not adequate in relation to the insurer's outstanding liabilities or to its financial needs. All matters pertaining to a proceeding or determination pursuant to this subsection shall be confidential and not subject to subpoena or public inspection under article six of the public officers law or any other statute, except to the extent that the superintendent finds release of information necessary to protect the public. The hearing shall be initiated within twenty days after written notice to the insurer. Any determination pursuant to this subsection shall contain findings specifying the factors deemed significant in regard to the particular insurer, and shall set forth the reasons supporting the suspension, restriction or limitation ordered by the superintendent. The following factors shall be considered by the superintendent in making such determination:

(1) the size of the insurer as measured by its admitted assets, capital and surplus to policyholders, reserves, premium writings, insurance in force and other appropriate criteria, with such surplus to policyholders for foreign insurers adjusted in accordance with section one thousand four hundred thirteen of this chapter;

(2) the extent to which the insurer's business is diversified among the several kinds of insurance;

(3) the number and size of risks insured in each kind of insurance and the insurer's loss experience in regard to such risks;

(4) the extent of geographical dispersion of the insurer's risks;

(5) the nature and extent of the insurer's reinsurance program;

(6) the quality, diversification and liquidity of the insurer's investment portfolio;

(7) the recent past and projected future trends in regard to the

insurer's loss experience and in the size of the insurer's surplus to policyholders;

(8) the surplus to policyholders maintained by other comparable insurers;

(9) the adequacy of the insurer's reserves; and

(10) the quality and liquidity of investments in subsidiaries made pursuant to this chapter.

(d) The superintendent shall identify and review those licensed property/casualty insurers needing immediate or targeted regulatory attention, and shall include the number of insurers so identified in the report required by section three hundred thirty-four of this chapter. Such report shall also include the name of each licensed property/casualty insurer placed in formal conservatorship, rehabilitation or liquidation during the preceding year. Nothing herein shall be construed to restrict or diminish any right or power of the superintendent under any other provision of this chapter.

§ 1105. Voluntarily ceasing to maintain license. When an authorized insurer proposes to cease to maintain its existing licensing status in this state, the insurer shall at least forty-five days prior to such proposed action submit to the superintendent a plan to protect the interests of the people of this state. Such proposed action shall not become effective without the approval of such plan by the superintendent. The plan shall include requirements and procedures for meeting the insurer's contractual obligations, providing security protection in the event of a subsequent insolvency, and meeting any applicable statutory obligations, including its obligations pursuant to articles fifty-three, fifty-four and fifty-five of this chapter. Such plan shall be in compliance with a regulation to be promulgated by the superintendent. A plan may request that the insurer be permitted to continue or service a life insurance policy or annuity contract from outside this state by telephone, video call, facsimile, web portal, electronic transfer of funds, or by any other electronic means as approved by the superintendent pursuant to subparagraph (C) of paragraph two of subsection (b) of section one thousand one hundred one of this article. In order to protect the interests of the people of this state,

the superintendent may require the deposit of securities in this state, in trust, in the name of the superintendent.

§ 1106. Additional requirements for foreign or alien insurer's license. (a) Before issuing a license to do business, except by way of a renewal license, to any foreign or alien insurer the superintendent in addition to the requirement set forth in subsection (b) hereof:

(1) shall require it to submit for filing a certified copy of its charter, and of its by-laws, if any, currently in force, and such other documents necessary to show the kinds of business which it is empowered to do, and a full statement, subscribed and affirmed as true under the penalties of perjury by two officers or responsible representatives in such manner as the superintendent shall prescribe, showing its assets, liabilities and financial condition; and

(2) may require a full statement of its income, disbursements, business done, and other facts required to be shown in its annual statement; and

(3) may either make an examination of the insurer's affairs at its principal office within the United States, or accept a report of an examination made by the insurance department or other insurance supervisory official of any other state or of any government outside the United States.

(b) (1) Before issuing any new or renewal license to any foreign or alien insurer, the superintendent may require satisfactory proof, either in the insurer's charter or by an agreement evidenced by a duly certified resolution of its board of directors, or otherwise as the superintendent may require, that such insurer will not engage in any insurance business in contravention of the provisions of this section or not authorized by its charter.

(2) The superintendent shall issue a renewal license to any foreign or alien insurer if satisfied, by such proof as he may require, that such an insurer is not delinquent with respect to any requirement imposed by this chapter and that its continuance in business in this state will not be hazardous or prejudicial to the best interests of the people of this state.

(c) No foreign insurer shall be licensed to do in this state any kind

of insurance business, or combination of kinds of insurance business, which are not permitted to be done by domestic insurers hereafter to be licensed under the provisions of this chapter. No foreign insurer shall be authorized to do business in this state if it does in this state or elsewhere any kind of business, other than an insurance business and such business as is necessarily or properly incidental to the kind or kinds of insurance business which it is licensed to do in this state.

(d) No alien insurer shall be licensed to do in this state any kind of insurance business, or any combination of kinds of insurance business, which are not permitted to be done by domestic insurers hereafter to be licensed under the provisions of this chapter. No alien insurer shall be authorized to do an insurance business in this state if it does anywhere within the United States any kind of business other than an insurance business and such business as is necessarily or properly incidental to the kind or kinds of insurance business which it is authorized to do in this state.

(e) Except as otherwise specifically provided in this chapter no foreign insurer and no United States branch of an alien insurer shall be or continue to be authorized to do an insurance business in this state if it fails to comply substantially with any requirement or limitation of this chapter, applicable to similar domestic insurers hereafter to be organized, which in the judgment of the superintendent is reasonably necessary to protect the interests of the people of this state.

(f) No foreign insurer and no United States branch of an alien insurer which does outside of this state any kind or combination of kinds of insurance business not permitted to be done in this state by similar domestic insurers hereafter organized, shall be or continue to be authorized to do an insurance business in this state, unless in the judgment of the superintendent the doing of such kind or combination of kinds of insurance business will not be prejudicial to the best interests of the people of this state.

(g) Subsections (e) and (f) hereof shall not affect the requirements of section one thousand one hundred two of this article or section four thousand two hundred five of this chapter with respect to business done within this state.

(h) Notwithstanding the provisions of subsection (c) hereof any foreign insurance company licensed to do the business of life insurance

in this state continuously since January first, nineteen hundred twenty may continue to be licensed, in the discretion of the superintendent, to do the kinds of insurance business it was authorized to do immediately prior to January first, nineteen hundred forty.

(i) (1) Notwithstanding any other provisions of this chapter, any foreign licensed mutual life insurer which intends to reorganize or convert to a stock life insurer shall file with the superintendent a copy of its plan of reorganization or conversion at least ninety days prior to the date of any public hearing required to be held on such a plan by the state of domicile of the insurer, or the proposed effective date of the reorganization or conversion, whichever is earlier.

(2) If, after examining the plan, the superintendent finds that the plan is not fair or equitable to the New York policyholders of such insurer he shall set forth the reasons for such findings and at least fifteen days prior to such hearing, or the proposed effective date of the reorganization or conversion, whichever is earlier, notify the commissioner, superintendent or director of the state of domicile and the insurer of such findings and such reasons and advise of any requirements he finds necessary for the protection of current New York policyholders in order to permit the insurer to continue to do business in New York as a stock insurer after such reorganization or conversion.

§ 1107. Licenses for unincorporated insurers. (a) No individual shall be or remain licensed to write fidelity and surety insurance who, in any court of this state having criminal jurisdiction or in any criminal action or proceeding, deposits money or property as bail for another or executes as surety any bail bond.

(b) No individual shall be or remain licensed to do an insurance business, as an insurer unless he is a resident of this state, complies with all requirements of this chapter as to capital, surplus, reserves, liabilities, investments, deposits and other financial requirements imposed upon insurers doing the same kinds of insurance business, confines his business exclusively to such insurance business and business authorized pursuant to the provisions of this chapter as incidental thereto, and in all respects conforms to all requirements imposed upon such insurance companies, except as to corporate existence

and requirements incidental thereto. No individual insurer shall do business under a corporate or fictitious name or under any name, style or title other than the true name of such individual.

(c) This section shall not affect the authority to do an insurance business conferred upon a reciprocal insurer or Lloyds underwriters pursuant to article sixty-one of this chapter.

§ 1108. Insurers exempt from licensing and other requirements. The following insurers, their officers, agents, representatives and employees shall be exempt from licensing and other requirements imposed by the provisions of this chapter (except article seventy-four hereof) to the extent specified below:

(a) Any charitable annuity society which complies with the requirements of section one thousand one hundred ten of this article, to the extent therein stated.

(b) Any fraternal benefit society, membership corporation or other organization exempted under the provisions of article forty-five of this chapter, to the extent therein stated.

(c) The state insurance fund of this state, except as to the provisions of subsection (d) of section two thousand three hundred thirty-nine, section three thousand one hundred ten, subsection (a), paragraph one of subsection (b), paragraph three of subsection (c) and subsection (d) of section three thousand two hundred one, sections three thousand two hundred two, three thousand two hundred four, subsections (a) through (d) of section three thousand two hundred twenty-one, subsections (b) and (c) of section four thousand two hundred twenty-four, section four thousand two hundred twenty-six and subsections (a) and (b), (g) through (j), and (n) of section four thousand two hundred thirty-five of this chapter and except as otherwise specifically provided by the laws of this state.

(d) Any corporate trustee or board of trustees acting pursuant to the banking law in relation to the fund for insurance of deposits in savings banks or the fund for insurance of shares of savings and loan associations.

(e) Any corporation, organized under the laws of any state, solely to provide gratuitously for support or relief of the priests, clergy or

ministers of any religious denomination, or their dependents, is exempt from all provisions of this chapter, except that any such corporation, created by special act of incorporation of this state, which by the provisions of such act is subject to the requirement of examination by, and making annual reports to, the superintendent, shall be subject to the provisions of article three of this chapter relating to examinations and statements or reports by insurers.

(f) Any retirement system or pension fund that was doing business on January first, nineteen hundred forty under the education law, the civil service law, the mental hygiene law, any special act of incorporation of this state, or any municipal charter adopted under the laws of this state, exclusively for the benefit of the members of such system or fund or for all or any classes of the employees of this state or any municipality thereof, shall be exempt from the provisions of this chapter, except that if the law under which such system or fund was organized subjects it to examination by, and the making of annual reports to, the superintendent, such system or fund shall be subject to the provisions of article three of this chapter relating to examinations and statements or reports by insurers.

(g) Any membership corporation or voluntary association organized and operating in this state prior to January first, nineteen hundred thirty-nine and its members may act as indemnitors of a licensed property/casualty insurance company in respect to surety bonds or policies of insurance required to be filed by such members pursuant to section three hundred seventy of the vehicle and traffic law and are exempted from the requirement of having an insurer's license; but no such membership corporation or association shall become a surety on any such bond or otherwise do an insurance business.

(h) Any relief department or pension plan of any common carrier subject to the the Railroad Retirement Act of 1974 (45 U.S.C. § 31), whose privileges and membership are confined to employees or former employees of such carrier or its affiliated or subsidiary companies, or to any association of such common carriers which administers any such department or plan.

(i) Every blood credit system established by a city, pursuant to section twenty-one-d of the general city law.

(j) Any group of employers authorized by the workers' compensation

board to provide workers' compensation benefits for the employees of all member employers pursuant to subdivision three-a of section fifty of the workers' compensation law.

* (k) A charitable bail organization holding a certificate issued by the superintendent pursuant to section six thousand eight hundred five of this chapter.

* NB There are 2 sb§ (k)'s

* (k) An institution of higher education, as defined in paragraph two of subsection (a) of section one thousand one hundred twenty-four of this article, that has a certificate of authority from the superintendent and complies with the requirements of section one thousand one hundred twenty-four of this article, to the extent therein stated.

* NB There are 2 sb§ (k)'s

(n) A resolution facility established pursuant to section seven thousand seven hundred nineteen of this chapter.

§ 1109. Limited exemption for health maintenance organizations. (a) An organization complying with the provisions of article forty-four of the public health law may operate without being licensed under this chapter and without being subject to any provisions of this chapter, except: (1) to the extent that such organization must comply with the provisions of this chapter by virtue of such article, and (2) the provisions of sections three hundred eight, one thousand three hundred one, one thousand three hundred two, one thousand three hundred seven, one thousand three hundred twenty-two, with regard to health maintenance organizations that are domiciled in this state and certified or operating in at least one other state, two thousand one hundred three, two thousand one hundred twelve, two thousand one hundred fourteen, two thousand one hundred fifteen, two thousand one hundred seventeen, two thousand one hundred twenty-three, two thousand six hundred eight-a, two thousand six hundred twelve, three thousand two hundred twenty-four-a, four thousand three hundred eight, four thousand three hundred seventeen, four thousand three hundred eighteen, four thousand three hundred twenty, four thousand three hundred twenty-one, four thousand three hundred twenty-two and four thousand three hundred twenty-three of

this chapter.

(b) An organization which provides health care services for a periodic fee paid in advance but which does not comply with the provisions of article forty-four of the public health law shall be deemed to be engaged in the business of insurance and may not operate without being licensed under this chapter.

(c) An organization referred to in subsection (a) or (b) hereof shall be subject to article seventy-four of this chapter.

(d) A health maintenance organization may make any investment permitted for a health service corporation organized pursuant to article forty-three of this chapter provided that the superintendent, after consultation with the commissioner of health, may modify such investment requirements, if such modification would permit the organization to more effectively implement its program without incurring undue risk to its subscribers.

(e) The superintendent may promulgate regulations in effectuating the purposes and provisions of this chapter and article forty-four of the public health law and may modify requirements applicable to the contracts between a health maintenance organization and its subscribers, subject to such limitations as the superintendent shall deem necessary or proper to insure the performance of such contracts.

§ 1110. Charitable annuity societies exempt; special permits. (a) The superintendent may, in his or her discretion, issue a special permit to make annuity agreements with donors to any duly organized domestic or foreign non-stock corporation or association conducted without profit and engaged in active operation for at least ten years prior thereto solely in bona fide charitable, religious, missionary, educational or philanthropic activities. The permit shall authorize such corporation or association to receive gifts of cash and other property conditioned upon, or in return for, its agreement to pay an annuity to the donor, or his or her nominee, and to make and carry out such annuity agreement. Every such corporation or association shall, before making such agreement, file with the superintendent copies of its forms of agreements with annuitants and a schedule of its maximum annuity rates, which shall be computed so as to return to it upon the annuitant's death

a residue at least equal to one-half the original gift or other consideration for such annuity. The maximum annuity rates may be unisex in nature and shall be computed on the basis of currently applicable mortality tables for calculating the reserves for individual annuities pursuant to section four thousand two hundred seventeen of this chapter. The yield of the ten year treasury bond plus two percent as of April thirtieth, rounded to the nearest 0.25%, shall be used to calculate the maximum annuity rates to become effective as of July first of the same year and the ten year treasury bond yield plus two percent as of October thirty-first, rounded to the nearest 0.25%, shall be used to calculate the maximum annuity rates to become effective as of January first of the following year. No other factors shall be used to calculate the maximum annuity rates.

(b) Every such domestic corporation or association shall maintain admitted assets at least equal to the greater of (i) the sum of its reserves on its outstanding agreements, calculated in accordance with section four thousand two hundred seventeen of this chapter, and a surplus of ten per centum of such reserves, or (ii) the amount of one hundred thousand dollars. In determining such reserves a deduction shall be made for all or any portion of an annuity risk which is reinsured by a life insurance company authorized to do business in this state. The required admitted assets shall be invested in accordance with the prudent investor standard as defined in section 11-2.3 of the estates, powers and trusts law and shall not be subject to the investment limitations set forth in this chapter. Such assets shall be segregated as separate and distinct funds, independent of all other funds of such corporation or association, and shall not be applied to pay its debts and obligations or for any purpose except the aforesaid annuity benefits.

(c) No such corporation or association organized under the laws of another state shall be permitted to make such annuity agreements in this state unless it complies with all requirements of this section imposed upon like domestic corporations or associations.

(d) No such corporation or association shall make or issue in this state any annuity contract before obtaining a permit issued in accordance with the provisions of this section except that if its requisite reserve on its outstanding annuity agreements computed in

accordance with section four thousand two hundred seventeen of this chapter does not exceed the amount of one million dollars, it may make gift annuity agreements in this state and shall be exempted from securing a permit provided it maintains the reserve required by section four thousand two hundred seventeen of this chapter and a surplus of at least twenty-five per centum of such reserve. If the superintendent finds, after notice and hearing, that any such corporation or association, having such a permit, has failed to comply with the requirements of this section, the superintendent may revoke or suspend such permit or order it to cease making new annuity contracts until it complies. The superintendent may, in the superintendent's discretion, either dispense with the requirement of annual statements by such corporations or associations or accept a sworn statement by two or more of its principal officers, in such form as will satisfy the superintendent that the requirements of this section are being complied with.

(e) Except as provided in this section every such corporation or association shall be exempt from the provisions of this chapter, other than articles one, two, three, twenty-five and seventy-four of this chapter.

(f) The superintendent may, in the superintendent's discretion, examine any such corporation or association that is exempt from obtaining a permit pursuant to subsection (d) of this section.

§ 1111. Compulsory insurance; bonds of surety companies; certificates of qualification. (a) Whenever by any law of this state any policy or contract of insurance is required, or is acceptable in lieu of any other requirement imposed by such law, the superintendent may, upon written request containing such information as he deems necessary, issue to any person a certificate of qualification, stating the qualification of any insurer authorized to do such business in this state if he finds that, as shown by the insurer's last filed annual statement or last filed report on examination, whichever is later, the insurer is solvent, responsible and otherwise qualified to make policies or contracts of the kind required. No insurer authorized to do business in this state shall issue or make any policy or contract of insurance or surety bond to

owners or operators of motor vehicles as required by the provisions of the vehicle and traffic law of this state, unless the superintendent shall have certified to the commissioner of motor vehicles that such insurer is qualified to issue such policy or contract, in the manner specified herein.

(b) (1) Whenever by any law of this state a bond, undertaking, recognizance, guaranty or like obligation is required, permitted, authorized or allowed, or the performance of any act, duty or obligation, or the refraining from any act, is required, permitted, authorized or allowed to be secured or guaranteed, such bond or like obligation, or such security or guaranty, may be executed by any insurance company authorized to do in this state the business of executing such instruments and empowered by its charter to execute them. The insurer's execution of such instrument by its officer, attorney-in-fact or other authorized representative shall be accepted as, and in all respects shall be, a full compliance with every law or other requirement, now or hereafter in force, that any such obligation be given or accepted or that it be executed by one or more sureties, or that such sureties be residents, householders or freeholders, or possess any other qualifications.

(2) The superintendent may on written application issue to any company his certificate of qualification stating the company's capital and surplus as shown by its last annual statement or its last filed report on examination, whichever is later, and that such capital and surplus complies with the requirements of this chapter. The certificate shall further indicate the limitation upon the amount of a single risk which such company is authorized to assume.

(c) The superintendent may refuse to issue any certificate pursuant to subsection (a) or (b) hereof if in his judgment refusal will best promote the interests of the people of this state. Such certificate, or a copy certified by the superintendent, shall be conclusive evidence, as of its date and thereafter until revoked, of either the insurer's qualification to issue the policy, contract of insurance or surety bond, if issued pursuant to subsection (a) hereof, or the company's qualification, and its sufficiency under any law of this state as surety or guarantor, and of the propriety of accepting and approving it as such, if issued pursuant to subsection (b) hereof, and this

certification shall be in lieu of any justification required of the insurer by any law of this state or any requirement pursuant thereto.

(d) If after notice to and hearing of any insurer the superintendent finds the insurer is no longer entitled to obtain a certificate, he may revoke it by filing an order of revocation in his office. He shall thereupon serve a copy of such order on the insurer and shall give notice of the revocation to any state official or board to whom the certificate was issued. The superintendent may publish notice of such revocation in such newspapers of general circulation in this state as he may deem proper in the public interest. No insurer and no officer, attorney-in-fact or other representative thereof shall, after receiving notice of revocation, make or execute, or hold itself out as authorized to make or execute, in this state, any policy, contract of insurance, bond or like obligation, or security or guaranty specified in subsection (a) or (b) hereof, as long as such revocation continues in effect.

§ 1112. Reciprocal provisions as to taxes, license fees, deposits, and other requirements. (a) (1) If, by the laws, or the action of any public official, of any other state, any insurer organized or domiciled in this state, or its duly authorized agents, shall be, required to deposit securities in such other state to protect policyholders or for any other purpose, or shall be required to pay taxes, fines, penalties, fees for licenses or certificates of authority or any other sum for the privilege of doing business in such other state, or shall be subjected to any restrictions, obligations, conditions or penalties, imposed for such privilege, and such requirements are greater than those required of similar insurers organized or domiciled in such other state by the laws of this state for the privilege of doing business herein, then all similar insurers organized or domiciled in such other state and their duly authorized agents in this state shall make like deposits for like purposes with the superintendent, and pay him for taxes, fines, penalties, fees for licenses or certificates of authority or for any other requirement for the privilege of doing business in this state, an amount determined in the manner prescribed by such other state, and shall be subjected to such greater requirements imposed by such other state upon similar insurers of this state and their duly authorized

agents.

(2) (i) For the amount due under this subsection for the calendar year nineteen hundred eighty-nine, an initial payment shall be made by each insurer subject to this subsection of an amount equal to the lesser of (a) ninety percent of the amount finally determined to be due under this subsection for the calendar year nineteen hundred eighty-seven or (b) eighty percent of the amount finally determined to be due under this subsection for the calendar year nineteen hundred eighty-nine. Such initial payment shall be made on or before March fifteenth, nineteen hundred ninety.

(ii) For the amount due under this subsection for calendar years after nineteen hundred eighty-nine, an estimated payment shall be due and payable on or before the fifteenth day of December. This payment shall be equal to the lesser of (a) ninety percent of the amount finally determined to be due under this subsection for the second preceding calendar year or (b) eighty percent of the amount finally determined to be due under this subsection for the calendar year.

(iii) If any insurer fails to pay all or any part of the initial payment or estimated payment due pursuant to subparagraph (i) or (ii) of this paragraph, it shall be deemed to have made an underpayment. There shall be added to the amount due pursuant to paragraph one of this subsection, an amount at the rate set for underpayments by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, minus four percentage points, or if no rate is set, at the rate of six percent per annum upon the amount of the underpayment for the period of the underpayment. In computing the amount of any interest required to be paid, such interest shall not be compounded. The amount of the underpayment shall be, with respect to the initial payment or any estimated payment, the excess of the amount required to be paid over the amount, if any, paid on or before the last day prescribed for such payment. If the superintendent demands payment of the initial payment or any estimated payment, and if such amount is paid within ten days after the date of such demand, interest on the amount so paid shall not be imposed for the period after the date of such demand. No portion of the interest imposed pursuant to this subparagraph may be waived.

(iv) Notwithstanding the provisions of section sixteen of the state

finance law, interest shall be allowed and paid at the rate set for overpayments by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, or if no rate is set, at the rate of six percent per annum upon any overpayment, from the date payment was due to a date (to be determined by the superintendent) preceding the date of a refund check by not more than thirty days. In the case of a payment which is made after the last date prescribed for payment of such payment, no interest shall be allowed or paid for any day before the date on which the payment was made. In computing the amount of interest required to be paid, such interest shall not be compounded. No interest shall be allowed or paid if the amount thereof is less than one dollar.

(v) If the period for which the amount is imposed pursuant to paragraph one of this subsection is less than twelve months, every insurer shall make estimated payments in accordance with regulations of the superintendent.

(b) If the superintendent finds that by the laws or official acts of any foreign country, insurers organized in this state are arbitrarily denied the privilege of doing business in such foreign country, or are subjected to unreasonable requirements therein, he may revoke the licenses of all insurers of such country doing business in this state, and may refuse to issue licenses to every insurer of such country thereafter applying for a license to do business in this state, or in lieu thereof, he may impose like requirements upon every insurer of such country, until he shall find that such arbitrary denial or unreasonable requirements no longer apply.

(c) If, by the existing or future laws of any other state, any broker resident within this state and duly licensed as such under this chapter may not be licensed as a broker in such other state, then no broker resident in such other state shall be licensed as a broker within this state, anything in this chapter to the contrary notwithstanding. If a license fee exceeding forty dollars per annum is imposed by any other state for issuing a license to a broker resident within this state, or the amount of commissions which may be paid to such broker on premiums on risks located in any other state shall be limited under the laws of such state, then, all brokers resident in such other state shall upon being licensed in this state pay a like fee in lieu of that prescribed

by this chapter, and insurance companies authorized to transact business in this state shall not pay to any such nonresident broker any commissions on premiums on risks located in this state exceeding those which the laws of such other state permit brokers of this state to receive on premiums on risks located in such other state.

* (d) (1) Should the insurance department, commissioner, director, or other similar insurance regulatory official of any other state or territory of the United States impose any sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations of any kind upon any insurance company organized or chartered in this state and licensed to transact business in such other state or territory, because of the failure of the New York insurance department to obtain, maintain, or receive accreditation certification or any similar form of approval, compliance, or acceptance from, by, or as a member of the National Association of Insurance Commissioners, or any committee, task force, working group, or advisory committee thereof, or because of the failure of the department to comply with any directive, financial annual statement requirement, model act or regulation, market conduct or financial examination report or requirement, or any report of any kind of the National Association of Insurance Commissioners, or any committee, task force, working group, or advisory committee thereof, the superintendent shall without exception or exclusion, impose upon any and all insurance companies organized or chartered in such other state or territory and licensed to do business in this state the same sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations imposed upon the insurance companies of this state.

(2) To the extent that it would be detrimental to the adequate and proper regulation of insurance in this state to use existing employees or resources of the department in order to comply in a timely manner with paragraph (1) of this subsection, the superintendent may engage such other qualified persons and services as may be necessary. The superintendent shall recover all of the costs of such compliance in the manner prescribed in section 313 of the insurance law.

* NB Expired March 31, 1995

* (e) The provisions of this section shall not apply to insurance

companies organized or domiciled in a state or country whose laws do not impose retaliatory taxes or other charges or which grant, on a reciprocal basis, exemptions therefrom to insurance companies organized or domiciled in this state.

* NB Expired March 31, 1995, relettering expired on such date is actually (d) from 367/84 on such date

§ 1112-a. Reports. On or before March first of each year the superintendent shall report the amounts imposed and required to be paid pursuant to section twenty-eight hundred seven-t of the public health law that are allowed on returns filed during the preceding calendar year as credits in assessing the taxes imposed by section one thousand one hundred twelve of this chapter. Such report shall also include the amount, if any, by which taxes due and owing pursuant to such section one thousand one hundred twelve have been reduced because of the allowance of such credits. Such report shall be provided to the director of the budget and the commissioner of health.

§ 1113. Kinds of insurance authorized. (a) The kinds of insurance which may be authorized in this state, subject to other provisions of this chapter, and their scope, are set forth in the following paragraphs. The power to do any kind of insurance against loss of or damage to property shall include the power to insure all lawful interests in such property and to insure against loss of use and occupancy, rents and profits resulting therefrom. No kind of insurance shall include life insurance, title insurance or insurance against legal liability for personal injury or death unless specified in this section. In addition to any power specifically conferred by this chapter to engage in any other kind of business than an insurance business, any insurer authorized to do business in this state may engage in other kinds of business to the extent necessarily or properly incidental to the kinds of insurance business it is authorized to do in this state.

(1) "Life Insurance," means every insurance upon the lives of human beings, and every insurance appertaining thereto, including the granting of endowment benefits, additional benefits in the event of death by

accident, additional benefits to safeguard the contract from lapse, accelerated payments of part or all of the death benefit or a special surrender value upon (A) diagnosis of terminal illness defined as a life expectancy of twelve months or less, (B) diagnosis of a medical condition requiring extraordinary medical care or treatment regardless of life expectancy, (C) certification by a licensed health care practitioner of any condition which requires continuous care for the remainder of the insured's life in an eligible facility or at home when the insured is chronically ill as defined by Section 7702(B) of the Internal Revenue Code and regulations thereunder, provided the accelerated payments qualify under Section 101(g)(3) of the Internal Revenue Code and all other applicable sections of federal law in order to maintain favorable tax treatment, (D) certification by a licensed health care practitioner that the insured is chronically ill as defined by Section 7702 (B) of the Internal Revenue Code and regulations thereunder, provided the accelerated payments qualify under Section 101(g)(3) of the Internal Revenue Code and all other applicable sections of federal law in order to maintain favorable tax treatment, (E) the insured's having been a resident of a nursing home, as defined in section twenty-eight hundred one of the public health law, for a period of three months or more, with an expectation that such insured will remain a resident of a nursing home until death, or (F) the insured's having been the recipient of end of life or palliative care, for a period of three months or more, at a residential health care facility as defined in subdivision three of section twenty-eight hundred one of the public health law, home care services as defined in subdivision one of section thirty-six hundred two of the public health law or hospice as defined in subdivision one of section four thousand two of the public health law, with the expectation that such insured will continue to require such services until death. "Life insurance" also includes a special surrender value upon total and permanent disability of the insured, optional modes of settlement of proceeds, and additional benefits to safeguard the contract against lapse in the event of unemployment of the insured or in the event the insured is a resident of a nursing home. Amounts paid the insurer for life insurance and proceeds applied under optional modes of settlement or under dividend options may be allocated by the insurer to one or more separate accounts pursuant to

section four thousand two hundred forty of this chapter.

(2) "Annuities," means all agreements to make periodical payments for a period certain or where the making or continuance of all or some of a series of such payments, or the amount of any such payment, depends upon the continuance of human life, except payments made under the authority of paragraph one hereof. Amounts paid the insurer to provide annuities and proceeds applied under optional modes of settlement or under dividend options may be allocated by the insurer to one or more separate accounts pursuant to section four thousand two hundred forty of this chapter.

(3) "Accident and health insurance," means (i) insurance against death or personal injury by accident or by any specified kind or kinds of accident and insurance against sickness, ailment or bodily injury, including insurance providing disability and family leave benefits pursuant to article nine of the workers' compensation law, except as specified in item (ii) hereof; and (ii) non-cancellable disability insurance, meaning insurance against disability resulting from sickness, ailment or bodily injury (but excluding insurance solely against accidental injury) under any contract which does not give the insurer the option to cancel or otherwise terminate the contract at or after one year from its effective date or renewal date.

(4) "Fire insurance," means insurance against loss of or damage to any property resulting from fire, including loss or damage incident to the extinguishment of a fire or to the salvaging of property in connection therewith.

(5) "Miscellaneous property insurance," means loss of or damage to property resulting from:

(A) lightning, smoke or smudge, windstorm, tornado, cyclone, earthquake, volcanic eruption, rain, hail, frost and freeze, weather or climatic conditions, excess or deficiency of moisture, flood, the rising of the waters of the ocean or its tributaries;

(B) insects, or blights, or disease of such property except animals;

(C) electrical disturbance causing or concomitant with a fire or an explosion in public service or public utility property;

(D) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe,

vandalism or malicious mischief, strike or lockout, collapse from any cause, or explosion; but excluding any kind of insurance specified in paragraph nine hereof, except insurance against loss of or damage to property resulting from:

(i) explosion of pressure vessels (except steam boilers of more than fifteen pounds pressure) in buildings designed and used solely for residential purposes by not more than four families,

(ii) explosion of any kind originating outside of the insured building or outside of the building containing the property insured,

(iii) explosion of pressure vessels which do not contain steam or which are not operated with steam coils or steam jackets, or

(iv) electrical disturbance causing or concomitant with an explosion in public service or public utility property; or

(E) lateral or vertical subsidence of the earth caused by past or present mining operations.

(6) "Water damage insurance," means insurance against loss or damage by water or other fluid or substance to any property resulting from the breakage or leakage of sprinklers, pumps or other apparatus erected for extinguishing fires or of water pipes or other conduits or containers, or resulting from casual water entering through leaks or openings in buildings or by seepage through building walls, but excluding loss or damage resulting from flood or the rising of the waters of the ocean or its tributaries; and including insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or containers.

(7) "Burglary and theft insurance," means:

(A) Insurance against loss of, or damage to, any property resulting from burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment by any person, or from any attempt thereof;

(B) Insurance against loss of, or damage to, moneys, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers or documents, resulting from any cause, except while in the custody or possession of, and being transported by, any carrier for hire or in the mail;

(C) Insurance of individuals by means of an all-risk type of policy commonly known as the "Personal Property Floater" against any kind and all kinds of loss of, or damage to, or loss of use of, any personal

property other than merchandise;

(D) Insurance covering a ransom or reward payment incurred as the result of an abduction or the theft of property; travel and lodging expense and lost wages incurred as the result of an act or threatened act of violence; expense incurred to locate or identify a missing or abducted person; or other expenses to respond to a violent act or threatened act, or to prevent a reoccurrence thereof; and

(E) Insurance against losses and expenses resulting from a "stolen identity event," which shall include the theft, accidental release, or publication of, or misappropriation of information related to, an individual's personal identification, social security number, or other method of identifying the individual, that has resulted in, or could reasonably result in, the wrongful use of the information.

(8) "Glass insurance," means insurance against loss of or damage to glass and its appurtenances resulting from any cause.

(9) "Boiler and machinery insurance," means insurance against loss of or damage to any property of the insured, resulting from explosion of or injury to:

(A) any boiler, heater or other fired pressure vessel;

(B) any unfired pressure vessel;

(C) pipes or containers connected with any such boilers or vessels;

(D) any engine, turbine, compressor, pump or wheel;

(E) any apparatus generating, transmitting or using electricity; or

(F) any other machinery or apparatus connected with or operated by any such boilers, vessels or machines; and including the incidental power to make inspections of, and issue certificates of inspection upon, any such boilers, apparatus, and machinery, whether insured or otherwise.

(10) "Elevator insurance," means insurance against loss of or damage to any property of the insured, resulting from ownership, maintenance or use of elevators, except loss or damage by fire.

(11) "Animal insurance," means insurance against loss of or damage to any domesticated or wild animal resulting from any cause.

(12) "Collision insurance," means insurance against loss of or damage to any property of the insured resulting from collision of any other object with such property, but excluding collision to or by elevators, or to or by vessels, craft, piers or other instrumentalities of ocean or inland navigation.

(13) "Personal injury liability insurance," means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability (including the insurer's obligation to pay medical, hospital, surgical and disability benefits to injured persons, and funeral and death benefits to dependents, beneficiaries or personal representatives of persons who are killed, irrespective of legal liability of the insured), arising out of death or injury of any person, or arising out of injury to the economic interests of any person, as the result of negligence in rendering expert, fiduciary or professional service, but excluding any kind of insurance specified in paragraph fifteen except insurance to protect an insured against liability for indemnification or contribution to a third party held responsible for injury to the insured's employee arising out of and in the course of employment when such insurance is written pursuant to this paragraph and not written pursuant to paragraph fifteen of this subsection.

(14) "Property damage liability insurance," means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the loss or destruction of, or damage to, the property of any other person, but not including any kind of insurance specified in paragraph thirteen, fifteen or twenty-eight of this subsection.

(15) "Workers' compensation and employers' liability insurance," means insurance against the legal liability, under common law or statute or assumed by contract, of any employer for the death or disablement of, or injury to, his employee, including volunteer firefighters' benefit insurance provided pursuant to the volunteer firefighters' benefit law including volunteer ambulance workers' benefit insurance provided pursuant to the volunteer ambulance workers' benefit law and insurance for workers' compensation benefits for death and injuries arising out of crimes provided by the independent livery driver benefit fund pursuant to article six-G of the executive law.

(16) "Fidelity and surety insurance," means:

(A) Guaranteeing the fidelity of persons holding positions of public or private trust; and indemnifying banks, thrifts, brokers and other financial institutions against loss of money, securities, negotiable instruments, other specified valuable papers and tangible items of

personal property caused by larceny, misplacement, destruction or other stated perils including loss while being transported in an armored motor vehicle or by messenger; and insurance for loss caused by the forgery of signatures on, or alteration of, specified documents and valuable papers;

(B) Insurance against losses that financial institutions become legally obligated to pay by reason of loss of customers' property from safe deposit boxes;

(C) Any contract bond; including a bid, payment or maintenance bond or a performance bond where the bond is guaranteeing the execution of any contract other than a contract of indebtedness or other monetary obligation;

(D) An indemnity bond for the benefit of a public body, railroad or charitable organization; a lost security or utility payment bond;

(E) Becoming surety on, or guaranteeing the performance of, any lawful contract, not specifically provided for in this paragraph, but does not include becoming surety on, or guaranteeing the performance of:

(i) any insurance contract except as authorized pursuant to section one thousand one hundred fourteen of this article; or

(ii) any contract, if becoming surety on, or guaranteeing the performance of that contract, would constitute:

a. mortgage guaranty insurance as defined in subsection (a) of section six thousand five hundred one of this chapter;

b. financial guaranty insurance as defined in subsection (a) of section six thousand nine hundred one of this chapter; or

c. service contract reimbursement insurance as defined in paragraph twenty-eight of this subsection;

(F) Becoming surety on, or guaranteeing the performance of, bonds and undertakings required or permitted in all judicial proceedings or otherwise by law allowed, including surety bonds accepted by states and municipal authorities in lieu of deposits as security for the performance of insurance contracts;

(G) Becoming surety on, or guaranteeing the performance of, any agreement for the lease or rental of non-residential real property or

tangible personal property, provided that the obligation of the insurer shall not exceed a period of five years, and the bond is not issued directly or indirectly in connection with the sale of securities, a pooling of financial assets or a credit default swap as defined by article sixty-nine of this chapter;

(H) Becoming surety on, or guaranteeing the performance of, a contract of indebtedness or other monetary obligation where: (i) the aggregate gross principal, interest, and other amounts of indebtedness or other monetary obligations of any obligor whose obligations are guaranteed by the insurer under all bonds issued to that obligor pursuant to this subparagraph by the insurer does not exceed ten million dollars; and (ii) the bond is not issued directly or indirectly in connection with the sale of securities, a pooling of financial assets, or a credit default swap as defined by article sixty-nine of this chapter; and (iii) the bond by its terms terminates upon any sale or other transfer of the insured obligation in connection with the sale of securities, a pooling of financial assets, or a credit default swap as defined by article sixty-nine of this chapter;

(I) A depository bond that insures deposits in financial institutions to the extent of the excess over the amount insured by the Federal Deposit Insurance Corporation; and

(J) Becoming surety on, or guaranteeing the performance of, a bond, which shall not exceed a period greater than five years, that guarantees the payment of a premium, deductible, or self-insured retention to an insurer issuing a workers' compensation or liability policy.

In this chapter "fidelity" insurance shall have the meaning set forth in subparagraphs (A) and (B) of this paragraph.

(17) "Credit insurance," means:

(A) Indemnifying merchants or other persons extending credit against loss or damage resulting from non-payment of debts owed to them, for goods and services provided in the normal course of their business, including the incidental power to acquire and dispose of debts so insured, and to collect any debts owed to such insurer or to the insured, but no insurance may be written as credit insurance if it falls within the definition of financial guaranty insurance as set forth in paragraph one of subsection (a) of section six thousand nine hundred one

of this chapter;

(B) Indemnifying any person for expenses disbursed or to be disbursed under a contract in connection with the cancellation of a catered affair;

(C) Indemnifying any person for tuition and other educational expenses disbursed or to be disbursed under a contract in connection with his or her dismissal or withdrawal from an educational institution; or indemnifying elementary or secondary schools, whether public, private, profit or non-profit, providing education in consideration of a tuition charge or fee against loss or damage in the event of non-payment of the tuition charges or fees of a student or pupil dismissed, withdrawn or leaving before the end of the school year for which the insurance is written. An educational institution may not require any person responsible for the payment of a student's or pupil's tuition charge or fee to pay for tuition refund insurance;

(D) (i) (I) Indemnifying an adoptive parent for verifiable expenses not prohibited under the law paid to or on behalf of the gestational parent when either one or both of the birth parents of the child withdraw or withhold their consent to adoption. Such expenses may include maternity-connected medical or hospital expenses of the gestational parent, necessary living expenses of the gestational parent preceding and during confinement, travel expenses of the gestational parent to arrange for the adoption of the child, legal fees of the gestational parent, and any other expenses that an adoptive parent may lawfully pay to or on behalf of the gestational parent;

(II) Indemnifying an intended parent for financial loss incurred as a result of the failure by the person acting as surrogate to perform under the surrogacy contract due to death, bodily injury, sickness, disappearance of the person acting as surrogate, late miscarriage, or stillbirth. Such financial loss shall include medical and hospital expenses, insurance co-payments, deductibles, and coinsurance, necessary living expenses of the person acting as surrogate during the term of the surrogacy contract, travel expenses to arrange for the surrogacy, legal fees of the person acting as surrogate, and any other expenses that an intended parent may lawfully pay to or on behalf of the person acting as surrogate; or

(III) Indemnifying an intended parent for expenses disbursed when

either the intended parent or a person acting as surrogate receives in-vitro fertilization or intrauterine insemination treatment that fails and does not result in the birth of a child. Expenses may include living expenses of the person acting as surrogate during the in-vitro fertilization or intrauterine insemination treatment and expenses incurred by the intended parent or person acting as surrogate to travel for the in-vitro fertilization or intrauterine insemination treatment. Expenses also may include medical and hospital expenses not covered under the intended parent's or person acting as surrogate's comprehensive health insurance and insurance co-payments, deductibles, and coinsurance, but credit insurance as defined in this clause shall not solely cover such medical and hospital expenses, co-payments, deductibles, or coinsurance; and

(ii) For the purposes of this subparagraph "adoptive parent" means the parent or the parent's spouse seeking to adopt a child, "gestational parent" means the person giving birth to the child, "birth parent" means the biological parents of the child, and the terms "donor", "intended parent", "person acting as surrogate", and "surrogacy agreement" shall have the meaning set forth in section 581-102 of the family court act; or

(E) Indemnifying professional sports participants (including any person who participates or expects to participate as a player, coach, manager, trainer, physician or other person directly associated with a player or a team) under contract or the teams with which the contract is made, entertainers under contract to perform or the entities with which the contract is made, or business executives under an employment contract or the entities with which the contract is made, where contracts between such persons and teams or entities cannot be fulfilled due to a sports participant's, entertainer's or business executive's death, personal injury by accident, sickness, ailment or bodily injury that causes disability, where such indemnification is for the amount of financial loss that is sustained by the insured party or parties due to the inability to fulfill the terms of the contract.

(F) Indemnifying any person for expenses disbursed or to be disbursed for a ticket to an event, including any fees, when the person cannot use the ticket and the event does not fully reimburse the person for the expenses or provide a ticket of equal value or a rain check.

(18) "Title insurance," means insuring owners of, and other persons lawfully interested in, real property and chattels real against loss by reason of defective titles and encumbrances and insuring the correctness of searches for all instruments, liens or charges affecting the title to such property, including power to procure and furnish information relative thereto, and such other incidental powers as are specifically granted in this chapter.

(19) "Motor vehicle and aircraft physical damage insurance," means insurance against loss of or damage to motor vehicles or aircraft and their equipment resulting from any cause; and insurance reimbursing a driver for costs including replacement car rental, commercial transportation and accommodations resulting from an automobile accident or mechanical breakdown occurring fifty miles or more from the driver's principal place of residence or garaging.

(20) "Marine and inland marine insurance," means insurance against any and all kinds of loss of or damage to:

(A) Vessels, hulls, craft, aircraft, cars, automobiles, trailers and vehicles of every kind, and all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks;

(B) Person or property in connection with or appertaining to marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of ownership, maintenance or use of automobiles);

(C) Precious stones, jewels, jewelry, gold, silver and other precious

metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise; and

(D) Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their improvements and betterments, furniture and furnishings, fixed contents and supplies held in storage), including auxiliary facilities and equipment attendant thereto; piers, wharves, docks and slips; other aids to navigation and transportation, including dry docks and marine railways.

In this chapter "inland marine" insurance shall not include insurance of vessels, crafts, their cargoes, marine builders' risks, or other similar risks, commonly insured only under ocean marine insurance policies.

(21) "Marine protection and indemnity insurance," means insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

(22) "Residual value insurance" means insurance issued in connection with a lease or contract which sets forth a specific termination value at the end of the term of the lease or contract for the property covered by such lease or contract, and which insures against loss of economic value of tangible personal property or real property or improvements thereto except loss due to physical damage to property, excluding any lease or contract that falls within the definition of financial guaranty insurance as set forth in paragraph one of subsection (a) of section six thousand nine hundred one of this chapter.

(23) "Mortgage guaranty insurance," means the kind of insurance specified in section six thousand five hundred one of this chapter.

(24) "Credit unemployment insurance" means insurance on a debtor in connection with a specified loan or other credit transaction within the state to provide payments to a creditor in the event of unemployment of the debtor for the installments or other periodic payments becoming due while a debtor is unemployed.

(25) "Financial guaranty insurance," means the kind of insurance

defined in paragraph one of subsection (a) of section six thousand nine hundred one of this chapter.

(26) "Gap insurance" means insurance covering the gap amount which is payable upon the total loss of personal property, which is the subject of a lease or loan or other credit transaction occasioned by its theft or physical damage. The kinds of gap insurance are:

(A) "Motor vehicle lessor/creditor gap insurance" which insures the lessor, creditor, or the lessor's or creditor's assignee, under a motor vehicle lease or loan or other credit transaction pursuant to which the lessor, creditor, or, in the absence of a waiver by the lessor or creditor, the assignee has waived the obligation of the lessee or debtor for the gap amount;

(B) "Motor vehicle lessee/debtor gap insurance" which insures the lessee or debtor under a motor vehicle lease or loan or other credit transaction pursuant to which the lessor, creditor, or the lessor's or creditor's assignee has not waived the obligation of the lessee or debtor for the gap amount;

(C) "Non-motor vehicle lessor/creditor gap insurance" which insures the lessor, creditor, or the lessor's or creditor's assignee, under a lease or loan or other credit transaction covering personal property other than a motor vehicle pursuant to which the lessor, creditor, or, in the absence of a waiver by the lessor or creditor, the assignee, has waived the obligation of the lessee or debtor for the gap amount; and

(D) "Non-motor vehicle lessee/debtor gap insurance" which insures the lessee or debtor under a lease or loan or other credit transaction covering personal property other than a motor vehicle pursuant to which the lessor, creditor, or the lessor's or creditor's assignee has not waived the obligation of the lessee or debtor for the gap amount.

(27) "Prize indemnification insurance," means insurance against financial loss by reason of payment of any sum or item awarded to a participant in any lawful contest or sports related event.

(28) "Service contract reimbursement insurance" means insurance issued to a provider pursuant to article seventy-nine of this chapter whereby the insurer agrees, for the benefit of service contract holders, to discharge the obligations and liabilities of such provider under the terms of the service contracts issued by such provider, including the return of unearned provider fees upon any termination or cancellation of

service contracts, in the event of non-performance of any such obligations or liabilities by such provider. Such insurance may also include insurance issued to a provider to indemnify the provider for losses sustained by reason of the performance of such provider's obligations under service contracts issued pursuant to article seventy-nine of this chapter.

(29) "Legal services insurance" means insurance providing legal services or reimbursement of the cost of legal services.

(30) "Involuntary unemployment insurance" means insurance against the loss of income due to the involuntary loss of full-time employment which is the result of an individual or mass layoff or employer termination, a temporary suspension or permanent cessation of employment or a business failure.

(31) "Salary protection insurance" means insurance against financial loss caused by the cessation of earned income due to disability from sickness, ailment or bodily injury, in an amount up to: (A) that portion of an individual's annual earned income which is in excess of the amount of in force disability insurance as defined in paragraph three of this subsection in an amount not to exceed seventy-five percent of the individual's annual earned income in total based upon the sum of the in force disability insurance and salary protection insurance when the benefits are payable to the individual or the individual's beneficiary; or (B) where such underlying disability insurance cannot be obtained by an individual from an authorized insurer, in an amount not to exceed seventy-five percent of the individual's annual earned income when the benefits are payable to the individual or the individual's beneficiary. Any insurer licensed to write disability insurance as defined in paragraph three of this subsection may also write salary protection insurance as defined in this paragraph.

(32) "Donor medical expense insurance" means insurance indemnifying an intended parent for medical or hospital expenses that the intended parent is contractually obligated to pay under a donor agreement when the expenses result from medical complications that occur as a result of the donation of gametes. For the purpose of this paragraph, "donor", "gametes" and "intended parent" shall have the meaning set forth in section 581-102 of the family court act.

(33) "Excess business disability insurance," means insurance against

financial loss experienced by a corporate entity or a partnership where an individual integral to the successful operation of such corporate entity or partnership becomes disabled due to sickness, ailment or bodily injury. Such insurance may be obtained in excess of a primary business-related disability policy, or in the absence of such a policy if coverage cannot be obtained from an authorized insurer. Excess business disability insurance coverage may include, but is not limited to, reimbursement for all overhead costs and expenses and all capital outlays of a corporate entity or partnership which such corporate entity or partnership incurs in the ordinary course of business during the period of disability; and buy/sell arrangements in an amount sufficient to purchase the disabled individual's interest share in the corporate entity or partnership.

* (34) "Business interruption insurance" means insurance against loss of use and occupancy, rents, and profits resulting from a business closure due to: (A) loss of or damage to insured or neighboring property; (B) an act or threatened act of violence while the perpetrator is on the business premises; or (C) a government order.

* NB There are 2 (34)'s

* (34) "Parametric insurance" means insurance against the occurrence of a weather-related event, such as windstorm, flood, snow, wildfire, tornado, cyclone, or earthquake, where the indemnification is based on the proximity and magnitude of the event as measured and reported by a state or federal government agency.

* NB There are 2 (34)'s

(35) "Substantially similar kind of insurance," means such insurance which in the opinion of the superintendent is determined to be substantially similar to one of the foregoing kinds of insurance and thereupon for the purposes of this chapter shall be deemed to be included in that kind of insurance.

(b) Nothing herein contained shall require any insurer to insure every kind of risk which it is authorized to insure.

§ 1114. Reinsurance business. (a) Any domestic stock or mutual insurance corporation or reciprocal insurer may reinsure only the kinds of insurance business which it is licensed to do in this state or which

it is otherwise authorized to reinsure by the terms of its license. Any such corporation may confine its business to reinsurance.

(b) Any foreign or alien stock or mutual insurance corporation or reciprocal insurer may engage in this state in reinsurance of the kinds of insurance which it is licensed to do in this state. Any such corporation may confine its business to reinsurance.

(c) An insurer authorized by any provision of this chapter to engage in fidelity and surety insurance or reinsurance business may also guarantee performance of a contract insuring against physical damage to property in favor of mortgagees or other loss payees named in such contract, provided:

(1) It is authorized to engage in the kinds of insurance included in such contract;

(2) It has assumed reinsurance on the guaranteed contract in whole or in part;

(3) It is charged with such amount as part of its unearned premium reserve as may be prescribed by regulation of the superintendent not exceeding the amount it would be required to maintain in accordance with the provisions of this chapter if it were the direct insurer of the guaranteed risks; and

(4) If the property is located in this state, the ceding insurer is licensed to engage in the kinds of insurance included in such contracts.

(d) An insurer authorized by any provision of this chapter to do business of the kinds referred to in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this article may also reinsure, by itself, or together with other insurance companies subject to any regulations of the superintendent, any risk referred to in such subsection arising from, related to, or incident to the manufacture, ownership or operation of aircraft.

(e) Any health service corporation organized under article forty-three of this chapter is authorized to engage in reinsurance of policies of:

(1) any other corporation organized under article forty-three of this chapter;

(2) any health maintenance organization organized under article forty-four of the public health law; and

(3) long term care insurance issued by accident and health insurers organized under article forty-two of this chapter.

§ 1115. Limitation of risk, in general. (a) Except as otherwise provided in this chapter, no insurer doing business in this state shall expose itself to any loss on any one risk in an amount exceeding ten percent of its surplus to policyholders. In determining the amount of risk, any portion reinsured in an assuming insurer authorized to do such business in this state or in an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter, shall be deducted. In determining the limitation of risk under any provision of this chapter, "surplus to policyholders" shall include voluntary reserves, or any part thereof, not required by law, and be determined from the insurer's last sworn statement on file with the superintendent, or the last report on examination filed by the superintendent, whichever is more recent at the time the risk is assumed. In applying the limitation under any provision of this chapter to alien insurers, such provision shall be deemed to refer to the exposure to risk and to the surplus to policyholders of the United States branch of such alien insurer.

(b) This section shall not apply to the insurance of marine risks, marine protection and indemnity risks, workers' compensation, employers' liability risks, mortgage guaranty risks, financial guaranty risks, risks insured for any dollar level of first party benefits provided pursuant to article fifty-one of this chapter, certificates of title, guaranties of title or policies of title insurance, or those insurers subject to the provisions of subsection (c) of section two thousand three hundred forty-three of this chapter.

(c) (1) An insurer, selling residual value insurance in this state must at all times maintain surplus to policyholders in the aggregate amount of no less than: (i) 0.3333 percent or 1/300th of the aggregate net liability under guaranties of commercial real estate; (ii) 0.6666 percent or 1/150th of the aggregate net liability under guaranties of commercial transportation, to include, but not inclusively, aircraft, helicopters, vessels and railcars; (iii) one percent or 1/100th of the aggregate net liability under guaranties of commercial industrial equipment; (iv) with regard to all other residual value guarantees, four percent or 1/25th of the aggregate net liability under such guarantees.

For purposes of subparagraphs (i) through (iv) of this paragraph residual value is defined as set forth in paragraph twenty-two of subsection (a) of section one thousand one hundred thirteen of this article including financial transactions demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof.

(2) An insurer, selling residual value insurance in this state shall limit its exposure on any one risk, net of collateral and reinsurance to an amount not to exceed ten percent of the aggregate of the insurer's surplus to policyholders. For the purposes of this section reinsurance must be placed with an authorized or accredited reinsurer in New York state. The credit for collateral shall not exceed fifty percent of the appraised value of the underlying asset at the date in the future that the value of the property is guaranteed.

§ 1116. Prepaid legal services plans and legal services insurance. (a) (1) An authorized insurer subject to the provisions of this chapter (except an insurer organized to write the kinds of insurance specified in paragraph eighteen, twenty-three or twenty-five of subsection (a) of section one thousand one hundred thirteen of this article or any corporation licensed or organized pursuant to article sixty-six of this chapter) may, if licensed to transact legal services insurance, as defined in paragraph twenty-nine of subsection (a) of section one thousand one hundred thirteen of this article, be authorized by the superintendent to issue contracts of legal services in connection with a prepaid legal services plan, if such plans satisfy the criteria set forth in subsection (b) of this section and the superintendent makes the determinations set forth in subsection (g) of this section. The provisions of this section shall be applicable to a corporation organized pursuant to article forty-three of this chapter only if the proposed plan and method of operations have been approved by a vote of at least two-thirds of the corporation's board of directors before the plan is submitted to the superintendent.

(2) A prepaid legal services plan may include legal services insurance as part of the plan, provided however, not more than an incidental amount of the premium with respect to such prepaid legal services plan

shall be attributable to legal services for defense only coverages for commercial or other business related lawsuits or arbitration proceedings commenced against the business entity that purchased the policy.

(3) Legal services insurance may not be written except (i) in conjunction with prepaid legal services plans as authorized in this section, or (ii) pursuant to a regulation promulgated by the superintendent permitting legal services insurance to be written as part of a policy of liability insurance covering related risks and, provided further, that legal services for defense only coverages for commercial or other business related lawsuits or arbitration proceedings commenced against the business entity that purchased the policy is not more than an incidental part of such liability insurance.

(b) The superintendent may, in accordance with the provisions of article twenty-three of this chapter, authorize the issuance of contracts in connection with a prepaid legal services plan when such plan satisfies the following criteria:

(1) its provisions are not misleading, confusing or inconsistent with the needs of the public;

(2) it avoids interference with judicial supervision over the professional and public obligations of lawyers;

(3) it provides for prompt resolution of grievances concerning benefits;

(4) it does not restrict the beneficiary's choice of attorney, provided, however, that compensation by the plan for attorneys not participating in the plan shall be subject to the schedule of benefits and fee structure set forth in the applicable contract and, provided further, that nothing herein shall be construed as prohibiting an attorney who is not participating in the plan from charging a fee for services provided in excess of the schedule of benefits or fee structure set forth in the applicable contract;

(5) it provides for a broad range of legal services, through personal and telephone consultations, such as wills, residential real estate matters and domestic relations matters, provided nothing herein shall require or prohibit the offering of a particular type of legal services by a prepaid legal services plan;

(6) it provides for written disclosure to contract holders, including a description of the schedule of benefits, fee structure, exclusions or

other limitations on benefits, and an explanation of a covered person's financial responsibility for the payment of premiums, co-payments, deductibles or amounts charged in excess of the schedule of benefits or fee structure by attorneys not participating in a plan;

(7) unless it provides for a shorter period, as provided in a paragraph two of subsection (d) of section three thousand four hundred twenty-six of this chapter, or for a longer period, the plan shall be issued or renewed for a one-year policy period;

(8) it may be cancelled by an insurer only if cancellation is based on one or more of the reasons set forth in paragraph one of subsection (c) of section three thousand four hundred twenty-six of this chapter upon no less than fifteen days written notice to a contract holder and shall include no less than a fifteen-day grace period in the event of a cancellation based on non-payment of premium, provided, however, in the event a contract is issued on a group basis, an individual group member may be canceled upon termination of his or her employment with or membership in the group contract holder;

(9) it may be nonrenewed by an insurer for any reason upon at least forty-five, but not more than sixty, days written notice to a contract holder; and

(10) it may be cancelled by a contract holder for any reason upon thirty days written notice to an insurer.

(c) The contracts may be issued on a group basis subject to regulations promulgated by the superintendent.

(d) Such contracts shall be subject to all other applicable provisions of this chapter and regulations thereunder.

(e) The superintendent may permit an authorized insurer subject to the provisions of this section to enter into contracts with any corporation or other organization, which provides or sponsors a prepaid legal services plan not subject to this chapter, to administer such plan if the plan satisfies the criteria set forth in subsection (b) of this section and provided the superintendent makes the determinations set forth in subsection (g) of this section. Such administration may include, but need not be limited to, marketing, actuarial, data processing, accounting, claims and other related services. Such contracts shall provide for the payment of a reasonable fee for such administrative services.

(f) The superintendent may permit an authorized insurer subject to the provisions of this chapter to reinsure the risk of any prepaid legal services plan as if it were legal services insurance if the plan satisfies the criteria set forth in subsection (b) of this section, provided the superintendent makes the determinations set forth in subsection (g) of this section. Such reinsurance agreements shall provide for the payment of a reasonable premium.

(g) The superintendent may take the actions set forth in subsections (a), (e) and (f) of this section only if the superintendent determines, with respect to each such action, that:

(1) the sponsors and other participants in the plan can reasonably be anticipated to be able to carry out their responsibilities under the plan, and

(2) the plan attempts to address the problem that desired legal services are unavailable to some citizens of this state because some individuals and families who are not eligible for government subsidized programs cannot afford the cost of those services, and

(3) the proposed activity by the authorized insurer will not cause or constitute an impairment of the insurer's ability to satisfy its existing and anticipated contracts and other obligations, including such standards as the superintendent prescribes concerning adequate capital and financial requirements.

(h) The superintendent shall promulgate such regulations that are necessary to implement the provisions of this section.

§ 1117. Health insurance plans for long term care. (a) An authorized insurer subject to the provisions of this chapter and organized to write the kind of insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this article, a corporation or health maintenance organization authorized pursuant to article forty-three of this chapter or article forty-four of the public health law, and a fraternal benefit society organized under article forty-five of this chapter, may be authorized by the superintendent to issue contracts in connection with plans providing benefits for long term care, provided such plans satisfy the criteria set forth in subsection (b) of this section and the superintendent has made the determinations

set forth in subsection (f) of this section.

(b) The superintendent may authorize such contracts in connection with a plan for long term care pursuant to the following criteria:

(1) the plan's provisions are not misleading or confusing;

(2) the plan's provisions are not inconsistent with the needs of the public;

(3) the plan's benefit structure provides options for use of long term care services;

(4) the plan, the contract and other materials describing the plan fully and clearly state the benefits and limitations of such plan;

(5) the authorized insurer, health maintenance organization, or fraternal benefit society agrees to provide such reports of the experience of the plan as may be requested by the superintendent. The superintendent may prepare abstracts and summaries of such reports at the request of other government agencies for purposes of research and studies related to long term care financing, provided however that the insurer, health maintenance organization, or fraternal benefit society may request that specified information included in the report be considered confidential; and

(6) prior to the earlier of the execution of a policy or certificate in connection with a plan providing a home care benefit and/or a nursing home benefit, or the payment of any premium or fee related to such a policy or certificate, the authorized insurer, corporation, health maintenance organization or fraternal benefit society shall provide the prospective insured or his or her representative with a disclosure statement, which contains the following:

(A) The maximum daily and lifetime benefit levels, if applicable, provided by the policy or certificate for home care services and nursing home services;

(B) The percentage of coverage provided for home care services and nursing home services, if applicable, and an explanation of the methodology on which the reasonable charge used in conjunction with such percentage amount is based;

(C) A description of any inflation protection feature included in or available for purchase under the policy or certificate and the additional premium required to purchase such option or options;

(D) (i) If available and accessible by the insurer or other entity

from the department of health, the most recently-published average, statewide rate for care in a nursing home, as well as the average rates for care in nursing homes for both the New York city-metropolitan and upstate regions of the state; or

(ii) If available and accessible by the insurer or other entity from the department of health, the most recently-published map of the estimated average regional rates in New York state for nursing home care;

(E) A graphic demonstration of the maximum daily nursing home benefit level provided by the policy or certificate, and the impact that the selection of any inflation protection options would have on such maximum daily nursing home benefit level;

(F) The right of the prospective insured, upon attaining the age of sixty-five years, to designate a third party who will receive a copy of any notices of nonpayment of premiums due or notice of cancellation for nonpayment of premiums that is sent to the prospective insured;

(G) (i) A written statement indicating that such policy or certificate may be subject to future premium rate increases and that such rate increases shall be subject to the approval or modification of the superintendent; and

(ii) A list of past premium rate increases for such policy or certificate over the previous ten years, or if such policy or certificate was not offered over the previous ten years, past premium rate increased for policies or certificates that offer similar benefits over the previous ten years;

(H) Directions on how to obtain information about the department's review of any rate filing or application, contact information for the department, and information on how to contact the authorized insurer, corporation, health maintenance organization or fraternal benefit society for more information;

(I) Whether or not there is a period in which rates will not change, and if so, when that time period expires;

(J) A description of whether or not the premium may change, and if so, the circumstances under which any such premium changes could occur, including whether the department must approve such changes;

(K) Whether the policy contains provisions providing for a refund or partial refund of premium upon the cancellation of the policy, and if

such provisions exist, provide a description of their terms;

(L) A description of the options policyholders will have to mitigate any premium increases;

(M) A description of the options policyholders will have should the premiums increase, and the policyholder deems it in their best interest to cancel the policy;

(N) A statement that the policyholder will be given at least ninety days notice before any premium change takes effect;

(O) A statement that if the authorized insurer, corporation, health maintenance organization or fraternal benefit society seeks to increase the premium rate, the department will post notice of the rate filing on its website prior to any determination by the department; and

(P) The right of the prospective insured to submit public comments on any rate filing or application regarding premium rates on the department's website.

For the purpose of this paragraph, "home care services" shall have the same meaning as defined in subdivision one of section thirty-six hundred two of the public health law. The prospective insured, or his or her representative, shall acknowledge that the required disclosure has been made by signing the disclosure statement prior to or contemporaneously with the effective date of the policy or certificate.

Failure to provide information required by subparagraph (D) of this paragraph shall not be construed as a violation of this section if such information has not been made available by the department of health.

(c) The duration of such contracts and the extent of exposure thereunder by insurers, health maintenance organizations or fraternal benefit societies shall be in the discretion of the superintendent.

(d) Contracts issued pursuant to the provisions of this section shall be subject to all other provisions of this chapter and the regulations promulgated thereunder applicable to the insurer, health maintenance organization, or fraternal benefit society which issues the contract, provided however that in order to permit the development of long term care plans, the superintendent may modify or suspend any such provision or regulation upon making the determinations set forth in subsection (f) of this section.

(e) The superintendent may permit an authorized insurer, health maintenance organization, or fraternal benefit society subject to the

provisions of this chapter to reinsure the risk of any long term care services plan, provided such plan satisfies the requirements of this section. Such reinsurance agreements shall provide for the payment of a reasonable premium.

(f) The superintendent may take the actions set forth in subsections (a), (d) and (e) of this section only if the superintendent determines that:

(1) the plan is a legitimate approach to expand the availability of insurance coverage for long term care services;

(2) any proposed modification or suspension of a provision of this chapter or a regulation promulgated thereunder is essential to the development of long term care plans pursuant to this section, and is directly related to the essential features of such plans;

(3) the premium rates for the long term care plan are reasonably related to the benefits provided, and are self-supporting; and

(4) the plan proposed by the insurer, health maintenance organization, or fraternal benefit society, and any proposed modification or suspension pursuant to subsection (d) of this section, will not cause or constitute an impairment of the insurer's, health maintenance organization's, or fraternal benefit society's ability to satisfy its existing and anticipated contracts and other obligations, including such standards as the superintendent shall prescribe concerning adequate capital and financial requirements.

(g) (1) Except for certain group contracts described in paragraph four of this subsection, in order for premium payments for long-term care insurance to qualify for purposes of section one hundred ninety, subdivision twenty-five-a of section two hundred ten, subsection (aa) of section six hundred six, subsection (k) of section one thousand four hundred fifty-six and subsection (m) of section one thousand five hundred eleven of the tax law, the long-term care insurance must be approved by the superintendent pursuant to this subsection. Prior to approving any such insurance, the superintendent shall conclude that it meets minimum standards, including minimum loss ratio standards under this section or section three thousand two hundred twenty-nine of this chapter and is a qualified long-term care insurance contract as defined in section 7702B of the internal revenue code.

(2) (A) No insurer, agent, broker, person, business or corporation

doing business in or into this state shall in any manner state, advertise or claim that a long-term care insurance policy qualifies for purposes of the above-referenced provisions of the tax law unless either: (i) the superintendent has issued a letter or other written instrument to the insurer stating that the policy has been determined to qualify under this subsection, or (ii) the policy qualifies under paragraph four of this subsection without the need for approval by the superintendent.

(B) Any policy which is held out or purported to be a long-term care insurance policy by any insurer, agent, broker, person, business or corporation doing business in or into this state which has not been determined by the superintendent to qualify and which does not qualify under paragraph four of this subsection for purposes of the above referenced provisions of the tax law shall so state clearly, legibly and in close physical proximity to any description of the policy as a long-term care insurance policy that it does not so qualify. This subsection shall also be deemed to cover any statement, advertisement or claim concerning such policy by any insurer, agent, broker, person, business or corporation doing business in or into this state.

(C) Violation of this paragraph shall be considered a misrepresentation under section twenty-one hundred twenty-three of this chapter.

(3) The superintendent shall maintain an ongoing list of those policies requiring approval of the superintendent that are found eligible for purposes of the above-referenced provisions of the tax law.

(4) Group contracts delivered or issued for delivery outside of the state, but which are qualified long-term care insurance contracts as defined in section 7702B of the internal revenue code shall be deemed to qualify for purposes of the provisions of the tax law specified in paragraph one of this subsection without the need to seek the approval of the superintendent pursuant to this subsection. Provided that they otherwise meet the requirements of this paragraph, such group contracts include, but are not limited to, those offered: (a) by professional associations and societies, membership organizations and not-for-profit groups, or by a subsidiary or affiliated entity of any of the foregoing, to the members of the association, society, organization or group, and (b) by employers to their employees.

(h) The department shall post on its website information describing the process that it uses in reviewing and approving premium rates for policies or contracts of long term care insurance.

(i) Whenever an authorized insurer, corporation, health maintenance organization or fraternal benefit society submits a rate filing or application to the superintendent to increase or decrease premium rates for any policy or certificate subject to this section, the superintendent shall post a public notice of the rate filing or application on the department's website within fourteen days. The superintendent shall provide for a process for the public to provide comments on such rate filing or application electronically or in writing for a period of thirty days after such public notice is posted on the department's website.

(j) The superintendent, upon rendering a decision regarding approval, disapproval or modification of a rate filing or application, shall issue a public notice of such decision. Such written decision and notice shall be made publicly available on the department's website no later than the date on which the rate filing or application is approved, disapproved, or modified. Such notification shall include:

(1) a summary of the determinations made and considerations used by the department regarding the approval, disapproval or modification of such rate filing or application, and

(2) a statement with relevant detail as to why the approval, disapproval or modification of the proposal is consistent with paragraph three of subsection (f) of this section.

(k) Upon receipt by an authorized insurer, corporation, health maintenance organization or fraternal benefit society covered by the provisions of this section of an approval or modification decision by the superintendent with respect to a rate filing application with the department, such authorized insurer, corporation, health maintenance organization or fraternal benefit society shall notify policyholders and certificate holders of such decision no later than ninety days prior to the effective date of the premium rate increase. Such notification shall include:

(1) a description of such decision; and

(2) a written statement conforming to the requirements set forth in subparagraph (G) of paragraph six of subsection (b) of this section.

(l) The provisions set forth in subparagraphs (G), (H), (I), (J), (K), (L), (M), (N), (O), and (P) of paragraph six of subsection (b) of this section shall not apply to policies or certificates that are exempt from premium rate increases.

§ 1118. Regional pilot projects for the uninsured. (a) An authorized insurer subject to the provisions of this chapter and organized to write the kind of insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this article, and a health maintenance organization authorized pursuant to article forty-three of this chapter or article forty-four of the public health law, may be authorized by the superintendent to issue contracts or otherwise enter into arrangements with approved organizations in connection with regional pilot projects to test models for the purpose of providing insurance and equivalent coverage mechanisms for the uninsured. Such plans must satisfy the criteria set forth in subsection (b) of this section and the superintendent shall make the determinations set forth in subsection (e) of this section. For the purpose of this section, regional pilot projects shall mean projects authorized pursuant to the expanded health care coverage act of nineteen hundred eighty-eight.

(b) The superintendent may authorize such contracts or arrangements for regional pilot projects pursuant to the following criteria:

(1) the plan's provisions are not misleading or confusing;

(2) the plan's provisions are consistent with the needs of the regional pilot projects; and

(3) the plan, the contract and other materials describing the plan fully and clearly state the benefits, limitations of the plan.

(c) The duration of such contracts and the extent of exposure thereunder by insurers or health maintenance organizations shall be determined by the superintendent.

(d) Notwithstanding any provisions of this chapter or the financial services law to the contrary, the superintendent may waive, modify or suspend any provision of this chapter, the financial services law or regulations promulgated thereunder as applicable to the insurers or health maintenance organizations that conduct the regional pilot projects, except as to mandatory benefits, provided such waiver,

modification or suspension is based on the criteria set forth in subsection (e) of this section.

(e) The superintendent may take the actions set forth in subsections (a) and (d) of this section upon the superintendent's judgment that:

(1) the plan is a reasonable and appropriate approach to expand the availability of health care coverage or equivalent coverage mechanisms for the uninsured;

(2) the premium rates and other sources of funding for the regional pilot project is reasonably related to the benefits provided and sufficient to support the program;

(3) any waiver, modification or suspension of provisions of this chapter, the financial services law or regulations promulgated thereunder is essential to the operation of the regional pilot project and to the rational development of programs to provide health care coverage or equivalent coverage mechanisms to the uninsured; and

(4) any waiver, modification or suspension of provisions of this chapter, the financial services law or regulations promulgated thereunder will not impair the ability of the insurer or health maintenance organization to satisfy its existing and anticipated contracts and other obligations, including such standards as the superintendent shall prescribe concerning adequate capital and financial requirements.

§ 1119. Limited exemption for continuing care retirement communities. (a) An organization complying with the provisions of article forty-six of the public health law may operate without being licensed under this chapter and without being subject to any provisions of this chapter, except to the extent that such organization must comply with the provisions of this chapter by virtue of such article, and such organization must comply with rules and regulations of the superintendent relating to:

(1) financial feasibility of the continuing care retirement community,

(2) actuarial principles established relating to such communities,

(3) approval of continuing care retirement contracts and the rates and rating system, if any, for such contracts.

(b) The superintendent may promulgate regulations in effectuating the

purposes and the provisions of this chapter and article forty-six of the public health law, which may include requirements applicable to the contracts between a continuing care retirement community and its residents.

(c) Such organization shall be subject to the provisions of article seventy-four of this chapter. Prior to commencing action under such article seventy-four, the superintendent shall consult with the continuing care retirement community council established pursuant to section forty-six hundred three of the public health law.

§ 1120. Child health insurance plan. (a) An authorized insurer subject to the provisions of this chapter and organized to write the kind of health insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this article, and a corporation or health maintenance organization authorized pursuant to article forty-three of this chapter or a health maintenance organization certified pursuant to article forty-four of the public health law, may be authorized by the superintendent to issue contracts or otherwise enter into arrangements with approved organizations for the purpose of providing child health insurance plan policies for eligible children pursuant to title I-A of article twenty-five of the public health law. Such contracts or arrangements shall satisfy the criteria set forth in subsection (b) of this section and the superintendent shall make the determinations set forth in subsection (e) of this section.

(b) The superintendent may authorize such contracts or arrangements pursuant to the following criteria:

(1) the provisions are not misleading or confusing;

(2) the provisions are consistent with the needs of the child health insurance plan; and

(3) the materials describing the contract or arrangement fully and clearly state the benefits and limitations of such contract or arrangement.

(c) The duration of such contracts or arrangements and the extent of exposure thereunder by insurers, article forty-three corporations or health maintenance organizations shall be determined by the superintendent.

(d) Notwithstanding any provisions of this chapter or the financial services law to the contrary, the superintendent may waive, modify or suspend any provisions of this chapter, the financial services law or regulations promulgated thereunder as applicable to the insurers, article forty-three corporations or health maintenance organizations that issue coverage pursuant to this section, provided such waiver, modification or suspension is based on the criteria set forth in subsection (e) of this section.

(e) The superintendent may take the actions set forth in subsections (a) and (d) of this section upon the superintendent's judgment that:

(1) the contract or arrangement is a reasonable and appropriate approach to expand the availability of health care coverage to children;

(2) the sources of funding for the contract or arrangement are reasonably related to the benefits provided and sufficient to support the contract arrangement;

(3) any waiver, modification or suspension of the provisions of this chapter, the financial services law or regulations promulgated thereunder is essential to the operation of the child health insurance plan and to the rational development of programs to provide covered services to children; and

(4) any waiver, modification or suspension of provisions of this chapter, the financial services law or regulations promulgated thereunder will not impair the ability of the insurer, article forty-three corporation or health maintenance organization to satisfy its existing and anticipated contracts and other obligations, including such standards as the superintendent shall prescribe concerning adequate capital and financial requirements.

(f) Each application used by an authorized insurer for purposes of enrolling eligible children into the child health insurance plan pursuant to this section and section twenty-five hundred eleven of the public health law shall include the notice required pursuant to subsection (d) of section four hundred three of this chapter.

§ 1121. Voucher insurance program. (a) The superintendent, in consultation with the commissioner of health, is authorized to conduct a program on a demonstration basis to the extent of funds available

therefor, through contractual arrangements with approved organizations, to assist individuals and families residing in specified urban, rural or suburban areas in purchasing health care coverage through insurers, health maintenance organizations and integrated delivery systems.

(b) The superintendent shall designate the urban, rural or suburban areas to be served by the voucher insurance program. The superintendent shall determine the overall amount of funding to be allocated for vouchers issued in designated urban, rural or suburban areas.

(c) The superintendent, in consultation with the commissioner of health, shall establish guidelines for the submission of proposals by organizations for the purposes of administering the voucher insurance program including, but not limited to the following:

(1) standards for enrollment of eligible persons, including mechanisms for determining eligibility, and annual recertification;

(2) standards for monitoring the performance of insurers, health maintenance organizations and integrated delivery systems participating in the voucher program; and

(3) such other criteria which may be deemed necessary.

(d) A proposal submitted by an organization to administer the voucher program shall include the following:

(1) a designation of the geographic area to be served;

(2) an estimation of the number of persons who will be eligible for the program and the estimated number of actual participants in the program in the specified geographic area;

(3) a description of the procedures for enrollment of eligible individuals and families in the voucher program;

(4) a demonstration of the availability and accessibility of offices where individuals and families could obtain information and enroll in the voucher program;

(5) a description of the mechanisms for preventing fraudulent enrollment;

(6) a description of the procedure for issuance of the voucher and for monitoring individual and family enrollment in health maintenance organizations, integrated delivery systems and insurers participating in the voucher program;

(7) a description of the mechanisms for monitoring the performance of health maintenance organizations, integrated delivery systems and

insurers participating in the program;

(8) a description of the procedures for marketing the voucher program and the proposed community outreach activities including the identification of any subcontractor who will perform these activities;

(9) a detailed description of the estimated expenses, including personnel costs and other types of administrative expenses which will be incurred in the development and implementation of the voucher program;

(10) a demonstration of the applicant's ability to meet the data analysis and reporting requirements of the program;

(11) a demonstration of the financial feasibility of the program; and

(12) such other information as the superintendent may deem appropriate.

(e) The superintendent, in consultation with the commissioner of health, shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the voucher program.

(f) An organization approved to administer the voucher program shall submit reports to the superintendent in such form and at times as may be required in order to facilitate evaluation of the operations and results of the voucher program.

(g) The superintendent may approve more than one organization to administer the voucher program in all or part of a geographic area.

(h) The superintendent shall determine the amount of funds to be allocated to an approved organization to administer the voucher program within such funds which are available for purposes of the voucher program.

(i) The superintendent shall review the marketing, community outreach activities and recruitment efforts of an organization administering the voucher program and may provide financial incentives if certain enrollment targets are met.

(j) An organization approved to administer the voucher program may be subject to financial penalties established by the superintendent for violating the standards of the voucher program. Organizations administering the program shall also be required to repay to the state all voucher payments issued on account of ineligible individuals or families. An organization approved to administer the voucher program may be removed by the superintendent as an approved organization and

must cooperate in the orderly transition of services to other approved organizations. The superintendent shall provide due notice and an opportunity for a hearing to an approved organization prior to implementing this subsection.

(k) Vouchers shall be issued by the organization administering the voucher program to eligible individuals and families residing in designated urban, suburban or rural areas. Individuals and families shall submit such vouchers to participating insurers, integrated delivery systems and health maintenance organizations for the purpose of obtaining insurance coverage.

(l) The superintendent shall establish, for those individuals and families eligible, the voucher amounts by regulation, and shall consider household size, gross annual income, the cost of obtaining health care coverage through a participating insurer, integrated delivery system or health maintenance organization and overall funding available for the voucher program.

(m) An insurer organized to write the kind of health insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this article, and a corporation or health maintenance organization authorized pursuant to article forty-three of this chapter or a health maintenance organization or integrated delivery system certified pursuant to article forty-four of the public health law may submit a proposal for participation in the voucher program to the superintendent who shall consult with the commissioner of health. Such proposal shall include:

(1) a description of the standards for provider enrollment if applicable;

(2) a description of the geographic area to be served, an estimate of the eligible and actual enrollees in such designated area; and a demonstration of the benefits to the community;

(3) a demonstration of access to and delivery of high quality health care services and, if applicable, that any network of health care providers includes sufficient numbers of geographically accessible providers to service program participants;

(4) a demonstration of the manner in which primary and preventive care and medical treatment will be emphasized or substituted for hospital inpatient or emergency room services in order to provide more

appropriate care and more cost effective use of general hospitals.

(5) a description of the procedures for marketing the program, if applicable;

(6) a description of health care provider payment methodologies;

(7) a description of the premium in relation to the benefit package;

(8) a description of the estimated expenses including personnel costs and other types of administrative expenses which will be incurred in the program;

(9) a description of the quality assurance and utilization review mechanisms to be implemented;

(10) a description of the provisions for arranging for or offering conversion coverage in the event of termination of coverage;

(11) a demonstration of an ability to meet data analysis and reporting requirements of the program; and

(12) such other information as the superintendent may deem appropriate.

(n) The superintendent, in consultation with the commissioner of health, shall make a determination whether to approve, disapprove or recommend a modification to an insurer's, integrated delivery system's or health maintenance organization's proposal to participate in the voucher program.

(o) The superintendent, in consultation with the commissioner of health, shall ensure, to the extent possible, that the voucher program is available in designated urban, suburban or rural areas. The superintendent may approve more than one insurer, integrated delivery system or health maintenance organization to serve all or part of a geographic area.

(p) An approved insurer, integrated delivery system or health maintenance organization shall submit reports to the superintendent and to the organization administering the voucher program in such form and at times as may be reasonably required in order to evaluate the operations and results of such program.

(q) An approved insurer, integrated delivery system or health maintenance organization may be removed from participation in the voucher program provided, however, that eligible persons shall continue to receive coverage of services until such time as the orderly transition to other approved insurers, integrated delivery systems and

health maintenance organizations can be effected. The superintendent shall provide due notice and an opportunity for a hearing to an approved insurer, integrated delivery systems or health maintenance organization prior to implementing this subsection.

(r) Notwithstanding any inconsistent provision of law or regulation to the contrary, benefits under the voucher program shall be considered secondary to any other plan of insurance or benefit program under which a person may have coverage.

(s) An insurer, integrated delivery system or health maintenance organization may issue contracts approved by the superintendent, providing coverage to voucher recipients, pursuant to the following criteria:

(1) the provisions are not misleading or confusing:

(2) the provisions are consistent with the needs of the voucher program;

(3) the materials describing the contract fully and clearly state the benefits and limitations of such contract;

(4) the duration of such contracts and the extent of exposure thereunder by insurers, article forty-three corporations, integrated delivery systems or health maintenance organizations shall be determined by the superintendent;

(5) the contract is a reasonable and appropriate approach to expand the availability of health care coverage;

(6) the funding for the contract is reasonably related to the benefits provided and sufficient to support the contract;

(7) any such contracts must include the preexisting condition provisions permitted by section three thousand two hundred thirty-two and section four thousand three hundred eighteen of this chapter as applicable; and

(8) notwithstanding any provisions of this chapter to the contrary, the superintendent may waive, modify or suspend any provisions of this chapter, except as to mandatory benefits, or department regulations as applicable to the insurers, article forty-three corporations, integrated delivery systems or health maintenance organizations which issue coverage pursuant to this section, provided such waiver, modification or suspension is based on the following:

(A) any waiver, modification or suspension of provisions of this

chapter or department regulations is essential to the operation of the voucher program and to the rational development of programs to provide health care coverage or equivalent coverage mechanisms to the uninsured; and

(B) any waiver, modification or suspension of provisions of this chapter or department regulations will not impair the ability of the insurer, article forty-three corporation, integrated delivery system or health maintenance organization to satisfy its existing and anticipated contracts and other obligations, including such standards as the superintendent shall prescribe concerning adequate capital and financial requirements.

(t) The contracts issued by insurers, integrated delivery systems or health maintenance organizations and approved by the superintendent providing coverage to voucher recipients must provide for only the following covered services:

(1) Outpatient diagnostic X-ray and lab services;

(2) Outpatient surgical services including anesthesia;

(3) Mammography screening.

(4) Cervical cytology screening.

(5) Well-child care from birth.

(6) Primary and preventive care services.

(u) In order to be eligible to purchase coverage under the voucher program, the individual or family shall meet the following criteria:

(1) reside or resides in a household having a gross household income at or below two hundred twenty-two percent of the non-farm federal poverty level (as defined and annually revised by the federal office of management and budget). An applicant shall provide the necessary documentation to initially, and annually thereafter, determine eligibility for a voucher. Such documentation shall include the latest annual income tax return. If no such income tax return has been filed or if the household income has changed since the date of the return, such documentation shall also include, but not be limited to: paycheck stubs; written documentation of income from all employers; or other documentation of income (earned or unearned) as determined by the superintendent, provided however, such documentation shall set forth the source of such income;

(2) is not eligible for medical assistance under title eleven of

article five of the social services law or for medicare pursuant to title eighteen of the federal social security act;

(3) does not have equivalent health care coverage as defined by the superintendent. The applicant shall attest to the source and nature of health care coverage available;

(4) is a resident of a designated urban, suburban or rural area in New York state. Such residency shall be demonstrated by adequate proof of a New York state street address or if the individual or family has no street address, then by other such proof;

(5) has not had equivalent health care coverage within the twelve month period prior to application for a voucher. This limitation shall not apply to persons who became ineligible for medical assistance or whose insurance terminated as a result of loss of employment within such period;

(6) the individual or family shall notify the organization administering the voucher program within sixty days, of any changes in income, health care coverage or residency that may make them ineligible for the voucher program; and

(7) any individual or family who, with the intent to obtain benefits, willfully misstates income or residence or other health care coverage to establish eligibility or willfully fails to notify an organization administering the voucher program of an increase in income or change in residence or health care coverage which may disqualify the individual or family for benefits shall repay such subsidy. Individuals seeking to enroll in the voucher program shall be informed that such willfull misstatement or failure to notify shall result in such liability.

(v) Nothing in this section shall be construed to provide a right or entitlement to insurance coverage, or a cause of action or right of action to eligible individuals and families, approved organizations, or providers of health care services for the provision of or payment for such services relating to the availability or implementation of insurance coverage under this section.

(w) The superintendent shall implement such requirements or procedures as necessary to prevent, detect and deter fraud and abuse in the voucher insurance program.

*** § 1122. New York state health insurance continuation assistance demonstration project.** (a) Definitions. For the purposes of this section, unless the context clearly requires otherwise:

(1) "Continuation assistance" means payments made by the superintendent to an eligible individual, a health plan or insurer, a participating employer, or a labor-management health benefits fund to allow an eligible individual to obtain or maintain continuation coverage.

(2) "Continuation coverage" means group health insurance coverage which a participating employer or labor-management health benefits fund is obligated to offer to an individual pursuant to the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended by the Tax Reform Act of 1986, or continuation provisions pursuant to subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four or subsection (e) of section four thousand three hundred five of this chapter.

(3) "Displaced worker" means an individual that is a resident of New York state and has been terminated or has received a notice of termination as a result of increased imports from, or shifts in production to, foreign countries as described in the Trade Act programs, Trade Adjustment Assistance (TAA) and Alternative Trade Adjustment Assistance (ATAA).

(4) "Eligible individual" means a person who is an entertainment industry employee or displaced worker and who:

(A) is not eligible for health insurance coverage or medical benefits pursuant to part A or B of title XVIII of the Social Security Act or title eleven of article five of the social services law;

(B) is eligible for or is currently enrolled under continuation coverage (and, with respect to an entertainment industry employee, is eligible for or enrolled under continuation coverage through a collectively bargained plan covering entertainment industry employees), where such eligible individual is not covered under continuation already subsidized through continuation assistance pursuant to the public health law;

(C) resides in a household having a gross monthly household income at or below four hundred percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human

services);

(D) is not eligible for employer provided coverage; and

(E) maintains the same level of insurance coverage as when they were employed.

(5) "Entertainment industry employee" means an individual who is a resident of New York state and is employed in the entertainment industry, as defined by the commissioner, including, but not limited to, the film, motion picture, television, theater, music, music recording, dance, radio, and circus industries.

(6) "Individual payment" means the amount of premium required for continuation coverage, less the amount of a continuation assistance payment made by the superintendent, to be paid by an eligible individual.

(7) "New York state health insurance continuation assistance demonstration project" means the pilot program for the entertainment industry employees and the pilot program for displaced workers.

(8) "Participating employer" means an employer who is obligated to continue coverage for an eligible individual pursuant to the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), or subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four, or subsection (e) of section four thousand three hundred five of this chapter.

(9) "Pilot program for displaced workers" means the program which assists eligible individuals who are displaced workers in obtaining or maintaining continuation coverage pursuant to this section.

(10) "Pilot program for entertainment industry employees" means the program which assists eligible individuals who are entertainment industry employees in obtaining or maintaining continuation coverage pursuant to this section.

(b) Pilot program for entertainment industry employees. (1) The pilot program for entertainment industry employees shall assist eligible individuals who are entertainment industry workers in maintaining or obtaining continuation coverage.

(2) An eligible individual may apply to the superintendent for continuation assistance by submitting an application therefor on a form prescribed by the superintendent. The information required on the application shall include, but not be limited to:

(A) the name and address of the entertainment industry employee;

(B) the name, address, and telephone number of the participating employer;

(C) the date the eligible individual became or will become eligible for continuation coverage, the date such eligibility ends, and, when available, correspondence to an entertainment industry employee from a labor-management health benefits fund proving eligibility;

(D) the names of all dependents who are covered or are to be covered under the continuation policy; and

(E) documentation establishing the household income of an eligible individual, which may include annual income tax returns and, if not prohibited by federal law for purposes of income verification, social security numbers, paycheck stubs, written documentation of income from all employers, or such other documentation as the superintendent may require.

(3) The superintendent shall review the applications and advise the applicants as to their eligibility to participate in the pilot program. Within amounts available for such purpose, the superintendent shall provide continuation assistance. Such assistance shall be issued, to the extent of funds available therefor, which is equivalent to seventy-five percent of the premium for the period covered by such assistance. Continuation assistance shall not be provided for more than twelve months within a five-year period.

(4) In approving applications from eligible individuals, the superintendent shall:

(A) make a determination as to the extent of available funds for the pilot program so as to assure, to the extent possible, that the funding will be available to provide continuation assistance to the applicant in an amount equal to seventy-five percent of the premium for a period of twelve months within five years; if the superintendent determines that such funding may not be available due to the level of enrollment in the pilot program at the time of the eligible individual's application, the superintendent shall deny such application; and

(B) require eligible individuals who are awarded continuation assistance to sign an acknowledgement that recipients who later become eligible for health insurance coverage through another employer are no longer eligible to receive assistance under this section and that the

state may seek to recover assistance provided after the date of such eligibility.

(5) The superintendent shall make continuation assistance payments available pursuant to this subsection directly to the collectively bargained labor-management health benefits fund on behalf of eligible individuals. The fund must provide the superintendent such information as the superintendent may reasonably require to enable the superintendent to administer the terms and conditions of the pilot program.

(6) The superintendent may promulgate rules and regulations necessary to the administration of this pilot program.

(7) The superintendent may contract with an organization to assist in the administration of this pilot program. If the superintendent deems it appropriate to utilize an organization to assist in the administration of this pilot program, the organization shall submit reports to the superintendent in such form and at such times as required by the superintendent. An organization approved to assist with program administration shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent.

(c) Pilot program for displaced workers. (1) The pilot program for displaced workers shall assist eligible individuals who are displaced workers in maintaining or obtaining continuation coverage.

(2) An eligible individual may apply to the superintendent for continuation assistance by submitting an application therefor on a form prescribed by the superintendent. The information required on the application shall include, but not be limited to:

(A) the name and address of the displaced worker;

(B) the name, address, and telephone number of the participating employer;

(C) the date the eligible individual became or will become eligible for continuation coverage, the date such eligibility ends, and, when available, correspondence to a displaced worker from a participating employer or labor-management health benefits fund proving eligibility;

(D) the names of all dependents who are covered or are to be covered under the continuation policy; and

(E) documentation establishing the household income of an eligible

individual, which may include annual income tax returns and, if not prohibited by federal law for purposes of income verification, social security numbers, paycheck stubs, written documentation of income from all employers, or such other documentation as the superintendent may require.

(3) The superintendent shall review the applications and advise the applicants as to their eligibility to participate in the pilot program. Within amounts available for such purpose, the superintendent shall provide continuation assistance. Such assistance shall be issued, to the extent of funds available therefor, which is equivalent to seventy-five percent of the premium for the period covered by such assistance. Continuation assistance shall not be provided for more than twelve months within a five-year period.

(4) In approving applications from eligible individuals, the superintendent shall:

(A) make a determination as to the extent of available funds for the pilot program so as to assure, to the extent possible, that the funding will be available to provide continuation assistance to the applicant in an amount equal to seventy-five percent of the premium for a period of twelve months within five years; if the superintendent determines that such funding may not be available due to the level of enrollment in the pilot program at the time of the eligible individual's application, the superintendent shall deny such application; and

(B) require eligible individuals who were awarded continuation assistance to sign an acknowledgement that recipients who later become eligible for health insurance coverage through another employer are no longer eligible to receive assistance under this section and that the state may seek to recover assistance provided after the date of such eligibility.

(5) The superintendent shall make continuation assistance payments available pursuant to this subsection directly to the individual or to the health plan or insurer, labor-management health benefits fund, or participating employer on behalf of eligible individuals. The fund or employer must provide the superintendent such information as the superintendent may reasonably require to enable the superintendent to administer the terms and conditions of the pilot program.

(6) The superintendent may promulgate rules and regulations necessary

to administer this pilot program.

(7) The superintendent may contract with an organization to assist in the administration of this pilot program. If the superintendent deems it appropriate to utilize an organization to assist in the administration of this pilot program, the organization shall submit reports to the superintendent in such form and at such times as required by the superintendent. An organization approved to assist with program administration shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent.

(d) The superintendent shall complete a study of the New York state health insurance continuation assistance demonstration project set forth in this section. Such study shall examine the efficacy of the project in impacting the insurance marketplace in New York state and the impact of the demonstration project in reducing the large number of uninsured individuals in the entertainment industry and other industries in New York characterized by seasonal and episodic employment. The superintendent may contract with an organization for the completion of the study. The study shall be provided to the temporary president of the senate and the speaker of the assembly.

* NB Repealed July 1, 2027

§ 1123. Immigration bail business. (a)(1) Any person, firm, corporation, or other entity who shall for another deposit money or property as bail or execute as surety any bond in any immigration action or proceeding who within a period of one month prior thereto shall have made such a deposit or given such bail in more than two cases not arising out of the same transaction shall be deemed to be doing an immigration bail business.

(2) Except for a corporation authorized to write fidelity and surety insurance and to do an immigration bail business pursuant to the provisions of this article and otherwise in compliance with all other requirements of this chapter to do such business, no person, firm, corporation, or other entity shall engage in an immigration bail business in this state.

(b) (1) No person, firm, corporation, or other entity shall in this

state do an insurance business or an immigration bail business as defined in subsection (a) of this section unless authorized by a license issued and in force as provided under this article.

(2) The superintendent may authorize a property/casualty insurance company that is authorized to write fidelity and surety insurance to do an immigration bail business in accordance with the provisions of this article, but no individual or entity shall be licensed to do such business.

(c) Any person, firm, corporation, or other entity that violates this section shall be subject to the penalty set forth in subsection (a) of section one thousand one hundred two of this article.

(d) Any agreement entered into by an entity subject to this section that is not authorized to do an immigration bail business in accordance with the provisions of this article shall be void and unenforceable.

*** § 1124. Institutions of higher education exempt; certificate of authority.** (a) For the purposes of this section:

(1) "Qualified actuary" means an actuary who is a member in good standing of the American Academy of Actuaries or Society of Actuaries, with experience in establishing rates for self-insured trusts providing health benefits or other similar experience.

(2) "Institution of higher education" or "institution" means an educational institution in this state that:

(A) admits as regular students only persons having a certificate of graduation from a school providing secondary education, or the recognized equivalent of such a certificate, or persons who have completed a secondary school education in a home school setting that is treated as a home school or private school under the laws of this state;

(B) is legally authorized within this state to provide a program of education beyond secondary education;

(C) provides an educational program for which the institution awards a bachelor's degree, graduate degree, or professional degree;

(D) is a public or other nonprofit institution;

(E) is accredited by a nationally recognized accrediting agency or association;

(F) is governed by the board of regents of this state; and

(G) maintains an endowment of at least one billion dollars.

(3) "Student" means a person enrolled in an institution of higher education and may include a postdoctoral fellow.

(4) "Student contract" means evidence of coverage furnished to a student that sets forth all benefits and terms and conditions, with regard to a student health plan.

(5) "Student health plan" or "plan" means any self-funded plan established or maintained by an institution of higher education for the purpose of providing medical, surgical, or hospital services to a student, the student's spouse or domestic partner, the student's child or children, or other persons chiefly dependent upon the student for support and maintenance.

(b) An institution of higher education shall not establish, maintain, or otherwise participate in a student health plan in this state unless the institution obtains and maintains a certificate of authority from the superintendent pursuant to the provisions of this section.

(c) Except as otherwise provided in this section or a regulation promulgated by the superintendent, an institution providing a plan shall:

(1) be subject to all consumer protection laws applicable to corporations organized under article forty-three of this chapter, including minimum requirements of article forty-three of this chapter and regulations thereunder regarding benefits, contracts, and rates; and

(2) provide that its plan will have an expected loss ratio of not less than eighty-two percent. In reviewing a rate filing or application by a plan, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain plan solvency. No later than one hundred twenty days after the close of a plan's fiscal year, a plan shall annually report the actual loss ratio for the previous plan fiscal year in a format acceptable to the superintendent. If the expected loss ratio is not met, the superintendent may direct the plan to take corrective action. Mandatory uniform student administrative health fees paid by the students irrespective of whether the student is a plan member to an institution shall not be deemed to be included in the premiums paid by students for

health benefit coverage under a plan.

(d) An institution shall file an application for a certificate of authority on such form as the superintendent may prescribe, and shall provide to the satisfaction of the superintendent the following:

(1) a copy of the student contract, including a table of the premium rates charged or proposed to be charged;

(2) a report indicating the benefit provisions, premium rates, and incurred medical losses associated with the institution's students under the insurance policy or contract insuring the institution's students, for the three years prior to the date of the application;

(3) the most recent certified independently-audited financial statement for the institution;

(4) a report prepared by a qualified actuary that supports the proposed premiums for the plan;

(5) a copy of all agreements between the institution and any plan administrator, with regard to the student health plan;

(6) a pro-forma balance sheet, including actuarially determined claims liabilities, and statement of revenue and expenses, including reasonably projected expenses, medical losses, and premiums to be charged to students for the plan during the first three years;

(7) a narrative description of the:

(A) accounting methodology that the institution will utilize, including a description of the separate accounts for revenues and expenses, including medical and hospital expenses and administration expenses, reserves for claims and expenses thereon, including incurred-but-not-reported, unearned premium reserves, contingent reserves, and any asset accounts (cash, premiums receivable, investments) relevant to the plan. The accounts may be established within the institution's general accounting ledger system, provided the general ledger accounts are clearly identifiable as pertaining to the plan, including any such accounts allocated to the plan;

(B) billing and claim payment procedures, including the names and contact information for those persons charged with handling accounting and claims issues; and

(C) any compensation the institution will receive in connection with the plan.

(8) copy of any stop-loss insurance policy issued or proposed to be

issued by an insurer authorized to do the business of accident and health insurance in this state or is a health service corporation organized under article forty-three of this chapter; and

(9) such other information as the superintendent may require.

(e) Upon compliance with this section, the superintendent may issue a certificate of authority to an applicant. Every certificate of authority shall contain the name of the certified entity and its home office address. The superintendent shall refuse to grant a certificate of authority to an applicant that fails to meet the requirements of this section. The superintendent may refuse to issue any certificate of authority if in the superintendent's judgment, the refusal will best promote the interests of the people of this state.

Notice of refusal shall be in writing and shall set forth the basis for refusal. If the applicant submits a written request within thirty days after receipt of the notice of refusal, then the superintendent shall conduct a hearing to give the applicant the opportunity to show cause why the refusal should not be made final.

(f) In order to obtain and maintain a certificate of authority, an institution shall:

(1) file a complete application with the superintendent in accordance with subsection (d) of this section;

(2) have within its own organization adequate resources and competent personnel to administer the student health plan or, in order to provide such administrative services, in whole or part, has contracted with a person or entity to serve as a plan administrator, determined by the institution to be qualified based upon written documentation furnished to the institution, provided that the documentation shall be made available to the superintendent upon request;

(3) establish and maintain premium rates sufficient to meet its contractual obligations and to satisfy the reserve requirements set forth in subsection (h) of this section;

(4) establish and maintain a fair and equitable process for claims review, dispute resolution, and appeal procedures, including arbitration of rejected claims, and procedures for handling claims for benefits in the event of plan dissolution, that are satisfactory to the superintendent and are subject to article forty-nine of this chapter;

(5) provide covered students with a student contract; and

(6) file all plan documents, including the summary plan description, and any amendments thereto, with the superintendent and receive the superintendent's approval in accordance with this section.

(g) An institution that has received a certificate of authority shall file with the superintendent, for the superintendent's prior approval, any amendments to the student contract, student health plan, or premium rates charged for the plan.

(h)(1) An institution shall establish reserves with the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including: (A) a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported, which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount shall be adequate; (B) a reserve for unearned premium equivalents, computed pro-rata on the basis of the unexpired portion of the policy period; and (C) a contingent reserve fund, established and maintained for the sole purpose of satisfying unexpected obligations of the plan in the event of termination of the plan, which shall not be less than five percent of the annualized earned premium equivalents during the current fiscal year of the plan.

(2) A qualified actuary may demonstrate that a lesser amount of a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred-but-not-yet-reported, shall be adequate by showing that the institution has obtained a medical stop-loss insurance policy issued by an insurer authorized by the superintendent to do the business of accident and health insurance in this state or is a health service corporation organized under article forty-three of this chapter. If at any time the reserve funds required to be established pursuant to this section fall below the required minimum amounts, then the institution shall immediately notify the superintendent of such impairment. The institution shall cure the impairment within five business days.

(3) The assets constituting the student health plan's contingent reserve fund shall consist solely of certificates of deposit issued by a United States bank and payable in United States legal tender, or

securities representing investments of the types specified in paragraphs one, two, three, eight, and ten of subsection (a) of section one thousand four hundred four of this chapter, or as otherwise expressly permitted by the superintendent. Any interest earned or capital gain realized on the money so deposited or invested shall accrue to and become part of the plan's reserve funds or contingent reserve, as applicable.

(4) The plan's assets, liabilities, income and expenses shall be accounted for separate and apart from all other assets, liabilities, income and expenses of the university. The accounting for the plan's contingent reserve fund shall show: (A) the purpose, source, date and amount of each sum paid into the fund; (B) the interest earned by such fund; (C) capital gains or losses resulting from the sale of investments of the plan's contingent reserve fund; (D) the order, purpose, date and amount of each payment from the contingent reserve fund; and (E) the assets of the contingent reserve fund, indicating cash balance and schedule of investments.

(5) The requirements for funding of the plan's reserves shall be calculated using generally accepted accounting principles. Only those expenses that relate to the plan shall be included in calculating the requirements for funding of the plan's reserve funds. Expenses allocated to the plan shall be allocated on an equitable basis in conformity with generally accepted accounting principles consistently applied. The books, accounts, and records of the plan shall be maintained as to clearly and accurately disclose the nature and details of all expenses so as to support the reasonableness of such expenses.

(i)(1) An institution of higher education shall file with the superintendent within one hundred twenty days of the close of the plan's fiscal year a report that contains:

(A) an annual financial statement, verified by the oath of at least two of the institution's principal officers, with direct knowledge of the operations of the student health plan, showing the financial condition of the plan during the most recent fiscal year, in accordance with law and generally accepted accounting principles, in a form prescribed by the superintendent;

(B) the identity of the qualified actuary utilized by the institution or plan and the amount paid to the qualified actuary by the institution

or plan during its most recent fiscal year;

(C) the identities of the plan's ten largest vendors by payment amount during its most recent fiscal year;

(D) the name and contact information of the person or entity appointed by the institution to administer the student health plan;

(E) a pro-forma statement of projected revenue and expenses for health benefits anticipated by the plan for the next twelve-month period of the plan's operation, provided on a fiscal year;

(F) a detailed report of the operations and condition of the plan's reserve funds; and

(G) such other information as the superintendent may require.

(2) An institution of higher education shall file with the superintendent within one hundred twenty days of the close of its student health plan's fiscal year the most recent certified, independently audited financial statement for the institution. The statement shall include an opinion of an independent certified public accountant. The notes to the financial statement shall show the financial results of the student health plan operations and a description as to how the institution meets the reserve requirements in paragraph one of subsection (h) of this section, including the amounts reported for each of the reserves, the method used to calculate the reserves, and the change in the reserves from the beginning of the plan's fiscal year to the end of the plan's fiscal year. In addition, the notes to financial statement shall detail the assets comprising the contingent reserve fund to demonstrate compliance with paragraph one of subsection (h) of this section.

(3) An institution that fails to file any report or statement required by this chapter, or fails to reply within thirty days to a written inquiry by the superintendent in connection therewith shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to one thousand dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

(j) The superintendent may, pursuant to section three hundred nine, three hundred ten, three hundred eleven, and three hundred twelve of this chapter, and pursuant to the financial services law, make an examination into the affairs of any institution, with regard to a

student health plan issued by the institution, as often as the superintendent deems it expedient for the protection of the interests of the people of this state. The expenses of every examination of the affairs of an institution, with regard to a student health plan established or maintained by the institution, shall be borne and paid by the institution so examined. The expenses of examination shall include reimbursement for the compensation paid for the services of persons employed by the superintendent or by the superintendent's authority to make such examination, and for the necessary traveling and living expenses of the person or persons making the examination.

(k)(1) The superintendent may suspend or revoke a certificate of authority issued to an institution if the superintendent finds, after notice and hearing, that the institution has failed to comply with any requirement imposed on it by the provisions of this chapter and if in the superintendent's judgment such suspension or revocation is reasonably necessary to protect the interests of the people of this state, including:

(A) for any cause that would be a basis for denial of an initial application for such a certificate;

(B) failure to maintain the reserves required by subsection (h) of this section; or

(C) the superintendent finds that the institution has refused to produce its accounts, records, and files for examination or has refused to cooperate or give information with respect to the affairs of the student health plan or to perform any other legal obligation relating to such an examination when required by the superintendent.

(2) Any certificate of authority suspended or revoked under this subsection shall be surrendered to the superintendent, and the institution shall notify all participating students of that decision in such form and manner as the superintendent may prescribe, but not later than ten days after receipt of notice of the superintendent's decision requiring suspension or revocation. In addition, the institution shall submit a plan for the superintendent's approval for winding up the plan's affairs in an orderly manner designed to result in timely payment of all benefits, in such form and manner as the superintendent may prescribe.

(3) Notwithstanding subdivision two of section eighty-seven of the

public officers law, all final decisions to suspend or revoke the certificate of authority with regard to an institution shall be public.

(l) In any case in which an institution determines that there is a reason to believe that the student health plan will terminate, the institution shall so inform the superintendent at least sixty days prior thereto, and shall file a sworn statement with the superintendent concerning all current and future liabilities under its discontinued plan. The institution also shall submit a plan for the superintendent's approval for winding up the plan's affairs in an orderly manner designed to result in timely payment of all benefits, in such form and manner as the superintendent may prescribe.

(m)(1) Any funds of the institution, as they pertain to the student health plan, shall be accounted for separate and apart from all other assets, liabilities, income and expenses of the institution until all plan benefits and other plan obligations have been satisfied. Until such time, the institution shall continue to maintain and fund the reserve funds required to be established under subsection (h) of this section. If at any time the superintendent determines that additional funds shall be deposited in the reserve funds, then the institution shall make the deposit within five days of the superintendent's determination.

(2) If, after twenty-four months, or such longer period as deemed necessary by the superintendent, all plan benefits and other plan obligations have been satisfied, the institution, upon approval by the superintendent, shall no longer be required to maintain assets within the plan's reserve funds within accounts within the institution's general accounting ledger system.

(n) An institution shall not issue a stop-loss insurance policy.

(o) The superintendent may promulgate such regulations as the superintendent deems necessary to implement the provisions of this section and to ensure that the plans established under this section are in the best interests of the students, students' spouses, the students' children, and other persons chiefly dependent upon the students for support and maintenance.

(p) Except as otherwise provided in this section, any institution of higher education that violates this section shall be subject to the penalties set forth in section one hundred nine of this chapter.

* NB There are 2 § 1124's

*** § 1124. Managed care health savings account.** (a) A health maintenance organization certified pursuant to article forty-four of the public health law may offer a group high deductible health plan, as defined in paragraph two of subsection c of section two hundred twenty-three of the internal revenue code in conjunction with a health reimbursement account or a health savings account established pursuant to federal tax law, when:

(1) The employer group purchasing the high deductible plan is a municipality, and

(2) The employer is obligated to contribute, pursuant to a collective bargaining agreement or other binding arrangement with its employees, an amount at least equal to the deductible required under the plan on behalf of each enrolled employee.

(b) A high deductible health plan offered pursuant to subsection (a) of this section, which otherwise meets the requirements of article forty-four of the public health law, shall be deemed to provide comprehensive health services and shall not be disapproved due to its cost share arrangement.

(c) A municipality for purposes of this section means a town.

(d) A health maintenance organization offering the high deductible health plan pursuant to this section shall report to the superintendent and commissioner of health the number of covered lives under the high deductible health plan offered pursuant to this section compared to similar non-high deductible health plans, the premiums of the high deductible health plan offered pursuant to this section compared to similar non-high deductible health plans, the claims experience under the high deductible health plan offered pursuant to this section compared to similar non-high deductible health plans, and any other pertinent information that may be required by the superintendent or the commissioner of health prior to April first, two thousand fourteen.

(e) The provisions of this section shall only apply to coverage offered pursuant to a collective bargaining agreement entered into prior to the effective date of this section.

* NB Repealed December 31, 2027

* NB There are 2 § 1124's

ARTICLE 12

ORGANIZATION AND CORPORATE PROCEDURE

Section 1201. Incorporation of stock or mutual insurance companies.
1202. Number of directors; independent directors and committees of the board of directors; duty of directors.
1203. Non-use of corporate charter.
1204. Sale of insurance securities.
1205. Existing corporations.
1206. Amendments to charters and increase of capital of insurance corporations.
1207. Options for the purchase of shares.
1208. Method of amending mutual company charters.
1209. Management and by-laws of mutual insurance corporations.
1210. By-laws of domestic stock life insurance companies.
1211. Mutual insurance corporations; membership and dividends.
1212. Service of process upon superintendent as attorney.
1213. Service of process on superintendent as attorney for unauthorized insurers.
1214. Acting for foreign corporation which has not designated superintendent as attorney.
1215. Forfeiture of office by director or trustee of a domestic mutual insurer.
1216. Notice of indemnification of directors and officers of insurance corporations.
1217. Vouchers for disbursements.
1218. Regulation of stock ownership, interlocking directors and common management.
1219. Misconduct by directors; insolvency.
1220. Misconduct by officers and directors of co-operative fire insurance companies and of fraternal benefit societies.
1221. Transactions by officers, directors and certain shareowners in the insurer's shares.

§ 1201. Incorporation of stock or mutual insurance companies. (a) A

corporation may be organized and licensed to do an insurance business in this state by taking the following successive steps, subject to applicable requirements of this chapter:

(1) The proposed incorporators, comprising at least nine natural persons (except as provided in section six thousand four hundred two of this chapter), shall submit to the superintendent, in writing, the corporation's proposed name, the county in which its principal office will be located, and the name and address of a public newspaper of general circulation in such county.

(2) If the superintendent approves the proposed name and newspaper, each as conforming to the requirements of law, he shall so notify the proposed incorporators, or their representative, in writing. Such approval shall become void if within six months from its date the declaration and charter referred to in paragraphs four and five hereof are not filed pursuant to paragraph six hereof.

(3) The proposed incorporators shall publish in such newspaper, twice a week for three successive weeks or once a week for six successive weeks, a notice of intention to form such a corporation, stating its proposed name, the kinds of insurance business to be transacted, the names and city and state of residence of the proposed incorporators, the location of its principal office in this state, and, if a stock corporation, the amount of its proposed initial capital.

(4) The proposed incorporators shall submit to the superintendent:

(A) proof of such publication by the affidavit of the publisher or of his foreman or clerk; and

(B) a declaration, signed by each incorporator and duly acknowledged before a notary public or other officer authorized to take acknowledgments of conveyances of real property within this state.

(5) (A) Such declaration shall be in the English language, shall state the proposed incorporators' intention to form a corporation to do one or more kinds of insurance business authorized by section one thousand one hundred thirteen of this chapter, shall specify the paragraphs defining such kinds of insurance business and shall set forth a copy of the corporation's proposed charter.

(B) The corporation's proposed charter shall contain:

(i) the corporation's name, which shall include a distinctive word or words, and, if a mutual corporation, shall contain the word "mutual";

(ii) the place where its principal office is to be located;

(iii) the kinds of insurance to be transacted, specified as above required;

(iv) the manner in which corporate powers are to be exercised;

(v) the number of directors, or that it shall be not less than a stated minimum nor more than a stated maximum. Except as provided in section six thousand four hundred two of this chapter the number of directors shall not be less than seven. As used in this item, "number of directors" means the total number of directors which the corporation would have if there were no vacancies;

(vi) the times and manner of electing directors and officers, the manner of filling vacancies, and provision that each director shall be at least eighteen years of age and that at all times a majority shall be citizens and residents of the United States, and that not less than one shall be a resident of this state;

(vii) the names and city and state of residence of the directors, who shall serve until the first annual meeting of such corporation;

(viii) the duration of its corporate existence, which shall be not less than thirty years;

(ix) the amount of its capital, if a stock corporation; and

(x) any other particulars necessary to explain the corporation's objects, purposes, management and control.

(C) The corporation's proposed charter may authorize the use in a foreign country where it does or proposes to do business of a specified translation of its name in any language commonly used in such country.

(D) The superintendent may, by regulation, prescribe additional information to be required, pursuant to this paragraph, of all companies or of any kind of company.

(6) The superintendent shall transmit such proof of publication, declaration, and charter to the attorney general. If approved by the attorney general, as conforming to the requirements of law, the superintendent shall thereupon file them in his office and issue a certified copy thereof to the proposed incorporators. If requested by such proposed incorporators, the superintendent shall also issue to them a certificate of incorporation executed by him in the name of the people of the state and thereupon such incorporators shall become a body corporate and have the powers enumerated in paragraph seven hereof, but

such corporation shall not be authorized to do the business of insurance until it obtains a license therefor.

(7) Every stock corporation, upon compliance with this chapter and the business corporation law, may create and issue the number of shares of capital stock stated in its charter which may be of one or more classes. If the charter authorizes shares which are entitled to preference in the distribution of dividends or assets it shall provide that:

(A) their dividend yield shall not exceed a rate equal to the maximum rate of interest provided in section 5-501 of the general obligations law, in effect at the time such shares are offered for sale; and

(B) the dividends may not be cumulative for more than three years.

(8)(A) A stock corporation shall have power to:

(i) open books to receive subscriptions to its capital shares,

(ii) keep them open until all such shares, or so many as may be necessary to satisfy the minimum capital requirements, are subscribed for,

(iii) receive payment for such subscriptions,

(iv) invest the monies as prescribed in this chapter, and

(v) expend money or incur liabilities necessary or proper as organization expenses, to be paid out of the proceeds of such subscriptions, such expenses not to exceed the maximum amount prescribed in its permit to solicit such subscriptions.

(B) The corporation shall not solicit subscriptions to its shares until it receives a permit therefor from the superintendent which shall be issued after the corporation submits to him an estimate of the total amount to be expended for organization expenses, and he approves the estimate. Such estimate shall be recited in the permit, which shall fix the maximum amount, to be prescribed by the superintendent, which may be expended for organization expenses.

(C) Such corporation shall not employ, as agents or brokers to sell its securities to the public, any persons who have not complied with the requirements of section one thousand two hundred four of this article.

(9) (A) A mutual corporation shall have power to:

(i) receive monies necessary to comply with the requirements of this chapter relative to its initial surplus fund;

(ii) borrow such monies in accordance with the provisions of section one thousand three hundred seven of this chapter;

(iii) open books to receive applications for insurance from persons desiring and eligible to become members;

(iv) keep them open until the minimum number and amount of applications, and the premium payments thereon, as required by this chapter are received;

(v) invest the monies as prescribed in this chapter for the investment of the minimum surplus of a mutual insurance company; and

(vi) expend money or incur liabilities necessary or proper as organization expenses, such expenses not to exceed the maximum amount prescribed in its permit to solicit such applications.

(B) The corporation shall not solicit applications for insurance or receive premium payments thereon until it receives a permit therefor from the superintendent. The permit shall be issued after:

(i) the superintendent is satisfied, by such evidence as he may require or by such examination as he may deem expedient, that the corporation holds in trust for prospective policyholders and creditors a fund, in cash or securities acceptable to him, at least equal to the amount required as its initial surplus fund, such trust to terminate when a license to do an insurance business of the kinds provided in the corporate charter has been obtained, and

(ii) the corporation submits to the superintendent an estimate of the total amount to be expended for organization expenses, and he approves the estimate. Such estimate shall be recited in the permit, which shall fix the maximum amount, to be prescribed by the superintendent, which may be expended for organization expenses.

(10) The directors and incorporators of any stock or mutual corporation shall be jointly and severally liable for all its debts and liabilities until it is licensed to do an insurance business of the kind or kinds proposed.

(b) This section shall not apply to co-operative fire insurance companies, fraternal benefit societies, or corporations organized under article forty-three or sixty-seven of this chapter.

§ 1202. Number of directors; independent directors and committees of the board of directors; duty of directors. (a) (1) Subject to item (v) of subparagraph (B) of paragraph five of subsection (a) of section one

thousand two hundred one of this article, and subject to any provision of the corporate charter of a domestic insurance company, the number of directors shall be fixed by the by-laws, or if not so fixed, by action of the directors.

(2) If not otherwise fixed under this article, the number shall be seven but it may be increased or decreased by amendment of the by-laws, or by action of the board, subject to the following limitations: (i) if the board is authorized by the by-laws to increase or decrease the number of directors, the amendment shall require the vote of a majority of the entire board; (ii) no decrease shall shorten the term of any incumbent director; and (iii) no decrease shall reduce the number of directors to fewer than seven.

(3) The charters of all domestic insurance companies approved before January first, nineteen hundred forty which fail to comply with item (v) of subparagraph (B) of paragraph five of subsection (a) of section one thousand two hundred one of this article but which were validated by section forty-eight-a of the former insurance law in effect prior to this chapter remain so validated and shall not be affected by such item or paragraph one or two of this subsection in respect of the minimum number of directors.

(b) (1) Subject to item (v) of subparagraph (B) of paragraph five of subsection (a) of section one thousand two hundred one of this article, not less than one-third of the directors of a domestic stock life insurance company and not less than one-third of the members of each committee of the board of directors of any domestic life insurance company shall be persons who are not officers or employees of such company or of any entity controlling, controlled by, or under common control with such company and who are not beneficial owners of a controlling interest in the voting stock of such company or any such entity. At least one such person shall be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(2) The board of directors of a domestic life insurance company shall establish one or more committees comprised solely of directors who are not officers or employees of the company or of any entity controlling, controlled by, or under common control with the company and who are not beneficial owners of a controlling interest in the voting stock of the

company or any such entity. Such committee or committees shall have responsibility for recommending the selection of independent certified public accountants, reviewing the company's financial condition, the scope and results of the independent audit and any internal audit, nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed by such committee or committees to be principal officers of the company, and recommending to the board of directors the selection and compensation of such principal officers and in the case of a domestic stock life insurance company, recommending to its board of directors any plan to issue options to its officers and employees for the purchase of shares of stock, pursuant to section one thousand two hundred seven of this article.

(3) The provisions of this subsection shall not apply to a domestic life insurance company if the holding company or parent corporation is a foreign or domestic insurance company, a mutual insurance holding company established pursuant to the laws of the United States, or a publicly held corporation incorporated in the United States, having a board of directors and committees thereof that meet the same requirements as have been established for a domestic stock life insurance company pursuant to paragraphs one and two of this subsection. In such a case, the directors of the holding company or parent corporation shall be subject to this chapter in the same manner as the directors of a domestic stock life insurance company.

(c) A director of a domestic life insurance company shall perform his duties as a director, including his duties as a member of any committee of the board upon which he may serve, in accordance with the provisions of section seven hundred seventeen of the business corporation law and the provisions of this chapter.

§ 1203. Non-use of corporate charter. (a) Any domestic insurance company which, after one year from the date of its incorporation, has not organized and obtained a certificate of authority or license to do an insurance business, shall, unless granted an extension, forfeit its corporate charter, and the superintendent may thereupon commence a proceeding, pursuant to the provisions of article seventy-four of this

chapter, to liquidate and dissolve such corporation. The superintendent may for good cause shown grant a written extension of such one-year period upon a written request filed with him within such period or during the pendency of any examination or investigation pursuant to paragraph one of subsection (e) of section one thousand one hundred two of this chapter, whichever is longer.

(b) Any domestic insurer which ceases to do any insurance business for more than one year continuously shall forfeit its right to resume an insurance business, except with the prior approval of the superintendent. Unless such approval shall be granted, the superintendent may commence a proceeding, pursuant to the provisions of article seventy-four of this chapter, to liquidate and dissolve such insurer.

§ 1204. Sale of insurance securities. (a) Subject to the provisions of subsection (e) hereof, no person, firm, association or corporation shall in this state sell or propose to sell to the public any security issued by any insurer not authorized to do business in this state, unless licensed to do so under this section. In this subsection and in subsection (b) hereof, "insurer" includes any corporation whose securities are to be sold or offered for sale (except by exchange for shares or assets and except securities issued upon a merger in conversion of securities of a merging company) primarily to acquire, organize or finance the operations of another insurer not authorized to do business in this state which is, or as a result of applying the proceeds of such offering will be, a subsidiary of such corporation.

(b) The superintendent may issue a license to a named person, firm, association or corporation to sell and propose to sell to the public in this state the specified securities of a specified insurer or other company subject to subsection (a) hereof. The applicant for such a license shall submit a written application, subscribed by the applicant and affirmed by him as true under the penalties of perjury and containing such information as the superintendent may require, including the following: the name, residence address, business address in this state and previous business experience of the applicant and of such insurer and of his or its officers, members and employees, and

information as to their trustworthiness; a copy of every security to be offered for sale; a statement in detail as to the insurer's financial condition, plans and purposes, the amount and par value of securities and their selling price, the manner in which the proceeds of sale are to be used, the rate of commissions to be paid for the sale of securities, the salaries to be paid to the insurer's officers, and the safeguards to be provided against diversion of proceeds from such plans and purposes. Before issuing any such license the superintendent may make such examination of the affairs of the proposed licensee and of such insurer as he deems expedient. The superintendent may refuse to issue such license, or may after notice and hearing revoke such license, if in his judgment such refusal or revocation will best promote the interests of the people of this state. Such license shall be for a term of one year unless sooner revoked. No license to sell or to propose to sell securities of any foreign or alien insurer shall be issued unless such insurer is qualified to obtain a license to do an insurance business in this state or, in the case of a corporation described in subsection (a) hereof, unless the insurer subsidiary is so qualified.

(c) No person, firm, association or corporation shall in this state issue, circulate or distribute any advertisement, circular, letter or other public announcement in connection with the sale or proposed sale to the public in this state of any securities of any insurer unless a copy of such announcement has been filed with the superintendent and approved by him. The superintendent may approve any such announcement if, after such examination or investigation as he sees fit, he finds it is not false, misleading or likely to deceive the public. In this subsection, "insurer" shall include any corporation whose securities are to be sold or offered for sale (except by exchange for shares or assets and other than securities issued upon a merger in conversion of securities of a merging company) primarily to acquire, organize or finance the operations of another insurer which is, or as a result of applying the proceeds of such offering will be, a subsidiary of such corporation; provided that examination or investigation of any such corporation shall be limited to matters relating to the operations of the insurance subsidiary.

(d) Every such license to sell or propose to sell the securities of an insurer shall state conspicuously in bold-face type: "The issuance of

this license by the superintendent of financial services of New York does not constitute a recommendation of these securities." No person, firm, association or corporation shall represent that the superintendent or the department of financial services or the state of New York has recommended any securities for purchase. The superintendent may in his discretion require the insertion in any public announcement to be approved by him of a statement that such approval does not constitute a recommendation of the securities therein referred to.

(e) This section shall not apply to the selling or proposing to sell securities after one year from the first date upon which the security was offered to the public in this state, except that subsections (c) and (d) hereof shall apply to any insurer authorized to do business in this state and to any other corporation described in subsection (c) hereof.

(f) (1) This section shall not apply to annuities or agreements to provide for annuities issued or to be issued by an authorized insurer pursuant to section four thousand two hundred forty of this chapter.

(2) The superintendent may by order or regulation exempt any other security or class thereof from all or part of this section on such terms and conditions as he deems appropriate upon a finding that its application thereto is not necessary to protect the public.

§ 1205. Existing corporations. Any insurance corporation incorporated under the provisions of any law of this state and doing business as an authorized insurer at the effective date of this chapter shall be subject to the provisions of this chapter relating to such a corporation, except that:

(a) It shall be entitled to exercise all powers conferred by virtue of its charter as in effect on the effective date of this chapter, during the term thereof, unless specifically prohibited by or pursuant to law.

(b) Subject to article seventy-four of this chapter, its duration shall be perpetual.

(c) If it has a guarantee capital represented by shares, it may amend any of the provisions of its charter.

§ 1206. Amendments to charters and increase of capital of insurance

corporations. (a) Any domestic insurance corporation may amend its charter as follows:

(1) It may change its name or authorize the use in a foreign country in which it does or proposes to do business of a specified translation of its name in any language commonly used in such country by delivering to the superintendent an amendment of its certificate of incorporation in the form prescribed by article eight of the business corporation law. If the superintendent finds such change is in conformity with law he may endorse his approval on such certificate of amendment.

(2) It may extend or diminish its charter powers as to the kinds of insurance business in which it may engage, in the form prescribed by the business corporation law, if a stock insurance corporation, or in the manner prescribed by this chapter, if a mutual insurance corporation. No such change shall be effective until the superintendent gives his approval. If the superintendent finds, after such investigation or examination as he deems it expedient to make, that such amendment will conform with the provisions of this chapter and that the corporation has the requisite minimum capital or surplus and meets all financial requirements of this chapter, he may grant such approval; but this section shall not permit a reduction in the capital of a stock insurance corporation or in the minimum surplus of a mutual insurance corporation unless the superintendent finds that all liabilities incident to the exercise of the powers to be eliminated have been terminated. Any domestic stock or mutual insurance corporation having charter power to do a part of any kind of insurance business specified in subsection (a) of section one thousand one hundred thirteen of this chapter, may after obtaining the superintendent's approval, by a majority vote of its board of directors at any regular or special meeting, amend its charter to acquire power to do all such kind of insurance business, if it may exercise such power under this chapter.

(3) Upon the filing in the office of the superintendent of any certificate of change, amendment, or restated charter under any provision of law, with his approval endorsed thereon, the superintendent shall certify a copy thereof for filing in the office of the clerk of the county where the corporation's principal office is located and may grant it a license conforming to such change.

(4) Notwithstanding any other provisions of this section, if the

corporation has a guarantee capital represented by shares, it may amend any provisions of its charter, including, without limitation, the increase, reduction or retirement of its capital and the interest thereon and the increase or decrease in the number or par value of the shares representing its capital, upon filing in the office of the superintendent, with his approval endorsed thereon, a certificate setting forth such amendments which shall become effective upon such filing. The certificate shall have been approved by its board of directors or trustees and consented to by holders of at least two-thirds of its outstanding shares. Such consent shall be given, either in person or by proxy, in writing or by vote at a meeting held on at least twenty days notice. Any holder of shares of guarantee capital not in favor of any such increase, decrease or retirement, who signifies such objection in the manner prescribed by section six hundred twenty-three of the business corporation law, shall have his rights determined in accordance with the provisions of such section of the business corporation law. All provisions of subsection (a) of section four thousand two hundred seven of this chapter shall apply to the payment of any cash dividends from profits to the holders of shares of such guarantee capital.

(5) It may, if it is a stock corporation, increase the total number of shares of any class of capital stock it has power to create and issue, subject to this chapter and the business corporation law.

(6) It may make any other change in conformity with law, which shall be effective upon the filing of the certificate thereof in the office of the superintendent with his approval endorsed thereon.

(b) Any corporation proposing to file a certificate of change of name or a restated or amended charter shall serve upon the superintendent a copy of the proposed changes, not less than thirty days before the meeting at which such changes will be submitted.

(c) The superintendent may certify the amount of issued and outstanding capital shares of any domestic stock insurance corporation, after such examination or investigation as he deems expedient, and, except as to a stock dividend or a reduction in capital stock, he shall require the affidavit of two principal officers of such corporation, stating the consideration for the issuance of such shares and that such transactions were genuine and bona fide sales of such shares for such consideration.

§ 1207. Options for the purchase of shares. (a) Notwithstanding any provision of the business corporation law, but subject to any provision in respect thereto set forth in its certificate of incorporation, or other certificate filed pursuant to law, a domestic stock insurance company, other than as described in subsection (d) of this section, may, with the consent of a majority of its shares entitled to vote thereon, provide and carry out a plan to issue options solely to its officers or employees for the purchase of any of its authorized but unissued shares for such consideration, value or benefit and upon such terms and conditions as may be fixed by the board of directors. In addition, a domestic stock life insurance company may provide and carry out a plan to issue such options only upon the recommendation by a committee of its board of directors pursuant to subsection (b) of section one thousand two hundred two of this article and approved by its board of directors. Any such plan must provide that:

(1) the company's right or power to make adjustments, reclassifications, reorganizations or changes of its capital or business structure, or to merge or consolidate, or dissolve, liquidate, sell, or transfer all or any part of its business or assets shall not be affected;

(2) the number of shares on which options may be granted, excluding shares involved in the unexercised portions of any cancelled, terminated or expired options, shall not exceed, in the aggregate, five percent of the company's authorized shares;

(3) the number of shares for which option rights may be granted to any individual under all options issued to him shall not exceed ten percent of the total number of shares authorized to be optioned;

(4) the option price of the shares shall not be less than eighty-five percent of the fair market value of such shares at the time the option is granted and shall not be less than their par value;

(5) the option shall not be transferable except by will or the laws of descent and distribution; and

(6) the option shall not be exercisable after ten years from the date the option is granted.

(b) In the absence of fraud in the transaction, the judgment of the

board of directors shall be conclusive as to the consideration, value or benefit, tangible or intangible, received or to be received by the company for the issuance of options to purchase its shares and the adequacy and sufficiency thereof. The required shareholders' consent may be given by vote at a shareholders' meeting held on notice prescribed by section six hundred five of the business corporation law, stating its object, or in writing signed by all shareholders having such voting rights.

(c) Any company, other than a company described in subsection (d) of this section, proposing any plan to issue options to purchase its shares under this section shall, not less than thirty days before the shareholders' meeting at which the plan is to be voted upon, submit to the superintendent a copy of the plan for his approval. Upon approval of the plan by the shareholders, a certificate evidencing their approval, subscribed by the secretary and affirmed by him as true under the penalties of perjury, and under the company's seal, shall be filed in the office of the superintendent. The plan shall be approved by the superintendent if he is satisfied it is fair and equitable to the company's policyholders and not inconsistent with law, and that no reasonable objection exists thereto. If the superintendent shall refuse to approve such plan, notification of such refusal, assigning the reasons therefor, shall, within ten days from the date of filing such certificate, be given in writing by such superintendent to the company. No such plan shall take effect until the superintendent approves as herein provided.

(d) A domestic stock life insurance company which is not directly or indirectly a subsidiary of a domestic mutual life insurance company, upon approval of the plan by the shareholders, shall file in the office of the superintendent a certificate evidencing their approval, subscribed by the secretary and affirmed by him as true under the penalties of perjury, and under the company's seal.

§ 1208. Method of amending mutual company charters. (a) A domestic mutual insurance corporation may change its name, or amend or restate its charter in the form prescribed by article eight of the business corporation law. Except as specified in subsections (b) and (c) hereof,

the following requirements shall apply to certificates of change of name and amended or restated charters of such corporations:

(1) The corporation's president or secretary shall call a meeting of its members pursuant to its by-laws, specifying any amendments to be voted upon at such meeting;

(2) If at such meeting three-fourths of the members present and voting in person or by proxy vote in favor of any amendments so specified, the corporation's president and secretary shall make a certificate, verified by their oaths, to the effect that the amendments were duly adopted by at least a three-fourths vote of the members present in person or by proxy at a meeting duly called for such purpose and setting forth the call for such meeting, the fact of service of such call upon all members of record on a specified date, and the minutes of such meeting; and

(3) Such certificate shall, within thirty days after such meeting, be submitted to the superintendent for his approval as conforming to the requirements of law.

(b) A domestic mutual insurance corporation except as specified in subsection (c) hereof, may, subject to the provisions of section one thousand two hundred six of this article, amend its charter as to the kind or kinds of insurance business it shall be empowered to do and to specify or change the location of its office, and may amend its charter as to any other provisions which do not impair the members' rights or enlarge their obligations under insurance policies, by a majority vote of its board of directors at a meeting held not less than thirty days after notice of the proposed amendment has been given to the directors and the superintendent.

(c) Any domestic mutual life insurance corporation doing business as such may file a certificate of change of name, or restate or amend its charter, by a majority vote of its board of directors at a meeting held not less than thirty days after notice of the proposed amendment has been given to the directors.

(d) A certificate of amendment or a restated charter filed pursuant to subsections (b) and (c) hereof shall be accompanied by a certificate signed by the corporation's president and secretary that such amendment or restatement was duly adopted by a majority vote of the corporation's board of directors at a meeting duly called for that purpose.

§ 1209. Management and by-laws of mutual insurance corporations. (a) The management of the business and affairs of a domestic mutual insurance corporation shall be vested in a board of directors.

(b) Such corporation shall have not less than seven directors. The directors, except as provided in section four thousand two hundred ten of this chapter, shall be elected at the annual meetings of the members, and all except four of the directors of such corporation, elected after the organization of the corporation is completed and it has been licensed to issue insurance policies, must be members of the corporation or officers of member corporations. At any time after the first annual meeting, the directors may be divided into not exceeding three groups as nearly equal as possible, and thereafter the directors in one group only or their successors shall be elected annually as provided in the by-laws. The board of directors of such corporation shall hold regular meetings at least four times in each calendar year. At least one of such meetings shall be held within this state and the other meetings may be held elsewhere.

(c) The board of directors of such corporation shall elect such officers as are provided for in the by-laws. At least one principal officer shall be a director, but the number of officers and salaried employees who are directors shall at all times be less than a quorum of the board of directors, as prescribed in the charter or by-laws.

(d) The by-laws of any such corporation organized after January first, nineteen hundred forty may be adopted at a directors' meeting held after receipt from the superintendent of a certificate of incorporation and before the issuance of a license to do an insurance business. The by-laws, except as to corporations which elect their directors pursuant to the provisions of section four thousand two hundred ten of this chapter, may thereafter be made or amended only by a majority vote of all members present in person or by proxy at any annual meeting or other stated or special meeting called for such purpose, except that the board of directors of any mutual insurance corporation may amend its by-laws as to any provisions which do not impair the members' rights or enlarge their obligations under insurance policies. The by-laws of any domestic mutual insurance corporation which elects its directors pursuant to the provisions of such section may be amended by the board of directors. No

by-law or amendment or repeal of a by-law of any domestic mutual insurance corporation shall be effective until approved by the superintendent. The superintendent may refuse such approval if he finds that such by-law, amendment or repeal does not conform with the requirements of law, or is not equitable to the corporation's policyholders, or is inconsistent with its objects and purposes.

(e) No domestic mutual insurance corporation, except a domestic mutual insurance company organized before January first, nineteen hundred forty to do only marine protection and indemnity insurance, shall enter into any agreement under which any person, partnership or corporation agrees to pay all or a portion of the expenses of management of such insurance corporation in consideration of an agreement to pay him either commissions on premiums due the insurance corporation or any other compensation for his services.

(f) No domestic mutual insurance corporation, except a domestic mutual insurance company organized before January first, nineteen hundred forty to do only marine protection and indemnity insurance, shall enter into any agreement with any of the officers or directors, or with any firm or corporation in which any such officer or director is pecuniarily interested directly or indirectly, whereby the insurance corporation agrees to pay, for the acquisition of business, any commission or other compensation which under the agreement is increased or diminished by the amount of such business or by the insurance corporation's earnings on such business. Notwithstanding the foregoing, and upon application by a domestic mutual insurance corporation, the superintendent may permit the insurance corporation to enter into such an agreement with a firm or corporation that is a licensed insurance producer if the superintendent determines that: (1) the insurance corporation's policyholders will not be adversely affected; (2) the officer or director has no pecuniary interest directly in the insurance producer; and (3) any benefit to the officer or director that accrues as a result of the agreement would not be material in relation to the insurance corporation's overall premium volume. Any such agreement approved by the superintendent shall be subject to annual reviews and, where the superintendent determines such agreement no longer conforms to this subsection, the superintendent shall revoke his or her prior approval.

§ 1210. By-laws of domestic stock life insurance companies. No by-law or amendment or repeal of a by-law of any domestic stock life insurance company shall be effective until approved by the superintendent. The superintendent may refuse such approval if he finds that such by-law or amendment or repeal does not conform with the requirements of law, or is not equitable to the company's policyholders, or is inconsistent with the objects and purposes of such company.

§ 1211. Mutual insurance corporations; membership and dividends. (a) Every domestic mutual insurance corporation shall be organized, maintained and operated for the benefit of its members as a non-stock corporation. Every policyholder shall be a member of such corporation and shall, except as provided in subsection (d) hereof, be entitled to vote at any regular or special meeting of such corporation, to notice thereof pursuant to the by-laws and to share equitably in dividends declared by the board of directors. The board of directors may, subject to limitations in this chapter, from time to time declare a dividend from the corporation's surplus. No dividend shall be declared or paid if thereby the company's minimum or other required surplus will be impaired. In declaring and paying any dividend the board of directors may make reasonable classifications of policies, and shall declare and pay such dividend in a manner that is fair and equitable to the policyholders. Unless otherwise provided in the corporation's charter or by-laws, each member shall be entitled to one vote at any regular or special meeting. The charter or by-laws may, with the approval of the superintendent, provide for distribution of voting power among members on the basis of the amount of insurance held, number of policies held, amount of premiums paid by them or on any other basis the superintendent finds fair and equitable.

(b) A member of any such corporation may vote at any such meeting in person or by proxy. No proxy or power of attorney given by him, to vote at any meeting of such corporation, shall be valid or effective after the next meeting. No person shall directly or indirectly sell or purchase, or offer to sell or purchase, any proxy or power of attorney to vote at any such meeting, nor shall any person directly or indirectly

give or receive, or offer to give or receive, any proxy or power of attorney to vote at any such meeting as an inducement to the negotiation or making of a contract of insurance or any renewal thereof, to the settlement of any claim thereunder, or to any other act relating thereto.

(c) All corporations, their directors and representatives and all persons, firms or corporations holding property in trust may insure the same in mutual insurance corporations and by so doing such directors, representatives or trustees, in their representative capacity, may assume the liabilities and be entitled to the rights of a member of such insurer, but shall not be personally liable as individuals upon such contract of insurance.

(d) The provisions of this section as to members' voting rights and the election of directors shall not apply to any domestic mutual life insurance company governed by the provisions of section four thousand two hundred ten of this chapter, nor shall they require any such company to hold a meeting of its members.

(e) As to any surety or fidelity bond or like obligation executed by a mutual property/casualty insurance company as a surety or guarantor, the principal, and not the obligee, shall be a member of such corporation.

§ 1212. Service of process upon superintendent as attorney. (a) No domestic, foreign or alien insurer, including a fraternal benefit society, shall be or continue to be authorized to do an insurance business in this state unless there shall be filed in the office of the superintendent a power of attorney, executed by such insurer, appointing the superintendent and his successors in office, and authorized deputies, as its true and lawful attorney in and for this state, upon whom all lawful process in any proceeding against it on a contract delivered or issued for delivery, or on a cause of action arising, in this state may be served. Such power of attorney shall be accompanied by the insurer's written certificate of designation of the name and address of the officer, agent, or other person to whom such process shall be forwarded by the superintendent or his deputy. Such designation may be changed by filing of a new certificate of designation in the office of the superintendent.

(b) Service of process upon any such insurer in any proceeding in any court of competent jurisdiction may be made by serving the superintendent, any deputy superintendent, or any salaried employee of the department whom the superintendent designates for such purpose, all of whom shall have authority to accept such service pursuant to any such power of attorney. The service of process upon a domestic fraternal benefit society shall only be made by serving the superintendent, any deputy superintendent, any salaried employee of the department whom the superintendent designates for such purpose or by serving the process at the home office of such society. The service of process upon any foreign or alien fraternal benefit society shall be made only by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose. Service of process so made shall be deemed to have been made within the territorial jurisdiction of any court in this state.

(c) At the time of service of process a fee of forty dollars shall be paid to the superintendent or his deputy.

(d) The power of attorney required by subsection (a) hereof shall be by its terms of indefinite duration, shall bind any person or corporation which as successor acquires the insurer's assets and assumes its liabilities by merger or consolidation, and shall not be terminated by the insurer or such successor so long as any contracts, or liabilities or duties arising out of contracts, issued or delivered by such insurer in this state are in effect. Except as provided herein, or in section one thousand two hundred thirteen of this article, the superintendent shall not be designated as attorney for the service of process upon any unlicensed alien or foreign insurer.

(e) Whenever any lawful process shall be served upon the superintendent, any deputy superintendent, or any salaried employee of the department whom the superintendent designates for such purpose under the provisions of this section, such person shall forward a copy of such process by mail, prepaid, directed to the person last designated by such insurer, as shown by the records of the department.

(f) When one or more underwriters of any Lloyds underwriters, or one or more subscribers of any reciprocal insurer, are joined in the same proceeding, and service of process is made pursuant to this section, only one copy of such process shall be so served, and such service shall

have the same effect as if made upon all such underwriters or all such subscribers. Such process shall be forwarded to the attorney-in-fact of such Lloyds underwriters or of such reciprocal insurer, and each such attorney-in-fact shall be designated to receive such process as specified in subsection (a) hereof.

(g) The superintendent shall keep records, issue certificates and destroy processes served upon him, all as provided in subsection (f) of section one thousand two hundred thirteen of this article.

§ 1213. Service of process on superintendent as attorney for unauthorized insurers. (a) The purpose of this section is to subject certain insurers to the jurisdiction of the courts of this state in suits by or on behalf of insureds or beneficiaries under certain insurance contracts. The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest, the legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this section, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of public law number fifteen, seventy-ninth congress of the United States, chapter twenty, first session, senate number three hundred forty, as amended, (15 U.S.C. § 1011) which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

(b) (1) Any of the following acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer:

(A) the issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein,

(B) the solicitation of applications for such contracts,

(C) the collection of premiums, membership fees, assessments or other considerations for such contracts, or

(D) any other transaction of business,

is equivalent to and constitutes its appointment of the superintendent, and his successors in office, to be its true and lawful attorney upon whom may be served all lawful process in any proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance, and shall signify its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

(2) Such service of process upon any such insurer in any such proceeding in any court of competent jurisdiction of this state may be made by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose with two copies thereof and the payment to him or her of a fee of forty dollars. The superintendent shall forward a copy of such process by registered or certified mail to the defendant at its last known principal place of business, as designated by the issuer of such process, and shall keep a record of all process so served upon him or her. Such service of process under this paragraph is sufficient, provided notice of such service and a copy of the process are sent within ten days thereafter by or on behalf of the plaintiff to the defendant at its last known principal place of business by registered or certified mail with return receipt requested. The plaintiff shall file with the clerk of the court in which the action is pending, or with the judge or justice of such court if there be no clerk, an affidavit of compliance herewith, a copy of the process, and either a return receipt purporting to be signed by the defendant or a person qualified to receive its registered or certified mail in accordance with the rules and customs of the post office department, or, if acceptance was refused by the defendant or its agent, the original envelope bearing a notation by the postal authorities that receipt was refused. Service of process so made shall be deemed made within the territorial jurisdiction of any court in this state.

(3) Service of process in any such proceeding shall in addition to the manner provided in paragraph two of this subsection be valid if served upon any person within this state who, in this state on behalf of such insurer, is:

(A) soliciting insurance;

(B) making, issuing or delivering any contract of insurance; or

(C) collecting or receiving any premium, membership fee, assessment or other consideration for insurance;

provided notice of such service and a copy of such process are sent within ten days thereafter, by or on behalf of the plaintiff to the defendant at the last known principal place of business of the defendant, by registered mail with return receipt requested. The plaintiff shall file with the clerk of the court in which the action is pending, or with the judge or justice of such court in case there be no clerk, an affidavit of compliance herewith, a copy of the process, and either a return receipt purporting to be signed by the defendant or a person qualified to receive its registered mail in accordance with the rules and customs of the post office department; or, if acceptance was refused by the defendant or its agent the original envelope bearing a notation by the postal authorities that receipt was refused.

(4) The papers referred to in paragraphs two and three of this subsection shall be filed within thirty days after the return receipt or other official proof of delivery, or the original envelope bearing a notation of refusal, is received by the plaintiff. Service of process shall be complete when such process and the accompanying papers are filed pursuant to this section.

(5) Nothing contained in this section shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner permitted by law.

(c) (1) Before any unauthorized foreign or alien insurer files any pleading in any proceeding against it, it shall either:

(A) deposit with the clerk of the court in which the proceeding is pending, cash or securities or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure payment of any final judgment which may be rendered in the proceeding, but the court may in its discretion make an order dispensing with such deposit or bond if the superintendent certifies to it that such insurer maintains within this state funds or securities in trust or otherwise sufficient and available to satisfy any final judgment which may be entered in the proceeding, or

(B) procure a license to do an insurance business in this state.

(2) The court in any proceeding wherein service is made pursuant to

paragraph two or three of subsection (b) of this section may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of paragraph one of this subsection and to defend such proceeding.

(3) Nothing in paragraph one of this subsection is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to set aside service made in the manner provided in paragraph two or three of subsection (b) hereof on the ground (i) that such unauthorized insurer has not done any act enumerated in paragraph one of subsection (b) of this section, or (ii) that the person on whom service was made pursuant to paragraph three of subsection (b) hereof was not doing any act therein enumerated.

(d) In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty days after demand prior to the commencement of the action to make payment pursuant to the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow plaintiff a reasonable attorney's fee and include such fee in any judgment rendered in such action. Such fee shall not exceed twelve and one-half percent of the amount the court finds the plaintiff is entitled to recover against the insurer nor be less than twenty-five dollars. Failure of an insurer to defend any such action shall be prima facie evidence that its failure to pay was vexatious and without reasonable cause.

(e) This section shall not apply to any proceeding against any unauthorized foreign or alien insurer arising out of any contract of insurance effectuated in accordance with subsection (b) or (c) of section two thousand one hundred seventeen of this chapter or in accordance with section two thousand one hundred five of this chapter where such contract designates the superintendent or his successors in office the insurer's true and lawful attorney upon whom may be served all lawful process in any proceeding instituted by or on behalf of an insured or beneficiary arising out of such contract.

(f) The superintendent shall keep a record of each process served upon him under this section and pursuant to section one thousand two hundred twelve of this article, including the date of service. He shall, upon

request made within ten years of such service, issue a certificate under his seal certifying as to the receipt of the process by an authorized person, the date and place of service and the receipt of the statutory fee. Process served upon the superintendent pursuant to this section or section one thousand two hundred twelve of this article shall be destroyed by him after a period of ten years from such service.

§ 1214. Acting for foreign corporation which has not designated superintendent as attorney. No person acting for himself or for others shall solicit or procure, or aid in soliciting or procuring, policies or certificates of insurance from, or adjust losses or in any manner aid the transaction of any business for, any foreign insurance corporation which has not executed and filed in the superintendent's office a written appointment of the superintendent as its true and lawful attorney in and for this state, upon whom all lawful processes in any proceeding against it may be served.

§ 1215. Forfeiture of office by director or trustee of a domestic mutual insurer. The office of a trustee or director of any domestic mutual insurer shall immediately become vacant whenever he fails to attend at least one regular meeting of the board of trustees or directors in any period of eighteen consecutive months, or unless excused by the board, which action shall be entered on the minutes, it shall appear at the end of any calendar year that he failed to attend at least one-half of such regular meetings held in such calendar year. A trustee or director whose office becomes so vacant shall not be eligible for election to such office until one year has elapsed from the date the vacancy occurred.

§ 1216. Notice of indemnification of directors and officers of insurance corporations. No payment of indemnification, advancement or allowance under sections seven hundred twenty-one to seven hundred twenty-seven inclusive of the business corporation law shall be made unless a notice has been filed with the superintendent not less than

thirty days prior to such payment, specifying the payees, the amounts, the manner in which such payment is authorized and the nature and status, at the time of such notice, of the litigation or threatened litigation. If any action with respect to indemnification of directors or officers of any domestic insurer shall be taken by amendment of the by-laws, such action shall be in accordance with the approval requirements in sections one thousand two hundred nine and one thousand two hundred ten of this article. If any action shall be taken by resolution of directors, or by agreement or otherwise, a notice shall be filed with the superintendent not less than thirty days thereafter specifying the action taken.

§ 1217. Vouchers for disbursements. No domestic insurance company shall make any disbursement of one hundred dollars or more unless evidenced by a voucher signed by or on behalf of the payee as compensation for goods or services rendered for the company, and correctly describing the consideration for the payment. If such disbursement be for services and disbursements, such vouchers shall set forth the services rendered and itemize the disbursements; if it is in connection with any matter pending before any legislative or public body or before any government department or officer, the voucher shall correctly describe also the nature of the matter and the company's interest therein. If such a voucher is unobtainable, the disbursement shall be evidenced by a statement of an officer or responsible employee affirmed by him as true under the penalties of perjury, stating the reasons therefor and setting forth the particulars above mentioned.

§ 1218. Regulation of stock ownership, interlocking directors and common management. (a) Any domestic insurer and any foreign or alien insurer authorized to do business in this state may retain, invest in or acquire all or any shares, or, by contract of reinsurance or otherwise, acquire the whole or a substantial part of the assets, of any other insurer, or have a common management with any other insurer, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this chapter or unless the effect thereof:

(1) in the case of a domestic or alien insurer, may be substantially to lessen competition in any line of commerce in insurance in any section of the country or to tend to create a monopoly therein, or

(2) in the case of a foreign insurer, may be substantially to lessen competition in any line of commerce in insurance in this state or to tend to create a monopoly therein.

(b) No person shall serve as a director of two or more insurers under this chapter which are or during the next preceding two years have been engaged in writing directly the same lines of commerce in insurance unless such interlocking directorate is not used as a means to substantially lessen competition generally in the business of insurance or create a monopoly therein, but any person otherwise qualified may be a director of two or more insurers having a common ownership or management which is not otherwise proscribed if such interlocking directorate is not used as a means of substantially lessening competition generally in the business of insurance or of creating a monopoly therein.

(c) (1) Whenever the superintendent believes this section is being violated, the superintendent shall serve upon the insurer or insurers and the director or directors, as the case may be, a notice pursuant to section three hundred four of the financial services law of a hearing before the superintendent to be held not less than thirty days after such service and requiring such insurer or insurers and such director or directors, as the case may be, to show cause why an order should not be made by the superintendent directing such insurer or insurers and such director or directors, as the case may be, to cease and desist from such violation.

(2) If, upon such hearing, the superintendent finds a violation of this section he shall issue and cause to be served upon each such insurer or insurers and such director or directors, as the case may be, an order reciting the facts found by him, and setting forth the respects in which there has been a violation, and directing such insurer or insurers and such director or directors, as the case may be, to cease and desist from such violation and he may in such order direct each such insurer to divest itself of the shares or assets held or to rid itself of the directors serving contrary to the provisions of subsection (a) or (b) of this section.

(3) A violation of any such cease and desist order shall, subject to judicial review, be deemed a violation of this chapter.

(4) The attorney general may maintain a proceeding upon his own information to prevent and restrain violations of this section and the judgment therein against any defendant may grant affirmative relief to the same extent as may the superintendent by an order issued pursuant to this section.

(5) Any person, firm, corporation or association shall be entitled to maintain a proceeding to obtain injunctive relief against loss or damages by a violation of this section at whatever time and under the same conditions and principles as when injunctive relief against conduct that will cause loss or damage is granted by the courts under the laws of this state governing such proceedings. In such proceeding, the plaintiff also may recover the damages sustained by him and the cost of suit, including a reasonable attorney's fee.

(d) Nothing contained in this section shall be deemed to alter or abridge any rights or remedies otherwise available to any person, the superintendent and the attorney general under any law of this state.

§ 1219. Misconduct by directors; insolvency. (a) Every director of an insurance corporation who:

(1) in case of the fraudulent insolvency of such corporation, shall have participated in such fraud, or

(2) as such director, either wilfully does any act expressly forbidden by statute, or wilfully omits to perform any duty imposed upon him by statute,

shall be guilty of a misdemeanor, unless otherwise prescribed by law.

(b) The insolvency of an insurance corporation is deemed fraudulent unless its affairs appear upon investigation to have been administered fairly, legally and with the same care and diligence that agents receiving a compensation for their services are bound, by law, to observe.

§ 1220. Misconduct by officers and directors of co-operative fire insurance companies and of fraternal benefit societies. No officer or

director of a co-operative fire insurance company or of a fraternal benefit society shall sell his position as such officer or director for any money or valuable consideration, or accept or receive, directly or indirectly, any money or valuable consideration for his resignation as such officer or director. He shall be guilty of a felony if any money or valuable consideration accepted or received for any such sale or resignation exceeds five hundred dollars. If it is a less amount, he shall be guilty of a misdemeanor.

§ 1221. Transactions by officers, directors and certain shareowners in the insurer's shares. (a) Every person who directly or indirectly owns beneficially more than ten percent of any class of shares of a domestic insurer or is a director or officer thereof shall file in the office of the superintendent:

(1) within ten days after he becomes such owner, director or officer a statement, in form prescribed by the superintendent, of the amount of all such shares of which he is the beneficial owner, and

(2) within ten days after the close of each calendar month in which a change in such ownership occurs a statement, in such form as the superintendent may prescribe, indicating his ownership at the close of such calendar month and such changes in his ownership as have occurred during such calendar month.

(b) To prevent unfair use of any information obtained by such beneficial owner, director or officer by reason of his relationship to such insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of the insurer's shares within any period of less than six months, unless the shares were acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the insurer, irrespective of any intention he had in entering into such transaction to hold the shares purchased or not to repurchase the shares sold for a period exceeding six months. A proceeding to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any shares of the insurer in the insurer's name and behalf if it fails or refuses to bring such suit within sixty days after request or fails diligently to prosecute it; but no such suit shall be brought more than

two years after the date such profit was realized. This subsection shall not apply to any transaction where such beneficial owner was not such at the time of both the purchase and sale, or both the sale and purchase, of the shares involved, or any transaction which the superintendent may by rules and regulations exempt as not comprehended within the purpose of this subsection.

(c) It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any shares of such insurer if the person selling the shares or his principal either does not own the shares sold, or, if owning them, does not deliver them against such sale within twenty days thereafter, or does not within five days after such sale deposit them in the mails or other usual channels of transportation; but no person shall be deemed to have violated this subsection if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

ARTICLE 13

ASSETS AND DEPOSITS

Section 1301. Admitted assets.
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1323. Issuance of capital notes by domestic life insurance companies.
1324. Risk-based capital for property/casualty insurance companies.
1325. Exemption.

§ 1301. Admitted assets. (a) In determining the financial condition of a domestic or foreign insurer or the United States branch of an alien insurer for the purposes of this chapter, there may be allowed as admitted assets of such insurer, unless otherwise specifically provided in this chapter, only the following assets owned by such insurer

(1) Cash, including legal tender or the equivalent in any office of such insurer or in transit under its control and the true balance of any deposit in a solvent bank, trust company or thrift institution.

(2) Investments acquired or held in accordance with the applicable provisions of this chapter, and the income due or accrued thereon subject to paragraphs three and four of this subsection as to dividends, interest, rents and accrued taxes paid.

(3) Declared and unpaid dividends on shares, unless the amount has otherwise been allowed as an admitted asset.

(4) Investment income due and accrued. Such amounts shall be assessed for collectibility. If it is probable that the investment income due and accrued balance is uncollectible, the amount shall be written off and shall be charged against investment income in the period such determination is made. Any remaining investment income due and accrued (i.e., amounts considered probable of collection) representing either

(i) amounts that are over ninety days past due (generated by any invested asset except mortgage loans in default), or (ii) amounts otherwise designated as nonadmitted shall be considered nonadmitted. If a mortgage loan in default has interest one hundred eighty days past due that has been assessed as collectible, all interest shall be considered a nonadmitted asset. Such nonadmitted amounts shall be subject to continuing assessments of collectibility and, if determined to be uncollectible, a write-off shall be recorded in the period such determination is made. For purposes of this paragraph, "probable" shall mean that the future event or events are likely to occur.

(5) Premium notes, policy loans and other policy assets and liens on policies, contracts or certificates of a life insurance company or fraternal benefit society, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual contract; the net amount of uncollected and deferred premiums, considerations or assessments of a life insurance company or of a fraternal benefit society which carries the full mean tabular reserve liability; for a fraternal benefit society which does not carry such reserve liability, the net amount of uncollected premiums.

(6) Premiums in course of collection, other than life insurance premiums, not more than ninety days past due, less commissions payable thereon. The foregoing limitation of ninety days shall not apply to: (i) premiums payable directly or indirectly by the United States government or any of its instrumentalities, (ii) reinsurance premiums payable by ceding insurers authorized to transact such business in this state, or (iii) reinsurance premiums payable which may be offset by amounts carried by the assuming insurer as liabilities for amounts due to the ceding insurer for unpaid losses or other mutual debts. However reinsurance premiums more than ninety days past due shall not be allowed in excess of ten per centum of the reinsurer's total admitted assets as shown on its most recent annual statement on file in the office of the superintendent pursuant to section three hundred seven of this chapter.

(7) Instalment premiums, other than life insurance premiums, as prescribed by regulation.

(8) Notes and like written obligations, not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves

carried thereon except as otherwise prescribed by regulation.

(9) Reinsurance recoverable by a ceding insurer: (i) from an insurer authorized to transact such business in this state, except from a captive insurance company licensed pursuant to the provisions of article seventy of this chapter, in the full amount thereof; (ii) from an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter, to the extent allowed by the superintendent on the basis of the insurer's compliance with the conditions of any applicable regulation; or (iii) from an insurer not so authorized or accredited or from a captive insurance company licensed pursuant to the provisions of article seventy of this chapter, in an amount not exceeding the liabilities carried by the ceding insurer for amounts withheld under a reinsurance treaty with such unauthorized insurer or captive insurance company licensed pursuant to the provisions of article seventy of this chapter as security for the payment of obligations thereunder if such funds are held subject to withdrawal by, and under the control of, the ceding insurer. Notwithstanding any other provision of this chapter, the superintendent may by regulation prescribe the conditions under which a ceding insurer may be allowed credit, as an asset or as a deduction from loss and unearned premium reserves, for reinsurance recoverable from an accredited reinsurer, an insurer not authorized in this state or a captive insurance company licensed pursuant to the provisions of article seventy of this chapter.

(10) Amounts receivable by an assuming insurer for funds withheld by a ceding insurer under a reinsurance treaty, not exceeding the amounts carried by such assuming insurer as liabilities for unpaid losses and reserves under such contracts.

(11) Amounts receivable under a funding agreement issued pursuant to section three thousand two hundred twenty-two of this chapter.

(12) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from suspended banking institutions, to the extent deemed by the superintendent available for the payment of losses and claims and at values determined by him.

(13) (A) Electronic data processing apparatus and related equipment constituting a data processing, record keeping, or accounting system and operating system software, provided that such assets shall be deemed admitted, subject to such regulations as may be promulgated by the

superintendent in an amount not to exceed three percent of the insurer's capital and surplus, or such other amount that the superintendent, in a regulation, determines to be appropriate in specified circumstances, as required to be shown on its statutory balance sheet for its most recently filed statement with the superintendent adjusted to exclude any net positive goodwill, electronic data processing apparatus and related equipment, operating system software and net deferred tax assets, provided that electronic data processing apparatus and related equipment and operating system software shall be amortized over the lesser of its useful life or three years. Nonoperating system software shall be nonadmitted and depreciated over the lesser of its useful life or five years.

(B) Notwithstanding the provisions of subparagraph (A) of this paragraph, until December thirty-first, two thousand eleven, electronic data processing apparatus and related equipment constituting a data processing, record keeping, or accounting system and operating system software of article forty-three corporations and public health law article forty-four health maintenance organizations, integrated delivery systems, prepaid health service plans and comprehensive special needs plans may be allowed as admitted assets if the cost of each such system is fifty thousand dollars or more and provided that such cost shall be amortized over a period not to exceed ten years. Effective January first, two thousand twelve, the provisions of subparagraph (A) of this paragraph shall apply to article forty-three corporations and public health law article forty-four health maintenance organizations, integrated delivery systems, prepaid health service plans and comprehensive special needs plans.

(14) Positive goodwill, provided that such asset shall be deemed admitted, subject to such limitations and conditions in regulations as may be promulgated by the superintendent in an amount not to exceed ten percent of the insurer's capital and surplus as required to be shown on its statutory balance sheet for its most recently filed statement with the superintendent adjusted to exclude any net positive goodwill, electronic data processing apparatus and related equipment, operating system software and net deferred tax assets, and provided further that such positive goodwill shall be amortized in full over the period in which the insurer benefits economically, not to exceed ten years. When

negative goodwill exists, it shall be recorded as a contra-asset.

(15) Amounts payable to the insurer from the property/casualty insurance security fund on behalf of insureds with medical malpractice insurance claims-made policies pursuant to subparagraph (G) of paragraph one of subsection (a) of section seven thousand six hundred three of this chapter.

(16) Gross deferred tax assets, provided that such assets shall be deemed admitted to the extent provided by regulations promulgated by the superintendent in an amount not to exceed the sum of:

(A) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year;

(B) the lesser of:

(i) the amount of gross deferred tax assets after the application of subparagraph (A) of this paragraph expected to be realized within one year of the balance sheet date; or

(ii) ten percent of the insurer's statutory capital and surplus as required to be shown on its statutory balance sheet for its most recently filed statement with the superintendent adjusted to exclude any net positive goodwill, electronic data processing apparatus and related equipment, operating system software and net deferred tax assets; and

(C) the amount of gross deferred tax assets after application of subparagraphs (A) and (B) of this paragraph that can be offset against existing gross deferred tax liabilities.

(17) Other assets, not inconsistent with the foregoing provisions, deemed by the superintendent available for the payment of losses and claims, at values determined by the superintendent.

(18) The superintendent may, be regulation, modify any requirement of this subsection to conform to any subsequent amendment to the accounting practices and procedures manual as adopted from time to time by the national association of insurance commissioners.

(b) Admitted assets may be allowed as deductions from corresponding liabilities, liabilities may be charged as deductions from assets, and deductions from assets may be charged as liabilities, in accordance with the form of annual statement applicable to such insurer as prescribed by the superintendent, or otherwise in his discretion.

(c) The superintendent may by regulation prescribe the application of

the provisions of this section.

§ 1302. Assets not admitted. (a) In addition to assets not admitted pursuant to section one thousand three hundred one of this article, the following shall not be allowed as admitted assets of a domestic or foreign insurer or the United States branch of an alien insurer in any determination of its financial condition:

(1) Trade names, agency plants and other like intangible assets.

(2) Prepaid or deferred charges for expenses except as provided in paragraph sixteen of subsection (a) of section one thousand three hundred one of this article, and commissions paid by the insurer.

(3) Advances to officers (except policy loans), whether secured or not, and advances to employees, agents and other persons on personal security only.

(4) Shares of such insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such shares through the ownership by such insurer of an interest in another firm, corporation or business unit.

(5) Tangible personal property, fixtures and printed matter except such as an insurer is permitted to hold pursuant to paragraph five of subsection (a) of section one thousand four hundred four of this chapter.

(6) Items of bank credits representing checks, drafts or notes returned unpaid after the date of statement.

(7) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of such insurer exceeds the aggregate value thereof as determined in accordance with the provisions of this chapter.

(b) All non-admitted assets and all other assets of doubtful value or character included as ledger or non-ledger assets in any statement by an insurer to the superintendent, or in any examiner's report to him, shall also be reported, to the extent of the value disallowed, as deductions from the gross assets of such insurer except where the superintendent permits a reserve to be carried among the liabilities of such insurer in lieu of any such deduction.

§ 1303. Loss or claim reserves. Every insurer shall, except as provided in section one thousand three hundred four of this article and subject to specific provisions of this chapter, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of statement, whether reported or unreported, which are unpaid as of such date and for which such insurer may be liable, and also reserves in an amount estimated to provide for the expenses of adjustment or settlement of such losses or claims.

§ 1304. Valuation reserves. Every insurer authorized under this chapter to transact the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter shall, subject to specific provisions of this chapter, maintain:

(a) reserves on all of its life insurance policies or certificates and annuity contracts in force, computed according to the applicable tables of mortality and rates of interest prescribed in this chapter;

(b) reserves for disability benefits, including reserves for disabled lives whether reported or unreported, and for accidental death benefits; and

(c) any additional reserves prescribed by the superintendent as necessary on account of such insurer's policies, certificates and contracts.

§ 1305. Unearned premium reserves. (a) Every authorized insurer shall, except as to reserves required under section one thousand three hundred four of this article and subject to paragraph nine of subsection (a) of section one thousand three hundred one of this article and other specific provisions of this chapter, maintain reserves equal to the unearned portions of the gross premiums charged on unexpired or unterminated risks and policies.

(b) (1) No deductions may be made from the gross premiums in force except for original premiums cancelled on risks terminated or reduced

before expiration, or except for premiums paid or credited for risks reinsured with other solvent assuming insurers authorized to transact such business in this state.

(2) Premiums charged for bulk or portfolio reinsurances assumed from other insurers shall be included as premiums in force on the basis of the original premiums and the original terms of the policies of the ceding insurer.

(3) Reinsurance ceded to such an authorized assuming insurer may be deducted on the basis of original premiums and original terms except in the case of excess loss or catastrophe reinsurance which may be deducted only on the basis of actual reinsurance premiums and actual reinsurance terms.

(c) (1) The liability for unearned premiums may be computed on the annual pro rata fraction basis applicable to the date of statement as prescribed by the superintendent.

(2) If the annual pro rata fractions do not produce an adequate reserve, the superintendent may, in his discretion, require an insurer to calculate its unearned premium reserve upon the monthly pro rata fractional basis or, if necessary, on each respective risk from the date of the issuance of the policy, and as to premiums covering indefinite terms he may prescribe special regulations.

(3) As to marine insurance, premiums on trip risks not terminated shall be deemed unearned and the superintendent may require a reserve to be carried thereon equal to one hundred percent of the premiums on trip risks written during the month ended as of the date of statement.

(4) At least ninety percent of the gross amount of premium deposits on perpetual fire insurance risks shall be charged as a liability.

(5) As to title insurance, unearned premium reserves shall be computed and maintained only as required by subsection (a) of section six thousand four hundred five of this chapter.

§ 1306. Miscellaneous liabilities. In addition to liabilities and reserves on contracts of insurance issued by it, every insurer shall be charged with the estimated amount of all its other liabilities, including taxes, expenses, other obligations due or accrued at the date of statement, and any special reserves required by the superintendent

pursuant to the provisions of this chapter.

§ 1307. Contingent liability for borrowings. (a) Any domestic stock, mutual or co-operative insurance company or reciprocal insurer may, without pledging any of its assets, receive advances or borrow funds to:

(1) conduct its business,

(2) enable it to comply with any surplus requirement or make good any impairment or deficiency or other requirement of this chapter,

(3) defray the reasonable expenses of its organization,

(4) provide any fund to be voluntarily contributed to surplus, or

(5) organize, acquire or invest in any subsidiaries authorized by this chapter.

(b) Such borrowing may only be made upon an agreement that such moneys and such interest thereon as may be agreed upon, at a rate not exceeding the maximum rate provided in section 5-501 of the general obligations law, in effect at the time the agreement is executed, shall be repaid only out of free and divisible surplus of such insurer with the approval of the superintendent whenever, in his judgment, the financial condition of such insurer warrants. In the event of insolvency of a mutual or co-operative insurance company unearned premiums shall be deemed to be part of its free and divisible surplus.

(c) Any sum so advanced or borrowed shall not be part of the legal liabilities of such insurer and shall not be a basis of any set-off but until repaid all statements published by such insurer or filed with the superintendent shall show, as a footnote, the amount then remaining unpaid.

(d) No such insurance company or reciprocal insurer shall directly or indirectly make any agreement for any advance or borrowing pursuant to this section unless such agreement is in writing and shall have been approved by the superintendent as not unfair, misleading or contrary to law.

§ 1308. Reinsurance, when permitted; effect on reserves. (a) (1) Any authorized insurer, hereinafter called the "ceding insurer", may, subject to the limitations of this chapter, reinsure its risks and

policy liabilities in any other assuming insurer with the effects herein prescribed. No prohibition or limitation in this chapter shall invalidate any reinsurance agreement as between the parties thereto.

(2) (A) No credit shall be allowed, as an admitted asset or deduction from liability, to any ceding insurer for reinsurance ceded, renewed, or otherwise becoming effective after January first, nineteen hundred forty, unless:

(i) the reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer, and

(ii) under the reinsurance agreement the liability for such reinsurance is assumed by the assuming insurer as of the same effective date.

(B) Except as provided by subsection (a) of section four thousand one hundred eighteen of this chapter, no such credit shall be allowed any ceding insurer for reinsurance ceded, renewed, or otherwise becoming effective after September first, nineteen hundred fifty-two, unless the reinsurance agreement provides that payments by the assuming insurer shall be made directly to the ceding insurer or its liquidator, receiver or statutory successor, except where:

(i) the agreement specifies another payee of such reinsurance in the event of the insolvency of the ceding insurer, or

(ii) the assuming insurer with the consent of the direct insureds has assumed such policy obligations of the ceding insurer as its direct obligations to the payees under such policies, in substitution for the obligations of the ceding insurer to such payees.

(3) Such reinsurance agreement may provide that the liquidator, receiver or statutory successor of an insolvent ceding insurer shall give written notice of the pendency of a claim against such insurer on the contract reinsured within a reasonable time after such claim is filed in the insolvency proceeding and that during the pendency of such claim any assuming insurer may investigate such claim and interpose, at its own expense, in the proceeding where such claim is to be adjudicated any defenses which it deems available to the ceding company, its liquidator, receiver or statutory successor. Such expense shall be chargeable subject to court approval against the insolvent ceding

insurer as part of the expense of liquidation to the extent of a proportionate share of the benefit which may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer. Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose defense to such claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though such expense had been incurred by the ceding company.

(b) In determining the ceding insurer's financial condition, if reinsurance is effected by the ceding insurer in any assuming insurer, the ceding insurer shall, in addition to any credit allowed against its loss reserves, and any reduction of reserves allowed pursuant to paragraph nine of subsection (a) of section one thousand three hundred one of this article for reinsurance recoverable from insurers not authorized in this state, receive credit for reinsurance effected with any assuming insurer authorized to do such business in this state, calculated as follows:

(1) as to reinsurance of all or any part of any risk not specified in paragraph two hereof, by way of deduction from its unearned premium liability calculated in accordance with the provisions of section one thousand three hundred five of this article; or

(2) as to reinsurance of all or any part of any life insurance or annuity or non-cancellable disability risk, by way of deduction from its reserve liability, in an amount not exceeding the reserve on the reinsured portion of such risk which the ceding insurer would have maintained if such portion had not been reinsured.

(c) Nothing in this section shall be deemed to permit the ceding insurer to receive through the cession of all or any part of any risk any advantage whereby its unearned premium reserve, or the net amount of its valuation reserves, is reduced below the amount required by this chapter.

(d) In determining its financial condition, any assuming insurer shall be charged:

(1) in its unearned premium liability with an amount equal to the deduction specified in paragraph one of subsection (b) hereof, and

(2) in its valuation reserve liability with an amount at least equal to the amount which it would be required to maintain in accordance with

the provisions of this chapter if it were the direct insurer of such assumed risks on the basis specified in the reinsurance agreement.

(e) (1) During any period of twelve consecutive months, without the superintendent's permission:

(A) no domestic insurer, except life, shall by any reinsurance agreement or agreements cede an amount of its insurance on which the total gross reinsurance premiums are more than fifty percent of the unearned premiums on the net amount of its insurance in force at the beginning of such period, and

(B) no alien insurer, except life, shall by any reinsurance agreement or agreements, involving the withdrawal or transfer of any interest in any of its trusteed assets in the United States, cede an amount of its insurance on which the total gross reinsurance premiums are more than fifty percent of the unearned premiums on the net amount of its insurance in force in the United States, at the beginning of such period.

(2) Paragraph one hereof shall not apply to reinsurance made in the ordinary course of business reinsuring specified individual risks under reinsurance agreements relating to current business.

(3) If any agreement or agreements at any time effect reinsurance of substantially all of the net insurance in force of such ceding insurer, no credit by way of deduction pursuant to subsection (b) hereof shall be allowed to such ceding insurer, unless either:

(A) the assuming insurer or insurers assume or have assumed the policy obligations of the ceding insurer as their direct obligations to the obligees under such policies and the provisions for cancellation, if any, of such reinsurance agreements have been approved by the superintendent, or

(B) such reinsurance agreement or agreements were made under pooling arrangements between insurers associated in a group for underwriting purposes and were approved by the superintendent as not impairing the protection of policyholders of such ceding or assuming insurers.

(f) (1) Unless the superintendent permits:

(A) No domestic life insurance company shall (i) reinsure its whole risk on any individual life or joint lives, or (ii) reinsure a substantial portion of its life insurance in force.

(B) No foreign or alien insurer shall reinsure its whole risk on any

individual life or joint lives, written under a policy or contract delivered or issued for delivery in this state.

(2) Any domestic life insurance company proposing to assume by reinsurance all or any part of the business in force, other than portions of individual risks, of any domestic, foreign or alien life insurance company, fraternal benefit society or other organization having outstanding policies or certificates of life insurance or accident and health insurance or annuity contracts shall make written application to the superintendent for permission to do so. If after due consideration the superintendent is satisfied that the proposed reinsurance will not prejudice the interests of the policyholders of either the applicant or the companies that are members of The Life Insurance Guaranty Corporation or of The Life and Health Insurance Company Guaranty Corporation of New York, the superintendent shall grant the permission.

(3) The superintendent, after notice to and an opportunity to be heard by all domestic life insurance companies, may issue and from time to time amend regulations establishing standards which tend to promote orderly growth and financial stability among the companies and otherwise effectuate the purposes of this subsection.

(g) Any domestic life insurance company which has discontinued doing any new business in a foreign country may, with the permission of the superintendent, reinsure all or any part of its risks outstanding in such country in any solvent insurer authorized to transact business therein. Thereafter such life insurance company shall not be required to charge as liabilities the reserves and other liabilities pertaining to the reinsured risks.

§ 1309. Insolvency of an insurer. (a) Whenever the superintendent finds from a financial statement or report on examination that an authorized insurer is unable to pay its outstanding lawful obligations as they mature in the regular course of business, as shown by an excess of required reserves and other liabilities over admitted assets, or by its not having sufficient assets to reinsure all outstanding risks with other solvent authorized assuming insurers after paying all accrued claims owed, such insurer shall be deemed insolvent and the

superintendent may proceed against it pursuant to the provisions of article seventy-four of this chapter.

(b) If an insurer deemed insolvent pursuant to subsection (a) hereof is a foreign or alien insurer, the superintendent may also revoke or suspend its license to do business in this state.

§ 1310. Impairment of a stock insurer. (a) Whenever the superintendent finds from a financial statement, or a report on examination, of any domestic stock insurer that (i) the admitted assets are less than the aggregate amount of its liabilities and outstanding capital stock or (ii) the admitted assets of any such insurer which is required to maintain a minimum surplus to policyholders are less than the aggregate amount of its liabilities and the amount of its minimum surplus to policyholders, he shall determine the amount of the impairment and order the insurer to eliminate the impairment within such period as he designates, not more than ninety days from the service of the order. He may also order the insurer not to issue any new policies while the impairment exists. If the impairment as determined by the provisions of item (i) hereof equals or exceeds twenty-five percent of the insurer's outstanding capital stock, or as determined by the provisions of item (i) or (ii) hereof is such that the insurer does not have the minimum capital or minimum surplus to policyholders required by this chapter, and if at the expiration of such designated period, such insurer has not satisfied the superintendent that such impairment has been eliminated, the superintendent may proceed against the insurer pursuant to the provisions of article seventy-four of this chapter on the ground that its condition is such that its further transaction of business will be hazardous to its policyholders or its creditors or the public.

(b) If any foreign stock insurer authorized to do business in this state is found to be impaired, the superintendent may, after notice and hearing, order such insurer not to issue during such time as he prescribes any new policies in this state, and may, after notice and hearing, revoke its license to transact business in this state.

§ 1311. Impairment of a mutual or reciprocal insurer. (a) In this

section "required surplus" includes any guaranty surplus or special contingent surplus or other specifically reserved surplus account of a domestic mutual insurer, a domestic reciprocal insurer or any other domestic insurer without capital stock, required by the provisions of this chapter to be maintained for any purpose, including: (i) issuance of non-assessable policies, (ii) payment of dividends, or (iii) transaction of business after a license has been issued by the superintendent.

(b) Whenever the superintendent finds from a financial statement or report on examination that the total admitted assets of any insurer required to maintain such required surplus are less than the aggregate amount of its liabilities and required surplus, he shall determine the amount of such impairment and order the insurer or its attorney-in-fact to eliminate such impairment within such period he designates, not exceeding ninety days from service of such order. He may also by order prohibit such insurer, while such impairment exists, from:

(1) issuing any non-assessable policies if its required surplus for the purpose of item (i) of subsection (a) hereof is impaired, or

(2) paying dividends if its required surplus for the purpose of item (ii) of subsection (a) hereof is impaired, or

(3) issuing new policies if its minimum surplus for the purpose of item (iii) of subsection (a) hereof is impaired.

(c) If the impairment so determined is such that such insurer does not have the minimum surplus required for item (iii) of subsection (a) hereof, and if when such designated period expires the insurer has not satisfied the superintendent that such impairment has been eliminated, the superintendent may proceed against such insurer pursuant to the provisions of article seventy-four of this chapter on the ground that its further transaction of business will be hazardous to its policyholders, its creditors or the public.

(d) If the required minimum surplus of any authorized foreign mutual or reciprocal insurer is found by the superintendent to be impaired, the superintendent may order such insurer not to issue during such time as he prescribes any new policies in this state, and may, after notice and hearing, revoke its license to do business in this state.

§ 1312. Trusteed surplus of alien insurers; impairment. (a) (1) In addition to other requirements of this chapter every authorized alien insurer shall, not later than the first day of March in each year, file with the superintendent a statement (herein called a "trusteed surplus statement"), on a form prescribed by him, showing at last year-end:

(A) all its general state deposits, meaning assets within the United States deposited with officers of any state in trust for the security of all its policyholders, or policyholders and creditors, within the United States;

(B) all its special state deposits, meaning assets within the United States deposited with officers of any state in trust for the security of its policyholders, or policyholders and creditors, in a particular state;

(C) all its trusteed assets, meaning assets within the United States held by a trustee or trustees for the security of all its policyholders, or policyholders and creditors, within the United States;

(D) if a life insurance company, the amount of its policy loans to policyholders within the United States, not exceeding the amount of the legal reserve required on each such policy;

(E) all its reserves and other liabilities arising out of policies or obligations issued, assumed or incurred in the United States; and

(F) such further information as may be necessary to apply the provisions of this section.

(2) In determining the net amount of the insurer's liabilities in the United States, a deduction may be made: (i) for reinsurance on losses with authorized insurers, less unpaid reinsurance premiums, with a schedule showing by companies the amount deducted, and (ii) for unearned premiums on agents' balances or uncollected premiums not more than ninety days past due. Any liability on an asset not considered in such statement may be applied against such asset.

(3) No credit shall be allowed in such statement for any special state deposit held for the exclusive benefit of policyholders, or policyholders and creditors, of any particular state except as an offset against the liabilities of such alien insurer in such state.

(4) The accrued interest at date of statement on assets deposited with states and trustees shall be allowed in such statement, where such interest is collected by the states or trustees.

(b) (1) Such trusteed surplus statement shall be signed and verified by the United States manager, attorney-in-fact, or a duly empowered assistant United States manager, of the alien insurer. The items of securities and other property held under trust deeds shall be certified to by the United States trustee or trustees. The superintendent may at any time require a further statement of the same kind and of such date as he may determine.

(2) Every report on examination of the United States branch of an alien insurer shall include a trusteed surplus statement as of the date of examination in addition to the general statement of the financial condition of such United States branch.

(c) (1) The aggregate value of the insurer's general state deposits and trusteed assets less the aggregate net amount of all of its liabilities and reserves in the United States as determined in accordance with this section shall be known as its "trusteed surplus" in the United States. Whenever it appears to the superintendent from any such statement or any report that an alien insurer's trusteed surplus is reduced below the greater of the minimum capital required of, or the minimum surplus to policyholders required to be maintained by, a domestic insurer licensed to transact the same kinds of insurance, he shall determine the amount of such impairment and order the insurer, through its United States manager or attorney, to eliminate such impairment within such period as he designates, not more than ninety days from service of the order. He may also by order revoke or suspend such insurer's license or prohibit it from issuing new policies in the United States while such impairment exists.

(2) If at the expiration of such designated period such insurer has not satisfied the superintendent that such impairment has been eliminated, the superintendent may proceed against such insurer pursuant to the provisions of article seventy-four of this chapter as an insurer whose condition is such that its further transaction of business in the United States will be hazardous to its policyholders, its creditors or the public in the United States.

§ 1313. Contents of advertisements and other public announcements concerning financial condition of insurers. (a) (1) Except as provided

in subsection (g) hereof or permitted by regulation, every advertisement or other public announcement published, issued or distributed in this state by any domestic or foreign insurer, a subsidiary thereof, a holding company or controlled person as defined by section one thousand five hundred one of this chapter, or by any agent of any of the foregoing, purporting to make known the insurer's separate financial condition, shall show the amount of its admitted assets, liabilities and reserves required or permitted by law, and its surplus to policyholders, and shall correspond with its last verified statement (annual or quarterly, at its option) made to the superintendent. Such surplus to policyholders shall show the amount of the insurer's paid up capital stock, if any.

(2) The provisions of paragraph one hereof shall not apply to an advertisement or other public announcement showing only the insurer's capital paid up, or its surplus and capital, if any, separately or combined, but such items shall not be in excess of the corresponding items shown on the insurer's last verified statement (annual or quarterly, at its option) made to the superintendent.

(b) (1) Every advertisement or other public announcement, published, issued or distributed in this state by any alien insurer doing business in this state, a subsidiary thereof, a holding company or controlled person as defined by section one thousand five hundred one of this chapter, or by any agent of any of the foregoing, purporting to make known the separate financial condition of the insurer, shall show as assets only its admitted assets held by its United States branch, its liabilities and reserves required by law, and its surplus to policyholders in the United States, and shall correspond with the insurer's last verified statement (annual or quarterly, at its option) made to the superintendent. Such surplus to policyholders shall show the amount of the statutory deposit of such United States branch.

(2) Notwithstanding the provisions of paragraph one hereof, any authorized life insurance company or fraternal benefit society organized under the laws of Canada or any province thereof may use in its advertising in this state a statement of its complete financial condition, in addition to its statement of admitted assets and liabilities in the United States, if a similar domestic insurer is permitted by the laws of Canada or the provinces thereof in which it

does an insurance business to advertise therein its complete financial condition on a corresponding basis.

(c) No statement of separate financial condition shall be published, issued or distributed as provided in subsection (a) or (b) hereof unless it or a footnote clearly shows the amount of securities, included in admitted assets, which are pledged as collateral for any loan or guaranty, or which are otherwise not available to pay losses and claims or are not held to protect the insurer's policyholders or creditors.

(d) No insurer doing business in this state nor any subsidiary thereof, or holding company or controlled person as defined in section one thousand five hundred one of this chapter nor any agent of any of the foregoing, shall in any advertisement or other public announcement make any statement or communication to the effect that the insurer has, or expects to have, reinsurance by any named assuming insurer not authorized to do such reinsurance business in this state, or to the effect that the insurer's policies are guaranteed wholly or partly by any other person, insurer or institution.

(e) Nothing in this section shall apply to reports issued to shareholders or government agencies or instrumentalities by a holding company or controlled person as defined in section one thousand five hundred one of this chapter or prohibit any supplemental reference concerning an insurer's separate financial condition on the basis of actual market values of its securities or the inclusion of supplemental factual information with respect to the separate financial condition of such insurer in a report issued by such insurer to its shareholders or policyholders.

(f) Advertisements and other public announcements directed primarily at calling the attention of policyholders or prospective policyholders to an insurer and containing a statement of the separate financial condition of the holding company system shall also contain a statement of the separate financial condition of the insurer which shall comply with this section.

(g) Consolidated financial statements of an authorized insurer and any of its subsidiaries may be used only to the extent authorized by the superintendent or required by any government agency or instrumentality.

§ 1314. Deposits; custody, beneficiaries, exchanges, inspection and income. (a) (1) The superintendent shall be the official custodian of all deposits of securities required or authorized by the provisions of this chapter, unless otherwise specifically provided by law. He shall keep the same in a safe place provided by the state or in custody for his account with a bank, trust company or national bank in this state which may be designated by the depositing insurer, subject to the approval of the superintendent.

(2) All such securities shall be held by the superintendent, in trust, without preference or priority to any beneficiary entitled to share therein, for the security of the depositing insurer's policyholders within the United States, its territories and possessions, except that securities deposited by an alien insurer shall be held in trust for the security of the policyholders and creditors of the depositing insurer within the United States, its territories and possessions.

(3) Such securities may be registered in the name of the superintendent as such trustee or, at the option of the depositing insurer, may be in bearer form.

(4) "Policyholders" as used in this chapter in any provision relating to beneficiaries of deposits includes all persons having a legal or equitable right against the depositing insurer or the insured arising out of an insurance or annuity contract. "Depositing insurer" as used in this chapter includes any lawful successor in interest to such insurer.

(b) The depositing insurer shall not assign or otherwise transfer all or any part of its interest in any such deposit, without the approval of the superintendent, and any such transfer, whether voluntary or by operation of law, without such approval, shall be void. The superintendent may approve transfer of all of the depositing insurer's residuary interest in such deposit if with his approval the transferee assumes all liabilities of the transferor to the beneficiaries of such deposit.

(c) No judgment creditor or other claimant may levy upon any deposit or part thereof. Upon the making of an order by a court of competent jurisdiction for the liquidation, rehabilitation or conservation of any depositing insurer, the deposit and the income therefrom shall be transferred to the superintendent as liquidator, rehabilitator or conservator.

(d) All deposits of securities held by the superintendent which were made pursuant to any prior insurance law shall be deemed to be held in compliance with the provisions of this chapter, for the purposes for which such deposits were originally made.

(e) The depositing insurer may from time to time exchange for any deposited securities other securities eligible under the provisions of this chapter if in the opinion of the superintendent the aggregate value of such deposit will not be thereby reduced below the amount required by law.

(f) So long as the depositing insurer shall continue solvent and shall comply with the laws of this state applicable to it, the superintendent shall permit it to collect and dispose of the income on deposited securities.

(g) (1) No exchange, release or other transfer of deposited securities, or any interest therein, shall be valid unless: (i) countersigned by a member of the state tax commission or a person designated for such purpose by such commission, and (ii) requested by the depositing insurer. Except for a transfer for redemption or refunding, the depositing insurer's request must be evidenced in such manner as the superintendent requires.

(2) The department of taxation and finance and the department of financial services shall each keep a book with entries showing the name of the insurer for whose account such transfer is made by the superintendent, the name of the transferee unless made in blank, and the par value of the securities transferred.

(3) Within five days after countersigning and entering the same, the commissioner of taxation and finance shall advise by mail the insurer from whose account such transfer is made, of the kind and amount of security transferred.

(h) Every depositing insurer shall, at least once during each calendar year, cause such securities to be examined by some person duly authorized in writing. Such person shall, at the request of the superintendent, execute a certificate stating the result of such examination.

§ 1315. Trusteed assets of alien insurers. (a) Whenever a licensed

alien insurer is required or permitted by this chapter to deposit assets with a trustee or trustees for the security of its policyholders and creditors in the United States, such assets shall be known as "trusteed assets". All trusteed assets shall be continuously kept within the United States and the trusteed assets of a licensed alien insurer entered through this state shall be continuously kept in this state. The deed of trust and all amendments thereto shall be authenticated in such form and manner as the superintendent may prescribe and shall not be effective unless approved by him. If he finds a deed of trust or its amendments: (i) are sufficient in form and in conformity with law, (ii) the trustee or trustees are eligible as such, and (iii) the deed of trust is adequate to protect the interests of the beneficiaries of the trust, he shall give his approval. If he finds, after reasonable notice to and hearing of the insurer, that the requisites for the approval no longer exist, he may withdraw such approval.

(b) The trustee or trustees of all trusts created after nineteen hundred thirty-nine shall be solvent banks or trust companies deemed by the superintendent suitable for such purpose.

(c) All trusts of trusteed assets existing before nineteen hundred forty shall be continued in accordance with the terms of the instruments creating them, if not inconsistent with this section. If the trustees of any trust created before nineteen hundred forty are individuals, and their number is reduced to less than three, by death, resignation or otherwise, the superintendent shall require substitution for such trustees of one or more banks or trust companies deemed by him suitable for such purpose. If the superintendent finds, after reasonable notice to and hearing of such alien insurer, that a deed of trust executed before nineteen hundred forty is inadequate to protect the interests of the beneficiaries of such trust, he shall require the execution of a new or amended deed of trust in conformity with the requirements of this section.

(d) The superintendent may from time to time approve modifications of, or variations in, any deed of trust, which in his judgment are not prejudicial to the interests of the people of this state.

(e) (1) Such deed of trust shall contain provisions which:

(A) vest legal title to trusteed assets in the trustees, and their successors lawfully appointed, in trust for the security of all

policyholders and creditors of the alien insurer within the United States;

(B) provide for substitution of a new trustee or trustees in case of a vacancy by death, resignation or otherwise, subject to approval of the superintendent;

(C) require that all trusteed assets shall be at all times maintained as a trust fund separate and distinct from all other assets; and

(D) require that the trustee or trustees shall continuously maintain a record at all times sufficient to identify the assets of such fund.

(2) Such deed of trust may provide that income, earnings, dividends or interest accumulations of the assets of such fund may be paid over to the United States manager of such alien insurer, upon his or its request.

(3) Such deed of trust shall provide, in substance, that no withdrawals of assets, other than income as above specified, shall be made or permitted by the trustee or trustees without the approval of the superintendent except to:

(A) make deposits required by law in any state for the security or benefit of all policyholders, or policyholders and creditors, of such alien insurer in the United States;

(B) substitute other assets permitted by law and at least equal in value to those withdrawn, upon the specific written direction of the United States manager or an assistant United States manager when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors; or

(C) transfer such assets to an official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

(f) Upon withdrawal of trusteed assets deposited in another state in which such insurer is authorized to do business, it shall be sufficient if the deed of trust requires similar written approval of the insurance supervising official of such state in lieu of approval of the superintendent. In all such cases the alien insurer shall notify the superintendent in writing of the nature and extent of such withdrawal.

(g) The superintendent may from time to time: (i) make examinations of the trusteed assets of any authorized alien insurer at the insurer's expense and (ii) require the trustee or trustees to file a statement, in such form as he may prescribe, certifying the assets of such trust fund

and the amounts thereof. Refusal or neglect of any trustee to comply with the foregoing requirements shall be ground for the revocation of such insurer's license or the liquidation of its United States branch.

(h) In the case of a Canadian life insurance company or a Canadian fraternal benefit society, the provisions of this section applicable to a United States manager refer to the president, vice-president, secretary or treasurer of the company at its home office in Canada or to any officer of the society elected by its supreme governing body, when duly empowered and authorized for such purpose.

§ 1316. Voluntary deposits. The superintendent may receive from any authorized insurer a deposit required by or pursuant to the laws of another state as a prerequisite to doing business in such other state, and may also receive from any insurer any additions to its deposits which are reasonably necessary to maintain the aggregate value of such deposit at least equal to the amount required.

§ 1317. Release of deposits. (a) (1) In this section, "release of deposits" means the transfer and delivery by the superintendent of deposited securities to the depositing insurer at its request, or to a person designated by it in writing, without substitution of other securities. The superintendent may require authentication or proof of such request, or of such designation, in such form and manner as he may prescribe.

(2) No depositing insurer shall be entitled to a total or partial release of its deposited securities except as specified in this section.

(3) No total or partial release of a deposit, made in good faith by the superintendent, shall impose any personal liability upon him.

(b) If the superintendent finds that the aggregate market value of the required deposit of any insurer doing business in this state exceeds one hundred five per centum of the amount required of such insurer by the laws of this state, he may release securities of such deposit, having a value not greater than the amount of such excess, but the par value of the securities remaining on deposit shall not be less than the amount required by the provisions of this chapter.

(c) If the superintendent finds that all or any part of any voluntary deposit of any insurer is no longer required to comply with the laws of this or any other state, he may to such extent release such deposit.

(d) If the superintendent finds that the aggregate market value of the required deposit of any insurer exceeds two hundred per centum of the total amount of its outstanding accrued and contingent liabilities assumed, or covering persons or risks located, within the United States, and that such insurer has ceased to do any new business within the United States, he may release securities of such deposit having a value not greater than the excess.

(e) In making any findings required by this section the superintendent may make such examination or other investigation of the affairs of such insurer as he deems expedient, and may require a statement subscribed by two principal officers of such insurer and affirmed by them as true under the penalties of perjury as to any facts therein.

§ 1318. Deposits, securities eligible. (a) Except as otherwise provided in this chapter, every deposit made with the superintendent shall be in the securities specified in paragraphs one and two of subsection (b) of section one thousand four hundred two of this chapter, estimated at an amount not exceeding their current market value, but their total par value shall not be less than the amount required.

(b) Such deposit made by a foreign insurer may be in like securities of its home state if similar domestic insurers doing business in such state are permitted to deposit therein like securities of this state.

(c) If the aggregate market value of the securities on deposit shall fall below the required amount, the superintendent may require the depositing insurer to deposit sufficient additional securities of like character.

§ 1319. Deposits by foreign insurers. (a) Every foreign insurer doing business in this state shall keep on deposit with the superintendent, or with the state officer of its home state designated by law for such purpose, the same amount of securities which a like domestic insurer transacting the same kinds of insurance is required to deposit with the

superintendent.

(b) Such securities shall be of the same character required or permitted by section one thousand three hundred eighteen of this article, except that such an insurer may, in the discretion of the superintendent, receive credit for a deposit with its home state consisting of bonds and mortgages, or deeds of trust, on improved unencumbered real property located in its home state or in this state worth fifty per centum more than the amount loaned thereon.

(c) The superintendent shall be furnished with the certificate of such state officer of the insurer's home state under his hand and official seal that he holds such securities in trust and on deposit for the benefit of all policyholders or all the policyholders and creditors of such insurer. Such certificate shall list the securities so held and their par or face value.

§ 1320. Deposits by alien insurers; statutory deposits. (a) No alien insurer authorized to do an insurance business in this state shall do such business unless it shall have securities deposited (for the benefit of all its policyholders, or all its policyholders and creditors, in the United States) with the superintendent or with proper state officers of other states, or held as trusteed assets, in an amount at least equal to one hundred fifty per centum of the capital required to be maintained by a domestic stock insurer licensed to do the same kinds of insurance. In any event the deposit with the superintendent shall at least equal:

(1) if such insurer is licensed in this state to do only one kind of insurance, five hundred thousand dollars;

(2) if such insurer is licensed in this state to do two or more kinds of insurance, an amount equal to the lesser of the capital required to be maintained by a domestic stock insurer licensed to do the same kinds of insurance, or one million dollars.

(b) Notwithstanding the foregoing, any alien insurer initially licensed to do an insurance business in this state prior to July first, nineteen hundred eighty-two shall have securities deposited or held as trusteed assets, as provided in subsection (a) hereof in an amount at least equal to fifty percent of the deposit requirements applicable to an alien insurer initially authorized to do an insurance business in

this state on or after July first, nineteen hundred eighty-two.

(c) Any licensed alien insurer may make additional deposits with the superintendent in order to comply with this section or section one thousand three hundred twelve of this article.

(d) In any financial statement of a United States branch of any such alien insurer the item corresponding to capital stock of a domestic stock corporation shall be termed its "statutory deposit" and shall be in an amount equal to the deposit required to comply with the provisions of subsection (a) or (b) hereof.

§ 1321. Commutation of reinsurance agreements. (a) If the superintendent finds that a domestic insurer or a United States branch of an alien insurer entered through this state is impaired or insolvent within the meaning of this chapter, the superintendent may permit such insurer to utilize commutations of reinsurance agreements to eliminate the impairment or insolvency, provided that such commutations are approved by the superintendent in accordance with standards prescribed by regulation.

(b) For purposes of this section, commutation of a reinsurance agreement is the elimination of all present and future obligations between the parties, arising from the reinsurance agreement, in exchange for a current consideration.

(c) Nothing herein contained shall preclude the superintendent from proceeding against such insurer under any other provision of this chapter.

§ 1322. Risk-based capital for life insurance companies, accident and health insurance companies, corporations organized pursuant to article forty-three of this chapter, and certain health maintenance organizations. (a) Definitions. In this section:

(1) "Adjusted RBC report" means a RBC report which has been adjusted by the superintendent in accordance with paragraph three of subsection (c) of this section.

(2) "Corrective order" means an order issued by the superintendent specifying corrective actions which the superintendent has determined

are required.

(3) "Domestic insurer" means any authorized life insurance company or accident and health insurance company incorporated or organized under any law of this state; corporation organized pursuant to article forty-three of this chapter; or health maintenance organization domiciled in this state and certified or operating in at least one other state.

(4) "Foreign insurer" means any authorized life insurance company or accident and health insurance company incorporated or organized under the laws of any state, other than this state.

(5) "Negative trend" means a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions defined in paragraph seven of this subsection.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including risk-based capital instructions, which in addition to any other matter which may be required to be stated therein, either by law or by the superintendent pursuant to law, shall conform substantially to the form of the report and instructions adopted from time to time for such purpose by, or by the authority of, the National Association of Insurance Commissioners, together with such additions, omissions or modifications, similarly adopted from time to time, as may be approved by the superintendent.

(8) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(A) "Company action level RBC" means the product of 2.0 and the insurer's authorized control level RBC;

(B) "Regulatory action level RBC" means the product of 1.5 and the insurer's authorized control level RBC;

(C) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(D) "Mandatory control level RBC" means the product of .70 and the insurer's authorized control level RBC.

(9) "RBC plan" means a comprehensive financial plan containing the elements specified in paragraph two of subsection (d) of this section. If the superintendent rejects the RBC plan, and it is revised by the insurer, with or without the superintendent's recommendation, the plan

shall be called the "Revised RBC plan."

(10) "RBC report" means the report required in subsection (c) of this section.

(11) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus; and

(B) Such other items, if any, as the RBC instructions may provide.

(b) Applicability. This section shall apply to every authorized life insurance company and accident and health insurance company incorporated or organized under any law of this state; corporation organized pursuant to article forty-three of this chapter; or health maintenance organization domiciled in this state and certified or operating in at least one other state.

(c) RBC reports. (1) Every domestic insurer other than a health maintenance organization domiciled in this state and certified or operating in at least one other state shall, on or prior to each March fifteenth, and every such health maintenance organization, on or prior to each April fifteenth (the "filing date"), prepare and submit to the superintendent a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, the insurer shall file the RBC report:

(A) With the National Association of Insurance Commissioners in accordance with the RBC instructions; and

(B) With the insurance commissioner in any state in which the insurer is authorized to do business, upon the written request of the insurance commissioner. The insurer shall file the RBC report by the later of:

(i) The filing date; or

(ii) Fifteen days after the date of the request.

(2) An insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall be determined in each case by applying the factors in the manner set forth in the RBC instructions, and shall take into account (and may adjust for the covariance between):

(A) The risk with respect to the insurer's assets;

(B) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(C) The interest rate risk with respect to the insurer's business; and

(D) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) If a domestic insurer files a RBC report which the superintendent determines is inaccurate, then the superintendent shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "Adjusted RBC report."

(d) Company action level event. (1) "Company action level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of a RBC report indicating that: (i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) (I) The insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of 3.0 and its authorized control level RBC; and

(II) there is a negative trend;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in item (i) or (ii) of subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section; or

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in item (i) or (ii) of subparagraph (A) of this paragraph, then the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(2) If there is a company action level event, the domestic insurer shall prepare and submit to the superintendent a RBC plan which:

(A) Identifies the conditions in the insurer which contribute to the company action level event;

(B) Contains proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(C) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence

of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, and capital and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(D) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(E) Identifies the quality of, and problems associated with, the insurer's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance.

(3) The RBC plan shall be submitted within forty-five days after the occurrence of the company action level event.

(4) (A) Within sixty days after the submission by an insurer of a RBC plan to the superintendent, the superintendent shall notify the insurer whether the RBC plan is satisfactory, unsatisfactory, or unacceptable.

(B) If the RBC plan is satisfactory, the insurer shall implement it.

(C) If the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory to the superintendent. Upon notification from the superintendent, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the superintendent, and shall submit the revised RBC plan to the superintendent:

(i) Within forty-five days after the notification from the superintendent; or

(ii) If, under subsection (h) of this section, the insurer challenges the notification from the superintendent, within forty-five days after a notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(D) If the RBC plan is unacceptable because it does not adequately address all of the elements specified in paragraph two of this subsection, the notification to the insurer shall set forth the reasons for the determination and shall state that the notification constitutes a regulatory action level event.

(5) (A) Every domestic insurer that files a RBC plan or revised RBC

plan with the superintendent shall file a copy with the insurance commissioner of any state in which the insurer is authorized to do business, upon the written request of the insurance commissioner, if the state has a RBC provision substantially similar to paragraph one of subsection (i) of this section.

(B) The insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) The date on which the RBC plan or revised RBC plan is filed under paragraph three or four of this subsection; or

(ii) Fifteen days after the date of the request.

(e) Regulatory action level event. (1) "Regulatory action level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of a RBC report indicating that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section;

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge;

(D) The failure of the insurer to timely file a RBC report, unless the insurer provides the superintendent with a satisfactory explanation for the failure and cures the failure within ten days after the filing date;

(E) The failure of the insurer to timely submit a RBC plan or a revised RBC plan to the superintendent;

(F) Notification by the superintendent that the RBC plan is unacceptable or the revised RBC plan is unsatisfactory, provided the insurer does not challenge the determination under subsection (h) of this section;

(G) If, under subsection (h) of this section, the insurer challenges a determination by the superintendent under subparagraph (F) of this paragraph, the notification by the superintendent to the insurer that

the superintendent has, after a hearing, rejected the challenge;

(H) Notification by the superintendent to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, and that the failure has a substantial adverse effect on the insurer's ability to eliminate the company action level event, provided the insurer does not challenge the determination under subsection (h) of this section; or

(I) If, under subsection (h) of this section, the insurer challenges a determination by the superintendent under subparagraph (H) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the challenge.

(2) If there is a regulatory action level event, the superintendent shall:

(A) Require the insurer to prepare and submit a RBC plan or, if applicable, a revised RBC plan, unless the RBC plan is unacceptable (in which case the superintendent may require a revised RBC plan) or the revised RBC plan has already been submitted;

(B) Perform such examination or analysis as the superintendent deems necessary of the assets, liabilities and operations of the insurer, including a review of the RBC plan or revised RBC plan; and

(C) Subsequent to the examination or analysis, issue a corrective order.

(3) In determining corrective actions, the superintendent may take into account such factors as are deemed relevant, based upon the superintendent's examination or analysis of the assets, liabilities and operations of the insurer, including the results of any sensitivity tests undertaken pursuant to the RBC instructions.

(4) The RBC plan or revised RBC plan shall be submitted:

(A) Within forty-five days after the occurrence of the regulatory action level event; or

(B) If, under subsection (h) of this section, the insurer challenges the superintendent's determination that a RBC plan is unsatisfactory, within forty-five days after notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(5) The superintendent may retain actuaries, investment experts and other consultants as the superintendent deems necessary to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer, and formulate the corrective

order. The fees, costs and expenses relating to consultants shall be borne by the affected insurer as directed by the superintendent.

(f) Authorized control level event. (1) "Authorized control level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of a RBC report indicating that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section;

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge;

(D) The failure of the insurer to respond, in a manner satisfactory to the superintendent, to a corrective order, provided the insurer has not challenged the corrective order under subsection (h) of this section; or

(E) If, under subsection (h) of this section, the insurer challenges a corrective order and the superintendent, after a hearing, rejects the challenge or modifies the corrective order, the failure of the insurer to respond, in a manner satisfactory to the superintendent, to the corrective order subsequent to rejection or modification by the superintendent.

(2) If there is an authorized control level event, the superintendent shall take such actions as are:

(A) Required under subsection (e) of this section regarding an insurer with respect to which a regulatory action level event has occurred; or

(B) Necessary to cause the insurer to be placed under rehabilitation or liquidation under article seventy-four of this chapter.

(g) Mandatory control level event. (1) "Mandatory control level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of a RBC report, indicating that the insurer's total adjusted capital is less than its mandatory control level RBC;

(B) Notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section; or

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(2) If there is a mandatory control level event, the superintendent shall take such actions as are necessary to cause the insurer to be placed under rehabilitation or liquidation under article seventy-four of this chapter. However, the superintendent may forgo action for up to ninety days after the occurrence of a mandatory control level event if the superintendent determines that there is a reasonable expectation that the mandatory control level event may be eliminated within the period.

(h) Hearings. (1) A domestic insurer shall have the right to a hearing upon notification to the insurer by the superintendent;

(A) Of an adjusted RBC report;

(B) That the insurer's RBC plan is unsatisfactory or unacceptable or the revised RBC plan is unsatisfactory;

(C) That the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event; or

(D) Of a corrective order.

(2) If a hearing is requested within five days after the superintendent gives a notification specified in paragraph one of this subsection, the superintendent shall give notice and a hearing in accordance with the provisions of article three of this chapter.

(3) The superintendent shall set a date for the hearing, which date shall be no less than ten nor more than thirty days after the date of the insurer's hearing request.

(i) Confidentiality and prohibition on announcements. (1) All RBC reports and adjusted RBC reports (to the extent the information therein is not required to be set forth in a publicly available annual statement

schedule), RBC plans, revised RBC plans, results or report of any examination or analysis of an insurer performed pursuant hereto, and corrective orders filed with or issued by the superintendent contain information that may be damaging to the insurer if made available to its competitors, and shall be confidential and not made public or subject to subpoena, except to the extent the superintendent finds release of information necessary to protect the public.

(2)(A) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally, and the use of the information to rank insurers may be misleading to the general public.

(B) Except as otherwise required under the provisions of this section, no authorized insurer, licensed insurance agent, licensed insurance broker, or any person on behalf of the insurer, agent or broker, or any other person licensed pursuant to this chapter shall, make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation.

(C) Notwithstanding subparagraph (B) of this paragraph, if a materially false or inappropriate statement, comparing an insurer's total adjusted capital or other amount to one or more of its RBC levels, is published in a written publication, and the insurer is able to demonstrate to the superintendent the falsity or inappropriateness of the statement, then the insurer may publish an announcement in a written publication to rebut the statement.

(j) Foreign insurers. (1) A foreign insurer shall, upon the written request of the superintendent, submit to the superintendent a RBC report as of the end of the calendar year just ended by the later of:

(A) The date a RBC report would be required to be filed by a domestic insurer under this section; or

(B) Fifteen days after the date of the request.

(2) A foreign insurer shall, upon the written request of the superintendent, within five days, submit to the superintendent a copy of its RBC plan or revised RBC plan that is filed with the insurance commissioner of any other state.

(3) (A) If there is a company action level event, regulatory action level event, or authorized control level event, and the insurance commissioner of the state of incorporation or organization of the insurer does not require the insurer to file a RBC plan, the superintendent may require the insurer to file an RBC plan with the superintendent within forty-five days of the superintendent's notification.

(B) If the RBC plan is unsatisfactory or if the insurer fails to timely file the RBC plan with the superintendent, the superintendent may order the insurer not to issue any new insurance policies or contracts in this state.

(4) If there is a mandatory control level event, the superintendent may make application under article seventy-four of this chapter.

(k) Notices. Unless a later date is specified, any notice by the superintendent to an insurer under this section which may result in regulatory action hereunder shall be effective upon delivery, except that, if the notice is mailed, it shall be effective three days after it is mailed.

(l) Phase-in provision. For RBC reports required to be filed in nineteen hundred ninety-four with respect to calendar year nineteen hundred ninety-three, the following requirements shall apply to the provisions of subsections (d), (e), (f) and (g) of this section:

(1) In the event of a company action level event with respect to a domestic insurer, the superintendent shall take no regulatory action hereunder.

(2) In the event of a regulatory action level event under subparagraph (A), (B) or (C) of paragraph one of subsection (e) of this section the superintendent shall take the actions required under subsection (d) of this section.

(3) In the event of a regulatory action level event under subparagraph (D), (E), (F), (G), (H) or (I) of paragraph one of subsection (e) of this section or an authorized control level event, the superintendent shall take the actions required under subsection (e) of this section

with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the superintendent shall take the actions required under subsection (f) of this section with respect to the insurer.

§ 1323. Issuance of capital notes by domestic life insurance companies. (a) A domestic life insurance company may at any time or from time to time issue capital notes pursuant to this section in an aggregate principal amount not exceeding (1) twenty-five percent of its total adjusted capital (including the aggregate principal amount of outstanding notes) as of the end of the immediately preceding calendar year, less (2) the aggregate principal amount of outstanding notes; provided, however, that capital notes shall not be issued for an aggregate principal amount which would cause the aggregate principal amount of all such insurer's capital notes scheduled to mature in any calendar year to exceed five percent, or the aggregate principal amount of all such insurer's capital notes scheduled to mature in any three consecutive calendar years to exceed twelve percent, of the insurer's total adjusted capital as of the end of the calendar year immediately preceding the issuance of such capital notes. For purposes of this section, outstanding notes shall include the outstanding aggregate principal amount of capital notes issued pursuant to this section and the outstanding aggregate principal amount of advances or borrowings incurred pursuant to section one thousand three hundred seven of this article.

(b) No such insurer shall issue capital notes pursuant to this section unless the terms thereof shall have been approved by the superintendent as not adverse to the interests of the insurer's policyholders.

(c) The insurer shall not pay or redeem the principal amount of any capital notes, make any sinking fund payment or pay any interest on such notes, and such principal, payment and interest shall not become due or payable if, based on the preceding year-end annual statement filed with the superintendent: (1) (A) the insurer's total adjusted capital is less than such insurer's company action level RBC or (B) the insurer's total adjusted capital is less than the product of 2.5 and its authorized control level RBC and there is a negative trend, as determined in

accordance with section one thousand three hundred twenty-two of this article or (2) the aggregate of all such payments or redemptions made during the current calendar year would if made immediately prior to the preceding year-end have caused (A) the insurer's total adjusted capital to be less than such insurer's company action level RBC or (B) the insurer's total adjusted capital at such time to be less than the product of 2.5 and its authorized control level RBC and there is a negative trend, as determined in accordance with section one thousand three hundred twenty-two of this article. Notwithstanding the foregoing, upon request by the insurer, the superintendent may approve, in whole or in part, any such payment or redemption on the capital notes if and at such time or times as in his judgment the financial condition of such insurer warrants. The amount of such redemptions or payments of principal amounts of any capital notes which cannot be made as the result of the provisions of this subsection may accumulate at the rate of interest of the capital notes.

(d) Capital notes issued pursuant to this section: (1) may provide (A) for interest payments at fixed or adjustable rates, sinking fund payments, and payments and redemptions of principal, in each case in accordance with the terms of the capital note and without the prior approval of the superintendent except to the extent that such approval is required pursuant to this subsection or subsection (c) of this section, (B) that such capital notes automatically become due and payable in the event the insurer becomes subject to an order of rehabilitation, liquidation or conservation granted pursuant to a proceeding under article seventy-four of this chapter, and (C) for such other features as the superintendent determines are appropriate for capital notes issued by a life insurance company; and (2) shall provide that if at the end of any calendar year the total amount of such insurer's total adjusted capital (including the aggregate principal amount of outstanding notes) is less than three times the aggregate principal amount of outstanding notes, the superintendent may notify such insurer that the financial condition of such insurer does not warrant the payment or redemption or sinking fund payment, in whole or in part, on the capital notes. Such action by the superintendent shall, without any action on the part of the insurer or any other person, automatically defer such payment or redemption until such time as the

superintendent finds that the financial condition warrants such payment or redemption. The amount of such redemptions or payments of principal amounts of any capital notes so deferred may accumulate at the rate of interest of the capital notes.

(e) Capital notes issued pursuant to this section shall be considered part of such insurer's total adjusted capital but shall not be considered part of such insurer's surplus; provided, however, (1) that, in the case of any capital note maturing fifteen years or less from the year in which such capital note is issued, one-fifth of the aggregate principal amount of such capital note shall be subtracted from total adjusted capital in each year starting with the fifth year immediately preceding the calendar year in which such capital note is scheduled to mature; and (2) that, in the case of any capital note maturing more than fifteen years from the year in which such capital note is issued; one-tenth of the aggregate principal amount of such capital note shall be subtracted from total adjusted capital in each year starting with the tenth year immediately preceding the calendar year in which such capital note is scheduled to mature, and further provided that, in no event shall the amount included in total adjusted capital for any capital note exceed the principal amount, at issue, of such outstanding capital note less the aggregate of all sinking fund payments made on such capital note. Such insurer shall be required to disclose the aggregate principal amount of capital notes then outstanding as a liability on its financial statements filed with the superintendent pursuant to this article.

(f) As used in this section, the terms "total adjusted capital", "company action level RBC" and "authorized control level RBC" shall have the same meanings as set forth with respect to such terms in section one thousand three hundred twenty-two of this article.

§ 1324. Risk-based capital for property/casualty insurance companies. (a) Definitions. In this section:

(1) "Adjusted RBC report" means an RBC report which has been adjusted by the superintendent in accordance with paragraph two of subsection (c) of this section.

(2) "Corrective order" means an order issued by the superintendent specifying corrective actions which the superintendent has determined

are required.

(3) "Domestic insurer" means any authorized property/casualty insurance company either incorporated or organized under any law of this state or, in the case of a United States branch of an alien insurer, entered into the United States through this state.

(4) "Foreign insurer" means any authorized property/casualty insurance company either incorporated or organized under the laws of any state, other than this state, or in the case of a United States branch of an alien insurer, entered into the United States through any state other than this state.

(5) "Property/casualty insurance company" means any property/casualty insurance company or United States branch of an alien insurer licensed under article forty-one of this chapter, any reciprocal insurer licensed under article sixty-one of this chapter or any advance premium corporation or assessment corporation organized and licensed under article sixty-six of this chapter.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including risk-based capital instructions in effect as of December thirty-first, two thousand four as issued by the national association of insurance commissioners, and which in addition to any other matter which may be required to be stated therein, either by law or by the superintendent pursuant to law, shall conform substantially to the form of the report and instructions adopted from time to time for such purpose by, or by the authority of, the national association of insurance commissioners, together with such additions, omissions, or modifications, similarly adopted from time to time, as may be approved by the superintendent.

(8) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(A) "Company action level RBC" means the product of 2.0 and the insurer's authorized control level RBC;

(B) "Regulatory action level RBC" means the product of 1.5 and the insurer's authorized control level RBC;

(C) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(D) "Mandatory control level RBC" means the product of .70 and the insurer's authorized control level RBC.

(9) "RBC plan" means a comprehensive financial plan containing the elements specified in paragraph two of subsection (d) of this section. If the superintendent rejects the RBC plan, and it is revised by the insurer, with or without the superintendent's recommendation, the plan shall be called the "revised RBC plan".

(10) "RBC report" means the report required in subsection (c) of this section.

(11) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus; and

(B) Such other items, if any, as the RBC instructions may provide.

(b) Applicability. (1) This section shall apply to every property/casualty insurance company, unless exempted under paragraph two of this subsection.

(2) Except as set forth in subparagraph (C) of this paragraph, with prior written approval, the superintendent may exempt from the provisions of this section a non-stock domestic property/casualty insurance company which:

(A)(i) Writes no direct business outside of this state;

(ii) Writes direct annual premiums of twenty million dollars or less; and

(iii) Assumes reinsurance premiums in an amount that is less than five percent of total direct premiums written; or

(B)(i) Has total direct premiums comprised of at least ninety percent medical malpractice liability insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter;

(ii) Assumes reinsurance premiums in an amount that is less than five percent of total direct premiums written; and

(iii) Writes ninety percent of its total direct premiums in this state.

(C) The exemptions permitted under subparagraphs (A) and (B) of this paragraph shall not apply to an insurer which:

(i) Is controlled by another insurer;

(ii) Owns or controls another insurer, unless the insurer that is owned or controlled is subject to the provisions of this section,

section one thousand three hundred twenty-two or section one thousand three hundred twenty-five of this article, as added by a chapter of the laws of 2007, or a substantially similar provision in another jurisdiction;

(iii) Is under common control of a person that controls another insurer; or

(iv) Is a party to a pooling agreement wherein risks underwritten by parties to the agreement are apportioned to the parties in a predetermined manner.

(c) RBC reports. (1) Every domestic insurer shall, on or prior to each March first (the "filing date"), prepare and submit to the superintendent a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, the insurer shall file the RBC report:

(A) With the National Association of Insurance Commissioners in accordance with the RBC instructions; and

(B) With the insurance commissioner in any state in which the insurer is authorized to do business, upon the written request of the insurance commissioner. The insurer shall file the RBC report by the later of:

(i) The filing date; or

(ii) Fifteen days after the date of the request.

(2) If a domestic insurer files an RBC report which the superintendent determines is inaccurate, then the superintendent shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report".

(d) Company action level event. (1) "Company action level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of an RBC report indicating that the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section;

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge; or

(D) The filing by the insurer of an RBC report indicating that the insurer has total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of three point zero and its authorized control level RBC, and with a combined ratio greater than one hundred twenty percent as determined in accordance with the trend test calculation in the RBC instructions.

(2) If there is a company action level event, the domestic insurer shall prepare and submit to the superintendent an RBC plan which:

(A) Identifies the conditions which contribute to the company action level event;

(B) Contains proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(C) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, and capital and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(D) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(E) Identifies the quality of, and problems associated with, the insurer's business, including its assets, liabilities, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance.

(3) The RBC plan shall be submitted within forty-five days after the occurrence of the company action level event.

(4)(A) Within sixty days after the submission by an insurer of an RBC plan to the superintendent, the superintendent shall notify the insurer whether the RBC plan is satisfactory or unsatisfactory.

(B) If the RBC plan is satisfactory, the insurer shall implement it.

(C) If the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory to the superintendent. Upon notification from the superintendent, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the superintendent, and shall submit the revised RBC plan to the superintendent:

(i) Within forty-five days after the notification from the superintendent; or

(ii) If, under subsection (h) of this section, the insurer challenges the notification from the superintendent, within forty-five days after a notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(5) If there is a company action level event, the superintendent may limit the premium writings of the insurer.

(6)(A) Every domestic insurer that files an RBC plan or revised RBC plan with the superintendent shall file a copy with the insurance commissioner of any state in which the insurer is authorized to do business, upon the written request of the insurance commissioner, if the state has an RBC provision substantially similar to paragraph one of subsection (i) of this section.

(B) The insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) The date on which the RBC plan or revised RBC plan is filed under paragraph three or four of this subsection; or

(ii) Fifteen days after the date of the request.

(e) Regulatory action level event. (1) "Regulatory action level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of an RBC report indicating that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section;

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge;

(D) The failure of the insurer to timely file an RBC report, unless the insurer provides the superintendent with a satisfactory explanation for the failure or cures the failure within ten days after the filing date;

(E) The failure of the insurer to timely submit an RBC plan or a revised RBC plan to the superintendent;

(F) Notification by the superintendent that the revised RBC plan is unsatisfactory, provided the insurer does not challenge the determination under subsection (h) of this section;

(G) If, under subsection (h) of this section, the insurer challenges a determination by the superintendent under subparagraph (F) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the challenge;

(H) Notification by the superintendent to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan or that the insurer has failed to attain the amount of capital projected in the RBC plan or revised RBC plan, and that the failure of either has a substantial adverse effect on the insurer's ability to eliminate the company action level event, provided the insurer does not challenge the determination under subsection (h) of this section; or

(I) If, under subsection (h) of this section, the insurer challenges a determination by the superintendent under subparagraph (H) of this paragraph, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the challenge.

(2) If there is a regulatory action level event, the superintendent shall:

(A) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(B) Perform such examination or analysis as the superintendent deems necessary of the assets, liabilities, and operations of the insurer, including a review of the RBC plan or revised RBC plan; and

(C) Subsequent to the examination or analysis, issue a corrective

order.

(3) In determining corrective actions, the superintendent may take into account such factors as are deemed relevant, based upon the superintendent's examination or analysis of the assets, liabilities and operations of the insurer.

(4) The RBC plan or revised RBC plan shall be submitted:

(A) Within forty-five days after the occurrence of the regulatory action level event; or

(B) If, under subsection (h) of this section, the insurer challenges the superintendent's determination that an RBC plan is unsatisfactory, within forty-five days after notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(5) The superintendent may retain actuaries, investment experts, and other consultants as the superintendent deems necessary to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer, and formulate the corrective order. The fees, costs and expenses relating to consultants shall be borne by the affected insurer as directed by the superintendent.

(6) If there is a regulatory action level event, the superintendent may limit the premium writings of the insurer.

(f) Authorized control level event. (1) "Authorized control level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of an RBC report indicating that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(B) The notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section;

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge;

(D) The failure of the insurer to respond, in a manner satisfactory to the superintendent, to a corrective order, provided the insurer has not

challenged the corrective order under subsection (h) of this section; or

(E) If, under subsection (h) of this section, the insurer challenges a corrective order and the superintendent, after a hearing, rejects the challenge or modifies the corrective order, the failure of the insurer to respond, in a manner satisfactory to the superintendent, to the corrective order subsequent to rejection or modification by the superintendent.

(2) If there is an authorized control level event, the superintendent shall take such actions as are:

(A) Required under subsection (e) of this section regarding an insurer with respect to which a regulatory action level event has occurred; or

(B) Necessary to cause the insurer to be placed under rehabilitation or liquidation under article seventy-four of this chapter.

(g) Mandatory control level event. (1) "Mandatory control level event" means, with respect to a domestic insurer:

(A) The filing by the insurer of an RBC report, indicating that the insurer's total adjusted capital is less than its mandatory control level RBC;

(B) Notification by the superintendent to the insurer of an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, provided the insurer does not challenge the adjusted RBC report under subsection (h) of this section; or

(C) If, under subsection (h) of this section, the insurer challenges an adjusted RBC report that indicates the occurrence of an event described in subparagraph (A) of this paragraph, notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge.

(2)(A) If there is a mandatory control level event, except as set forth in subparagraph (B) of this paragraph, the superintendent shall take such actions as are necessary to cause the insurer to be placed under rehabilitation or liquidation under article seventy-four of this chapter.

(B) The superintendent may forgo action set forth in subparagraph (A) of this paragraph after the occurrence of a mandatory control level event if:

(i) The insurer has demonstrated within a ninety day period that the

mandatory control level event will be eliminated under a plan approved by the superintendent; or

(ii) No business is being written or renewed, any existing policyholder obligations are being run-off under a plan approved by the superintendent and the insurer meets the minimum capital and surplus as otherwise required under this chapter.

(h) Hearings. (1) An insurer shall have the right to a hearing upon notification to the insurer by the superintendent:

(A) Of an adjusted RBC report;

(B) That the insurer's RBC plan is unsatisfactory or the revised RBC plan is unsatisfactory;

(C) That the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event; or

(D) Of a corrective order.

(2) If a hearing is requested within five days after the superintendent gives a notification specified in paragraph one of this subsection, the superintendent shall give notice and a hearing in accordance with the provisions of article three of this chapter, except that the hearing, and any report resulting from such hearing, shall be kept confidential in accordance with the provisions of paragraph one of subsection (i) of this section.

(3) The superintendent shall set a date for the hearing, which date shall be no less than ten nor more than thirty days after the date of the insurer's hearing request.

(i) Confidentiality; prohibition on announcements; prohibition on use in rate making; excess of capital over the amount indicated in the RBC report. (1) All RBC plans, revised RBC plans, results or reports of any examination or analysis of an insurer performed pursuant to this section, corrective orders filed with or issued by the superintendent and any report resulting from a hearing held pursuant to subsection (h) of this section contain information that may be damaging to the insurer if made available to its competitors, and shall be confidential and not made public or subject to subpoena, except to the extent the superintendent finds release of information necessary to protect the public.

(2)(A) The comparison of an insurer's total adjusted capital to any of

its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally, and the use of the information to rank insurers may be misleading to the general public.

(B) Except as otherwise required under the provisions of this section, no authorized insurer, licensed insurance agent, licensed insurance broker, or any person on behalf of the insurer, agent or broker, or any other person licensed pursuant to this chapter shall make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation.

(C) Notwithstanding subparagraph (B) of this paragraph, if a materially false or inappropriate statement, comparing an insurer's total adjusted capital or other amount to one or more of its RBC levels, is published in a written publication, and the insurer is able to demonstrate to the superintendent the falsity or inappropriateness of the statement, then the insurer may publish an announcement in a written publication to rebut the statement.

(3) RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans shall not be used by the superintendent in determining whether rates comply with standards set forth in this chapter and shall not be considered or introduced as evidence in any hearing involving such standards.

(4) An excess of capital over the amount produced by the RBC requirements contained in this section is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this section. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the RBC requirements contained in this section.

(j) Foreign insurers. (1) A foreign insurer shall, upon the written

request of the superintendent, submit to the superintendent an RBC report, in the same form as required of a domestic insurer, as of the end of the calendar year just ended by the later of:

(A) The date an RBC report would be required to be filed by a domestic insurer under this section; or

(B) Fifteen days after the date of the request.

(2) A foreign insurer shall, upon the written request of the superintendent, within five days, submit to the superintendent a copy of its RBC plan or revised RBC plan that is filed with the insurance commissioner of any other state.

(3)(A) If there is a company action level event, regulatory action level event, or authorized control level event, and the insurance commissioner of the state of incorporation or organization of the insurer does not require the insurer to file an RBC plan, the superintendent may require the insurer to file an RBC plan, in the same form as required of a domestic insurer, with the superintendent within forty-five days of the superintendent's notification.

(B) If the RBC plan is unsatisfactory or if the insurer fails to timely file the RBC plan with the superintendent, the superintendent may order the insurer not to issue any new insurance policies or contracts in this state.

(4) If there is an authorized control level event or a mandatory control level event, the superintendent may make application under article seventy-four of this chapter.

(k) Notices. Unless a later date is specified, any notice by the superintendent to an insurer under this section which may result in regulatory action hereunder shall be effective upon delivery, except that, if the notice is mailed, it shall be effective three days after it is mailed.

§ 1325. Exemption. For the purposes of exempting certain insurance companies from the provisions of section one thousand three hundred twenty-four of this article, the superintendent shall exempt, through December thirty-first, two thousand twenty-eight, those stock and non-stock insurance companies to which subparagraph (B) of paragraph two of subsection (b) of such section applies.

ARTICLE 14

INVESTMENTS

Section 1401. Definitions and rules of general application.
1402. Minimum capital or minimum surplus to policyholder investments.
1403. Reserve and other investments; certain requirements.
1404. Types of reserve investments permitted for non-life insurers.
1405. Investments of life insurers.
1406. Policy loans.
1407. Non-reserve and prohibited investments for property/casualty and certain other insurers.
1408. Acquisition of insurance company shares; limitations thereon.
1409. Limitation of investments.
1410. Derivative transactions and derivative instruments.
1411. Authorization of, and restrictions on, investments.
1412. Disposal or deduction of investments unlawfully acquired.
1413. Investments of foreign and alien insurers.
1414. Valuation of investments.
1415. Investments of domestic insurers in persons included on list of persons engaged in investment activities in Iran treated as nonadmitted assets.

§ 1401. Definitions and rules of general application. (a) In this article: (1) "Invested assets" means the admitted assets of an insurer that conform to the requirements of paragraphs one and two of subsection (a) of section one thousand three hundred one of this chapter, but excluding the income due or accrued thereon.

(2) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent thereto) by a nationally recognized securities rating agency and either:

(A) represents ownership of one or more promissory notes or certificates of interest or participation in such notes (including any

rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of such notes, certificates, or participation of amounts payable under, such notes, certificates, or participation), which notes:

(i) are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in section 5402(6) of Title 42 of the U.S.C.A., whether such manufactured home is considered real or personal property under the laws of the state in which it is to be located; and

(ii) were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution which is supervised and examined by a federal or state authority, or by a mortgage approved by the secretary of housing and urban development pursuant to sections 1709 and 1715-b of Title 12 of the U.S.C.A., or, where such notes involve a lien on the manufactured home, by any such institution or by any financial institution approved for insurance by the secretary of housing and urban development pursuant to section 1703 of Title 12 of the U.S.C.A.; or

(B) is secured by one or more promissory notes or certificates of interest or participations in such notes (with or without recourse to the issuer thereof) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of items (i) and (ii) of subparagraph (A) of this paragraph or certificates of interest or participation in promissory notes meeting such requirements.

For the purpose of this paragraph the term "promissory note", when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidence by a retail installment sales contract or other instrument.

(3) "Partnership interests" when used in connection with the permissible types of investments made by any domestic insurer, other than a domestic life insurer, means, an interest as a limited partner in a limited partnership. A "limited partnership" means a partnership formed by two or more persons pursuant to the provisions of the

applicable law, having as members one or more general partners and one or more limited partners. The limited partners as such shall not be bound by the obligations of the partnership.

(4) "United States" means, when used to signify place, only the states of the United States, the Commonwealth of Puerto Rico, the District of Columbia and includes lands and waters adjacent to the foregoing and under the jurisdiction of the United States.

(5) "Cap" means an agreement obligating the seller to make payments to the buyer with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(6) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

(7) "Derivative instrument" means an agreement, option, instrument or a series or combination thereof:

(A) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(B) that has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

The term "derivative instrument" includes options, warrants, caps, floors, collars, swaps, swaptions, forwards, and futures.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(9) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

(10) "Forward" means an agreement (other than a future) to make or take delivery in the future of one or more underlying interests, or effect a cash settlement, based on the actual or expected price, level, performance or value of such underlying interests, but shall not mean or

include spot transactions effected within customary settlement periods, when-issued purchases, or other similar cash market transactions.

(11) "Future" means agreement traded on a futures exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(12) "Hedging transaction" means a derivative transaction which is entered into and at all times maintained to reduce:

(A) the risk of economic loss due to a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) the risk of economic loss due to changes in the currency exchange rate or the degree of exposure as to assets or liabilities denominated in a foreign currency which an insurer has acquired or incurred or anticipates acquiring or incurring.

(13) "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate or effect a cash settlement based on the actual or expected price, spread, level, performance or value of one or more underlying interests.

(14) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance or value of one or more underlying interests.

(15) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. A swaption does not mean a swap with an embedded option.

(16) "Underlying interest" means the assets, liabilities, other interests, or a combination thereof, underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities or derivative instruments.

(17) "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement.

(18) "Replication transaction" means a derivative transaction or combination of derivative transactions effected either separately or in conjunction with cash market investments included in the insurer's investment portfolio in order to replicate the investment characteristic

of another authorized transaction, investment or instrument and/or operate as a substitute for cash market transactions. A derivative transaction entered into by the insurer as a hedging transaction or income generation transaction authorized pursuant to this section shall not be considered a replication transaction.

(b) All financial tests and other requirements for the making of any investment are satisfied if complied with on the date of acquisition by the insurer, except as otherwise permitted by this chapter or by regulation.

(c) None of the financial tests or other requirements for the making of any investment under this article, or as otherwise required by this chapter or by regulation promulgated pursuant thereto, are preempted by the provisions of section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. § 77r-1)("SMMEA"). The provisions of this chapter and any regulation promulgated pursuant thereto that pertain to investments in the categories of securities specified in paragraphs one and two of subsection (a) of section 106 of such act shall remain in full force and effect notwithstanding the enactment of SMMEA.

§ 1402. Minimum capital or minimum surplus to policyholder investments. (a) Before investing its funds in any other investments, every domestic insurer shall invest and maintain an amount equal to the greater of the minimum capital required by law or the minimum surplus to policyholders required to be maintained by law for a domestic stock corporation authorized to transact the same kinds of insurance, only in investments of the types specified in this section which are not in default as to principal or interest. Investments equal in value, determined pursuant to section one thousand four hundred fourteen of this article, to such amount and of such types shall at all times be maintained free and clear from any security interest other than as impressed upon a deposit with any government within the United States for the security of all policyholders or all policyholders and creditors of the insurer or upon trusteed assets held in trust for the security of all policyholders and creditors of the insurer.

(b) Not less than sixty percent of the amount of the required minimum

capital or surplus to policyholder investments shall consist of the types specified in paragraphs one and two hereof:

(1) Obligations of the United States or of any agency thereof provided such agency obligations are guaranteed as to principal and interest by the United States.

(2) Direct obligations of this state or of any county, district or municipality thereof.

(3) Direct obligations of any state of the United States.

(4) Obligations secured by first mortgage loans which meet the standards specified in paragraph four of subsection (a) of section one thousand four hundred four of this article on property located in this state.

§ 1403. Reserve and other investments; certain requirements. (a) If the requirements of section one thousand four hundred two of this article are met:

(1) any domestic life insurance company may invest its funds in, or otherwise acquire, or loan upon, only the types of investments specified in section one thousand four hundred two, this section, sections one thousand four hundred five, one thousand four hundred six, one thousand four hundred ten, four thousand two hundred forty and article seventeen of this chapter, subject to the limitations therein contained. The provisions of section one thousand four hundred four of this article shall not have any application to investments of life insurance companies, except to the extent provided in paragraph four of subsection (b) of section one thousand four hundred two of this article;

(2) any domestic corporation subject to article forty-three or sixty-four of this chapter and any domestic fraternal benefit society subject to article forty-five of this chapter may invest its funds in, or otherwise acquire, or loan upon, only the types of investments specified in section one thousand four hundred two, this section and section one thousand four hundred four of this article, except as may be modified by said article forty-three or sixty-four of this chapter as to corporations organized thereunder or by article forty-five of this chapter as to societies organized thereunder. Any such corporation subject to article forty-three or any such society governed by

subsection (a) of section forty-five hundred twenty-nine of this chapter may also invest in, or otherwise acquire, subsidiaries to the extent permitted by subsection (b) of section one thousand seven hundred one of this chapter. Any such fraternal benefit society may also make policy loans under section one thousand four hundred six of this article.

(b) A domestic charitable annuity society, the investments of which are subject to the provisions of section eleven hundred ten of this chapter, may invest such of its assets (the investment of which is controlled by section eleven hundred ten) in, or otherwise acquire, or loan upon, only the types of securities specified in section one thousand four hundred two, this section and section one thousand four hundred four of this article. A retirement system subject to the provisions of article forty-six of this chapter may invest its funds only as provided in article forty-six of this chapter. In addition, a retirement system subject to article forty-six may acquire subsidiaries under article seventeen of this chapter and may establish separate accounts under section four thousand two hundred forty of this chapter, in each case to the extent permitted by article forty-six of this chapter.

(c) If the requirements of section one thousand four hundred two of this article are met, any domestic insurer, other than an insurer subject to subsection (a) or (b) of this section, may, except as set forth below, invest its funds in, or otherwise acquire, or loan upon, only the types of investments specified in such section, this section and subsection (a) of section one thousand four hundred four of this article (except paragraphs eight and ten of subsection (a) of such section); provided that any such domestic insurer may also invest its funds in, or otherwise acquire or loan upon investments permitted under sections one thousand four hundred seven (including investments of the classes described in paragraphs eight and ten of subsection (a) of section one thousand four hundred four), section one thousand four hundred eight of this article and article sixteen of this chapter, so long as it maintains cash, investments required by section one thousand four hundred two of this article and reserve investments under subsection (a) of section one thousand four hundred four of this article, free from any lien or pledge, which, when valued in accordance with the provisions of this chapter, shall at least equal fifty percent

of the aggregate amount of its unearned premium, loss and loss adjustment expense reserves as shown by its last sworn statement, annual or quarterly, on file with the superintendent. If an insurer, other than an accident and health insurance company, maintains cash, investments required by section one thousand four hundred two of this article and reserve investments under subsection (a) of section one thousand four hundred four of this article, free from any lien or pledge, which, when valued in accordance with the provisions of this chapter, shall at least equal the aggregate of seventy percent of its loss and loss adjustment expense reserves and fifty percent of its unearned premium reserves as shown by its last sworn statement, annual or quarterly, on file with the superintendent, then such insurer, other than an accident and health insurance company, may in addition enter into the types of transactions set forth in section one thousand four hundred ten of this article, subject to the limitations set forth in such section. The term "lien or pledge" as used in this subsection shall not include any deposit of securities or cash with any government, nor trusteed assets, held in trust for the benefit or protection of all or any class of the policyholders, or policyholders and creditors, of such insurer.

(d) (1) Except for investments referred to in subsection (e) of this section, investments that are neither interest bearing nor income paying shall be purchased or acquired only under, and to the extent permitted by, subsection (b) of section one thousand four hundred four of this article (in the case of insurers that make investments under section one thousand four hundred four of this article other than insurers making investments under the authority of subsection (c) of this section), paragraph eight of subsection (a) of section one thousand four hundred five of this article (in the case of insurers that make investments under section one thousand four hundred five) or section one thousand four hundred seven of this article (in the case of insurers that make investments under the authority of subsection (c) of this section), however, a default in interest or income occurring subsequent to the purchase or other acquisition of an investment shall not affect the allowance thereof as an admitted asset at the market value thereof.

(2)(A) Notwithstanding any other provision of this article, a domestic insurer making investments pursuant to paragraph two of subsection (a) of this section, a domestic charitable annuity society and a retirement

system making investments pursuant to subsection (b) of this section, and a domestic accident and health insurer making investments pursuant to subsection (c) of this section may sell call options on securities, provided that:

(i) such options are traded on a securities exchange registered under the laws of the United States, and

(ii) the insurer holds, or can immediately acquire through the exercise of warrants or conversion rights already owned at a contractually specified price, the underlying securities during the entire period the option is outstanding.

(B) An insurer selling call options on securities pursuant to subparagraph (A) of this paragraph may purchase any such option to offset an outstanding option previously sold by the insurer for the same kind and amount of securities.

(e) (1) Nothing contained in this chapter shall prohibit the acquisition by any insurer of other securities or property (i) received as a dividend or pursuant to a judicial or lawful non-judicial plan of reorganization or dissolution or pursuant to a lawful and bona fide agreement of bulk reinsurance or consolidation; or (ii) received through the exercise of rights of conversion, stock warrants or stock options acquired by it in accordance with this subsection or section one thousand four hundred four, one thousand four hundred five, one thousand four hundred seven or one thousand four hundred ten of this article. Nor shall anything in this chapter prohibit acquisition of (1) an investment permitted under section one thousand four hundred four, one thousand four hundred five, one thousand four hundred seven or one thousand four hundred ten of this article because such investment is convertible into other securities in which such insurer is not permitted to invest under this chapter, or because such insurer receives in connection with such investment stock warrants, whether detachable or non-detachable, stock options, stock, property interests or other assets of any kind or (2) securities or property (real or personal) or any interest therein received in satisfaction of a debt previously owing to such insurer. If any securities or other property received by any insurer in accordance with the first sentence of this paragraph shall consist in whole or in part of shares of any institution or of obligations or other property not meeting the requirements specified in section one thousand four

hundred four (in the case of insurers making investments under the authority of section one thousand four hundred four) or section one thousand four hundred five (in the case of insurers making investments under the authority of section one thousand four hundred five) of this article, then any such shares and any such obligations or property so received shall be disposed of within five years from the time of acquisition or before the expiration of such further period or periods of time as may be prescribed in writing by the superintendent, unless at any time after such acquisition such shares, obligations or property shall have met such requirements and the insurer has notified the superintendent thereof.

(2) Except as otherwise specifically provided in this chapter, investments in subsidiaries are not subject to the provisions of this section, section one thousand four hundred four (except paragraph nine of subsection (a) thereof) or one thousand four hundred five of this article.

(f) (1) Subsidiaries of domestic life insurance companies, whether acquired under subsection (e) of this section, sections one thousand four hundred five, four thousand two hundred forty, or otherwise, shall be subject to the provisions of article seventeen of this chapter to the extent therein provided.

(2) Subsidiaries of domestic corporations subject to article forty-three of this chapter and of domestic retirement systems, whether acquired under subsection (e) of this section, section one thousand four hundred four, four thousand two hundred forty (in the case of retirement systems), or otherwise, shall be subject to the provisions of article seventeen of this chapter to the extent therein provided.

(g) This section does not prohibit any domestic insurance company from acquiring shares under article seventy-one of this chapter or any domestic life insurance company from acquiring shares of its own capital stock pursuant to section seven thousand three hundred two of this chapter.

(h) With respect to all transactions between a domestic insurer and any person, five percent or more of whose voting securities are held, directly or indirectly, by such insurer, but which is not a subsidiary, the insurer shall maintain books, accounts and records that disclose clearly and accurately the nature and detail of such transactions.

(i) (1) Except as provided in subparagraph (A) of paragraph two of subsection (a) of section four thousand two hundred forty of this chapter, investments made for separate accounts under the provisions of section four thousand two hundred forty of this chapter shall be disregarded, and shall be excluded from admitted assets, in applying the quantitative investment limitations contained in this chapter to other investments.

(2) Except as provided in subparagraph (A) of paragraph two of subsection (a) or paragraph four of subsection (a) of section four thousand two hundred forty of this chapter, the restrictions, limitations and other provisions relating to investments specified in this chapter shall not apply to investments made for separate accounts under the provisions of section four thousand two hundred forty of this chapter.

§ 1404. Types of reserve investments permitted for non-life insurers. (a) In addition to the investments specified in subsection (b) hereof, but excluding any investment prohibited by the provisions of paragraph one, three, four, six, eight, nine or ten of subsection (a) of section one thousand four hundred seven of this article, the reserve investments of a domestic insurer authorized to make investments under the authority of this section shall consist of the following:

(1) Government obligations. Obligations which are not in default as to principal or interest, which are valid and legally authorized, and which are issued, assumed, guaranteed or insured by:

(A) the United States or by any agency or instrumentality thereof,

(B) any state of the United States,

(C) any territory or possession of the United States or any other governmental unit in the United States, or

(D) any agency or instrumentality of any governmental unit referred to in subparagraphs (B) and (C) of this paragraph, provided that obligations to be eligible under this paragraph shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment, but in no event shall

obligations be eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements.

(2) Obligations of American institutions.

(A) Obligations which are issued by any solvent American institution or which are assumed or guaranteed by any solvent American institution (other than an insurance company) and which are not in default as to principal or interest provided such obligations:

(i) are adequately secured by collateral security having a market value not less than the principal amount thereof and have investment qualities and characteristics wherein the speculative elements are not predominant, or

(ii) are rated A or higher (or the equivalent thereto) by a securities rating agency recognized by the superintendent, or if not so rated, are similar in structure and in all material respects to other obligations of the same institution which are so rated, or

(iii) are insured by one or more authorized insurance companies (other than the investing insurer or any parent, subsidiary or affiliate of such insurer) who are licensed to insure obligations in this state and, after considering such insurance, are rated Aaa (or the equivalent thereto) by a securities rating agency recognized by the superintendent, or

(iv) have been given the highest quality designation by the Securities Valuation Office of the National Association of Insurance Commissioners.

(B) No investment in or loan upon the obligations of any institution, other than an institution which issues mortgage related securities, and no investment in any one mortgage related security, made pursuant to the provisions of this paragraph shall exceed five per centum of the admitted assets of such insurer as shown by its last statement on file with the superintendent.

(3) Preferred or guaranteed shares of American institutions. (A) Preferred or guaranteed shares issued or guaranteed by a solvent American institution if all of the institution's obligations are eligible as investments under item (ii) or (iv) of subparagraph (A) of paragraph two of this subsection.

(B) No investment in the preferred or guaranteed shares of any institution made pursuant to the provisions of this paragraph shall

exceed two percent of such insurer's admitted assets as shown by its last statement on file with the superintendent.

(4) Loans secured by real property. (A) Loans secured by first or second mortgages which are liens on improved real property in the United States (including leasehold estates having an unexpired term of not less than twenty years, inclusive of the term or terms which may be provided by enforceable terms of renewal) meeting the following requirements:

(i) Priority of mortgages. The mortgaged property shall be subject to no prior lien, except a first mortgage and liens for non-delinquent ground rents, taxes, assessments and similar charges. There shall be no condition or right of re-entry or forfeiture not insured against under which the mortgage can be cut off, subordinated or otherwise disturbed. No loan secured by a second mortgage shall be made if the principal amount secured by a prior first mortgage can be increased without the insurer's consent unless the amount of increase is applied to reduce the second mortgage.

(ii) Leaseholds. If the mortgaged property is a leasehold:

(I) the lease shall provide for a term of at least twenty-one years,

(II) the property underlying the leasehold shall be subject to no prior lien except for liens for non-delinquent ground rents, taxes, assessments and similar charges and there shall be no condition or right of re-entry or forfeiture not insured against under which the insurer is unable to continue the lease in force for the duration of the loan, and

(III) the loan shall provide for such payments that at any time during the period of the loan the aggregate payments of principal to be made will be sufficient to repay the loan within the lesser of forty years or a period equal to eighty percent of the term of the lease, through payments of interest only for five years and equal payments applicable first to interest and then to principal at the end of each year thereafter. "Term", as used in this paragraph six with reference to a lease, means its unexpired term at the date of the loan, plus any term which may be provided by options of the lessee to renew.

(iii) Participations. If the investment is a participation in a loan:

(I) all participations shall be held by the insurer, or

(II) the participation held by the insurer shall give it substantially the rights of a first or second mortgagee, and shall be prior to those of the holders of the other participations, or

(III) each participation shall be of equal rank, and

(aa) the loan shall comply with items (i), (ii), and (iv) of this subparagraph (A) and with any regulations prescribed by the superintendent for investments under this clause (III), and

(bb) if, when the participation is acquired by the insurer, there are more than five holders of participations in the loan, or more than three such holders and such loan is less than five million dollars in original principal amount, the mortgagee shall be (and, in the case of a participation in an obligation, the obligation shall be held by) a bank or trust company duly authorized and licensed to act as a corporate trustee (with or without a co-trustee). "Participation", as used in this paragraph four, means an obligation forming part of an issue of bonds, notes or other evidences of indebtedness which are secured by the same mortgage and also an instrument evidencing a participating interest in any such bond, note or other evidence of indebtedness.

(iv) Amount of loan. The amount of the loan (excluding any part guaranteed or insured under title three of the Servicemen's Readjustment Act of 1944, 38 U.S.C. §§ 1801-1827), when added to the amount unpaid on any prior first mortgage, shall not exceed the following percentages of the value of the real property or leasehold securing the loan, as determined by an appraisal made by an appraiser for the purpose of the investment:

(I) sixty-six and two-thirds percent,

(II) seventy-five percent, if the mortgage provides for such payments of principal that at no time during the period of the loan shall the aggregate payments of principal required to be made be less than would have been necessary to reduce the amount of the loan (plus the amount secured by any such prior mortgage) to sixty-six and two-thirds percent of such value by the end of thirty-five years, through payments of interest only for five years and equal payments applicable first to interest and then to principal at the end of each year thereafter, or

(III) ninety percent, if the loan is secured by a first mortgage on real property improved primarily with a residential building, which may be a condominium unit, for not more than four families and provides for monthly payments of principal and interest sufficient to repay the loan within the lesser of forty years or the remaining useful life of the building as estimated in the appraisal.

(v) Investment limitations.

(I) Investments held by an insurer, except a fraternal benefit society, under this subparagraph (A) shall not exceed:

(aa) in the aggregate twenty-five percent of its admitted assets as shown by its last statement on file with the superintendent excluding any amount guaranteed or insured under the Servicemen's Readjustment Act of 1944, 38 U.S.C. §§ 1801-1827, or

(bb) in the aggregate two percent of its admitted assets as shown by its last statement on file with the superintendent in loans secured by other than first mortgages.

(II) Investments held by a fraternal benefit society under this paragraph shall not exceed:

(aa) in the aggregate fifty percent of its admitted assets as shown by its last statement on file with the superintendent, excluding any amount guaranteed or insured under the Servicemen's Readjustment Act of 1944, 38 U.S.C. §§ 1801-1827, or

(bb) in the aggregate two percent of its admitted assets as shown by its last statement on file with the superintendent in loans secured by other than first mortgages.

(III) No insurer or society shall invest in or lend upon the security of any one property more than the greater of thirty thousand dollars or two percent of its admitted assets as shown by its last statement on file with the superintendent.

(IV) Separate evidences of indebtedness which are separately transferable shall be deemed to constitute separate loans which may be separately qualified under this paragraph whether or not secured by a single mortgage.

(B) Purchase money mortgages. Purchase money mortgages or like securities received by the insurer on the sale or exchange of real property held under paragraph five hereof.

(5) Real property or interests therein. (A) The following investments in real property (including incidental equipment thereto) located in the United States, if acquired and held directly or through partnership interests engaged exclusively in the business of acquiring, owing and managing such property:

(i) The land and the building thereon in which the insurer has its principal office.

(ii) Real property requisite for the insurer's convenient accommodation in the transaction of its business.

(iii) Real property acquired in total or partial satisfaction of mortgages, liens, judgments, claims or indebtedness held by the insurer in the course of its business.

(iv) Real property acquired as an investment for the production of income or to be improved or developed for such investment purpose.

(B) Investments under this paragraph shall be subject to the following limitations:

(i) The cost of each parcel acquired under item (iv) of subparagraph (A) of this paragraph, including the estimated cost to the insurer of the improvement or development thereof, shall not exceed one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, and when added to the book value of all other real property then held by it pursuant to such item (iv), shall not exceed twelve and one-half percent of such admitted assets. Unless otherwise required by the superintendent under subsection (b) of section one thousand four hundred fourteen of this article, each parcel of real property held under such item (iv) together with each capital improvement or development thereof existing at acquisition or made subsequently shall be valued on the insurer's books as of each last year-end so as to write down the cost of such improvement or development, at a rate averaging at least two percent per annum commencing on the date of acquisition or completion, as the case may be, of such improvement or development.

(ii) The acquisition of real property serving as the residence of an employee, except a director or trustee of such insurer, if acquired in connection with the relocation by the insurer of the employee's place of employment, including any relocation in connection with his initial employment, at a purchase price not exceeding the property's value as determined by an independent appraiser for the purpose of such acquisition, provided such employee has made reasonable efforts otherwise to dispose of such property during the month before such acquisition. Such property must be acquired under item (ii) of subparagraph (A) hereof, and, in the case of a non-director officer, such acquisition is subject to the provisions of subsection (h) of section one thousand four hundred eleven of this article.

(iii) Real property acquired pursuant to items (i) and (ii) of subparagraph (A) hereof shall be disposed of within five years after it shall have ceased to be necessary for the convenient accommodation of such insurer in the transaction of its business, and real property acquired pursuant to item (iii) of subparagraph (A) hereof shall be disposed of within five years after the date of acquisition, unless the superintendent certifies that the interests of the insurer will suffer materially by the forced sale thereof and extends the time in such certificate.

(iv) No real property shall be acquired by any domestic insurer pursuant to items (i) and (ii) of subparagraph (A) hereof if its cost, together with the book value of all real property then held pursuant to such items (i) and (ii), exceeds ten percent of the insurer's admitted assets as shown by its last statement on file with the superintendent.

(v) Except with the superintendent's approval, no domestic insurer shall:

(I) acquire any real property pursuant to items (i) and (ii) of subparagraph (A) of this paragraph, if the real property being acquired is greater than one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, or

(II) with respect to any building which was acquired under items (i) and (ii) of subparagraph (A) of this paragraph, make any improvement which should be capitalized according to generally accepted accounting principles if the annual expenditure for such improvements for any such building will exceed the greater of ten percent of its book value or one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent.

(6) Foreign investments. (A) Investments in a foreign country or in a possession of the United States which are substantially of the same kinds, classes and investment grades as those eligible for investment under other provisions of this subsection. The aggregate amount of foreign investments including cash in the currency of such country or possession, obligations of American institutions payable outside of the United States and cash deposited in a bank, trust company or thrift institution located outside of the United States held at any time pursuant to the provisions of this section shall not exceed ten percent of the insurer's admitted assets as shown by its last statement on file

with the superintendent.

(B) Investments in any one possession of the United States or in any one foreign country, other than Canada, made pursuant to this paragraph shall not exceed (i) in the case of any possession or country having the highest sovereign debt rating, as established by a securities rating agency recognized by the superintendent, three percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, or

(ii) in the case of any other possession or country one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent.

(7) Development bank obligations. Obligations issued or guaranteed by the international bank for reconstruction and development, the inter-American development bank, the Asian development bank, the African development bank or the international finance corporation; provided that

(i) obligations of such banks and the international finance corporation are rated AA or higher (or the equivalent thereto) by a securities rating agency recognized by the superintendent, or if not so rated are similar in structure and in all material respects to other obligations of the same institution which are so rated, and

(ii) the aggregate investment made pursuant to the provisions of this paragraph in each such bank and the international finance corporation at any time, shall not exceed five percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, and

(iii) the aggregate investment made pursuant to the provisions of this paragraph in all such banks and the international finance corporation shall not exceed fifteen percent of the insurer's admitted assets as shown by its last statement on file with the superintendent.

(8) Equity interests. (A) Investments in common shares or partnership interests of any solvent American institution, if:

(i) all its obligations and preferred shares, if any, are eligible as investments under this subsection and

(ii) such equity interests of any such institution except an insurance company are registered on a national securities exchange, as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§78a-78kk or otherwise registered pursuant to said act and, if so otherwise registered, price quotations therefor are furnished through a nationwide automated

quotations system approved by the National Association of Securities Dealers, Inc., provided that an insurer may invest under this paragraph an amount not exceeding one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent even though such equity interests are not so registered and are not issued by an insurance company.

(B) Investment limitations. (i) No insurer subject to the provisions of paragraph two of subsection (a) or subsection (b) of section one thousand four hundred three of this article shall invest in or loan upon any one institution's outstanding equity interests an amount exceeding one percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, and (ii) the cost of any investment in equity interests, made pursuant to this paragraph, when added to the aggregate cost of all other investments in equity interests then held pursuant to this paragraph, paragraph six and clause (ii) of subparagraph (A) of paragraph ten of this subsection shall not exceed:

(I) in the case of an insurer authorized to make investments under item (i) of this subparagraph except a retirement system organized pursuant to article forty-six of this chapter, the lesser of its surplus to policyholders or ten percent of its admitted assets as shown by its last statement on file with the superintendent, and

(II) in the case of a retirement system organized pursuant to article forty-six of this chapter, thirty percent of its admitted assets as shown by its last statement on file with the superintendent.

(9) Investments made by subsidiaries. The net investment in real property and loans secured by real property made by subsidiaries engaged or organized to engage exclusively in the acquisition, ownership and management of such investments. Such loans and real property must qualify as a reserve investment under paragraph four or five of this subsection. The subsidiary's net investment in such real property and loans shall be included under such paragraph when computing any limitations applicable to such real property and loans and excluded when computing the limitations applicable to equity interests under paragraph eight of this subsection. In order to qualify, a subsidiary must be wholly-owned either by the insurer or by two or more insurance companies domiciled in the United States who are members of the same holding company system, as such term is defined in article fifteen of this

chapter, and each individual insurer's share of the net investments made by such subsidiary shall be computed in proportion to its equity interest in such subsidiary.

(10) Investment companies. (A) Securities of any investment company registered pursuant to the federal Investment Company Act of 1940, 15 U.S.C. § 802, if such company:

(i) invests at least ninety percent of its assets in the types of securities which qualify as a reserve investment pursuant to the provisions of paragraph one, two or three of this subsection or which invest in securities which are determined by the superintendent to be substantively similar to the types of securities set forth in such paragraphs; or

(ii) invests at least ninety percent of its assets in the types of equity interests which qualify as a reserve investment pursuant to the provisions of paragraph eight of this subsection.

(B) Investment limitations. Investments made by an insurer subject to the provisions of paragraph two of subsection (a) or subsection (b) of section one thousand four hundred three of this article shall not exceed the following limitations:

(i) in any investment company qualifying under item (i) of subparagraph (A) hereof, ten percent of such insurer's admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment companies shall not exceed twenty-five percent of such insurer's admitted assets as shown by its last statement on file with the superintendent; and

(ii) in any investment company qualifying under item (ii) of subparagraph (A) hereof, five percent of such insurer's admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to the provisions of subparagraph (B) of paragraph eight of this subsection.

(11) Credit union shares, share certificates and share draft accounts. Shares, share certificates and share draft accounts issued by credit unions and federal credit unions not to exceed the amounts which are assumed, guaranteed or insured by the United States or any agency or instrumentality thereof.

(b) Leeway provision. Investments which do not qualify or are not permitted under subsection (a) hereof, but excluding any investment prohibited by the provisions of paragraph six of subsection (a) of this section or by the provisions of paragraph one, two, three, four, six, eight, nine or ten of subsection (a) of section one thousand four hundred seven of this article, provided that:

(1) the aggregate cost of such investments shall not exceed five percent of the admitted assets of the insurer as shown by its last statement on file with the superintendent, and

(2) investments that are neither interest-bearing nor income-paying, made under this subsection as provided in paragraph one of subsection (d) of section one thousand four hundred three of this article shall not in the aggregate exceed three percent of the admitted assets of the insurer as shown by its last statement on file with the superintendent.

§ 1405. Investments of life insurers. (a) The assets of a domestic insurer that is authorized to make investments under this section may be invested in the following types of investments, in addition to investments otherwise authorized, subject in the case of investments made under this section to the limitations set forth below and the provisions of subsections (c), (d) and (e) of this section:

(1) Governmental obligations. Obligations, not in default, issued, assumed, guaranteed or insured by (i) the United States of America or by any agency or instrumentality thereof, (ii) any state of the United States of America, (iii) the District of Columbia, (iv) any territory or possession of the United States of America or any other governmental unit in the United States, or (v) any agency or instrumentality of any governmental unit referred to in items (ii), (iii) and (iv) above, provided that, in the case of obligations issued, assumed, guaranteed or insured by any governmental unit referred to in item (iv) above or any agency or instrumentality referred to in item (v) above, such obligations are by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment, but in no event shall obligations be eligible for investment

under this paragraph if payable solely out of special assessments on properties benefited by local improvements.

(2) Obligations and preferred shares of American institutions. (i) Obligations, not in default, whether or not secured and with or without recourse, issued, assumed, guaranteed, insured or accepted by American institutions (or trustees or receivers therefor) and (ii) preferred shares of any such institution, provided, however, that after giving effect to any such investment in preferred shares of any institution, the aggregate amount of investments in preferred shares of such institution made under this section shall not exceed two percent of the insurer's admitted assets.

(3) Obligations secured by real property or interests therein. Obligations, or participations therein, secured by liens on real property or interests therein located within the United States and not eligible under paragraph one or two of this subsection, provided that no insurer making investments under the authority of this section shall invest in or loan upon the security of any one property, under the authority of this paragraph, more than thirty thousand dollars or two percent of admitted assets, whichever is the greater.

(4) Real property or interests therein. Investments in real property or interests therein located in the United States, held directly or evidenced by partnership interests, stock of corporations (including, without limitation, subsidiaries engaged or organized to engage exclusively in the ownership and management of real property or interests therein), trust certificates or other instruments, and acquired (i) as an investment for the production of income or to be improved or developed for such investment purpose, or (ii) for the convenient accommodation of the insurer's business; provided that, after giving effect to any such investment, (I) the aggregate amount of such investments made under this paragraph and then held by such insurer shall not exceed twenty-five percent of the insurer's admitted assets, (II) the aggregate amount of investments made under item (i) of this paragraph and then held by such insurer shall not exceed twenty percent of the insurer's admitted assets, and (III) investments held under item (i) above in each property constituting such investment (including improvements thereon) shall not in the aggregate exceed two percent of the insurer's admitted assets, and provided, further, that no investment

in real property may be made under item (ii) herein, (aa) if, after giving effect thereto, the aggregate amount of such investments then held by the insurer would exceed ten percent of the insurer's admitted assets, (bb) without the prior approval of the superintendent, if, after giving effect thereto, the aggregate amount of such investments in each property constituting such investment (including improvements thereon) then held by such insurer would exceed two percent of the insurer's admitted assets, and (cc) without the prior approval of the superintendent, in the case of an investment by a domestic insurer in real property located outside this state, if, after giving effect thereto, the aggregate amount of such investments in the property constituting such investment (including improvements thereon) would exceed one-fifth of one percent of the insurer's admitted assets.

(5) Personal property or interests therein. Investments in personal property or interests therein located or used wholly or in part within the United States, held directly or evidenced by partnership interests, stock of corporations (including, without limitation, subsidiaries engaged or organized to engage exclusively in the ownership and management of personal property or interests therein), trust certificates or other instruments, provided that, after giving effect to any such investment, (i) the aggregate amount of such investments made under this paragraph and then held by such insurer shall not exceed ten percent of the insurer's admitted assets and (ii) investments held under this paragraph in the item of personal property constituting such investment shall not in the aggregate exceed one percent of the insurer's admitted assets.

(6) Equity interests. Investments (in addition to investments of the types described in this paragraph but made or acquired under article seventeen, section one thousand four hundred three, paragraphs four and five of this subsection or section four thousand two hundred forty of this chapter) in common shares, partnership interests, trust certificates or other equity interests (other than preferred shares) of American institutions, provided that, after giving effect to any investment made under this paragraph, (i) the aggregate amount of investments made under this paragraph in the institution in which such investment is then being made and then held by such insurer shall not exceed two percent of the insurer's admitted assets and (ii) the

aggregate amount of all investments made under this paragraph and then held by such insurer shall not exceed twenty percent of the insurer's admitted assets.

(7) Foreign investments. (A) Canadian investments substantially of the same types as those eligible for investment under paragraphs one through six of this subsection, provided that, after giving effect to any investment made under this subparagraph, the aggregate amount of investments made under this subparagraph and then held by such insurer shall not exceed ten percent of the insurer's admitted assets, except where a greater amount is permitted under subparagraph (B) below (in which case the provisions of this subparagraph shall not be applicable).

(B) In the case of any domestic insurer that is authorized to do business in a foreign country or possession of the United States of America or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in such foreign country or possession, investments in such foreign country or possession that are substantially of the same types as those eligible for investment under paragraphs one through six of this subsection; provided that, except where a greater amount is permitted under subparagraph (A) above, after giving effect to any investment in such foreign country or possession made under this subparagraph, the aggregate amount of cash in the currency of such foreign country or possession and of investments in such foreign country or possession made under this subparagraph and then held by such insurer shall not exceed one and one-half times the amount of such insurer's reserves and other obligations under such contracts or the amount which such insurer is required by law to invest in such country or possession, whichever shall be greater.

(C) Investments in foreign countries, in addition to Canadian investments and investments permitted by subparagraph (B) of this paragraph, that are substantially of the same types as those eligible for investment under paragraphs one through six of this subsection, provided that, after giving effect to any investment made under this subparagraph, the aggregate amount of investments qualified under this subparagraph and then held by such insurer shall not exceed twenty percent of the insurer's admitted assets; and

(i) the issuer or obligor is (I) a jurisdiction, which is rated in one of the four highest rating categories by an independent, nationally

recognized United States rating agency, (II) any political subdivision or other governmental unit of any such jurisdiction, or any agency or instrumentality of any such jurisdiction, political subdivision or other governmental unit or (III) an institution which is organized under the laws of any such jurisdiction or, in the case of such paragraphs three and four of this subsection, the real property is located in any such jurisdiction; and

(ii) an insurer shall not make any investment in any foreign country pursuant to this subparagraph, if such investment, together with all other investments in the same foreign country so made and then held by such insurer, would exceed seven percent of the insurer's admitted assets.

(D) In addition to the foreign investments permitted under the preceding subparagraphs of this paragraph, foreign investments that are substantially of the same types as those eligible for investment under paragraphs one through six of this subsection, provided that, after giving effect to any investment made under this subparagraph, the aggregate amount of investments made under this subparagraph and then held by such insurer shall not exceed six percent of the insurer's admitted assets, and provided further that an insurer shall not make any investment in any foreign country pursuant to this subparagraph, if such investment, together with all other investments in the same foreign country so made and then held by such insurer, would exceed three percent of the insurer's admitted assets.

(8) Other investments. Investments that do not qualify or are not permitted under any other paragraph of this subsection, provided that, after giving effect to any such investment, (i) if such investment is of a type described in paragraph three or five or item (i) of paragraph four or paragraph six of this subsection, the aggregate amount of investments of such type made under this paragraph and then held by such insurer shall not exceed five percent of the insurer's admitted assets, (ii) if such investment is of a type described in paragraph six of this subsection, the aggregate amount of such investments made under this paragraph in the institution in which such investment is then being made and then held by such insurer shall not exceed two percent of the insurer's admitted assets, (iii) if such investment is of a type described in paragraph seven of this subsection, the aggregate amount of

investments of all types described in said paragraph seven and made under this paragraph and then held by such insurer shall not exceed two percent of the insurer's admitted assets, and (iv) the aggregate amount of all investments made under this paragraph and then held by such insurer shall not exceed fourteen percent (but not more than ten percent in investments in institutions not having their principal operations in this state and in real and personal property and interests therein located outside this state and in mortgages and security interests with respect to real and personal property located outside this state) of the insurer's admitted assets. Investments that are neither interest bearing nor income paying, made under this paragraph as provided in paragraph one of subsection (d) of section one thousand four hundred three of this article, shall be subject to all the provisions of this paragraph and may not be acquired if the aggregate amount thereof immediately after such acquisition would exceed three percent of the insurer's admitted assets.

(b) (1) For the purposes of this section, article seventeen of this chapter and section one thousand four hundred three of this article,

(A) "aggregate amount" of investments means, subject to the provisions of the final sentence of this subsection, the aggregate depreciated cost thereof, in the case of investments of the types described in paragraphs four and five of subsection (a) of this section, and the aggregate cost thereof in the case of investments of other types;

(B) "admitted assets" means the amount thereof as of the last day of the most recently concluded annual statement year subject to the following adjustments;

(i) assets held in separate accounts established under section four thousand two hundred forty of this chapter shall be included only to the extent of amounts allocated to such separate accounts pursuant to paragraph three of subsection (a) of said section four thousand two hundred forty; and

(ii) investments in subsidiaries referred to in subsection (c) of section one thousand seven hundred four of this chapter shall be excluded; and

(C) the eligibility of any investment under any paragraph of subsection (a) of this section shall be determined at the time of acquisition thereof, except that (i) any investment qualified pursuant

to item (ii) of subparagraph (C) of paragraph seven of such subsection (a) shall remain so qualified only at such time or times as the hedging requirements of such item (ii) are met with respect thereto; and (ii) investments qualified under paragraph eight of said subsection (a) may be requalified at a later date under another paragraph of said subsection (a), if the relevant conditions are satisfied at the time of such requalification. In computing depreciated cost of investments of the types described in paragraphs four and five of subsection (a) of this section, depreciation may be computed at a rate no greater than that permitted for federal income tax purposes and, in the case of investments described in said paragraph four, the cost of an investment shall be depreciated over its estimated useful life, not to exceed fifty years.

(2) In computing the "aggregate amount" of investments, as provided in the first sentence of paragraph one of this subsection, (A) valuation of investments acquired under paragraph four of subsection (a) of this section shall also be subject to any regulation with respect to such valuation that the superintendent may prescribe and (B) investments of investment subsidiaries as defined in section one thousand seven hundred two of this chapter shall be valued as though the parent corporation owned the assets of such subsidiaries directly instead of the stock of such subsidiaries and shall be subject to the provisions of subsection (d) of section one thousand seven hundred four of this chapter.

(c) In addition to other requirements of law (statutory or otherwise) that affect the standard of care of directors and officers of corporations, in making investments under this section, directors and officers shall perform their duties in good faith and with that degree of care that an ordinarily prudent individual in a like position would use under similar circumstances. In the case of investments made under paragraphs two and six of subsection (a) of this section and investments that are substantially of the same types as those eligible for investment under such paragraphs, but are made under paragraph seven of such subsection, the institution that determines the eligibility of any such investment shall be a solvent institution whose obligations, if any, are not in default as to principal or interest, unless such investment is necessary to protect an investment theretofore made in the securities of such institution.

(d) After giving effect to any investment of a type described in item (i), (ii) or (iii) below, the aggregate amount of (i) investments in subsidiaries charged against the limit contained in paragraph one of subsection (a) of section one thousand seven hundred five of this chapter, (ii) investments made under item (i) of paragraph four and paragraphs five and six of subsection (a) of this section, and (iii) investments of the types described in said item (i) of paragraph four and such paragraphs five and six but made under paragraph seven or eight of subsection (a) of this section, shall not exceed forty percent of the insurer's admitted assets plus, to the extent permitted by the superintendent, investments (not exceeding five percent of the insurer's admitted assets) of the types referred to above in (I) new business enterprises located in the state; (II) technologically oriented businesses located in the state; (III) minority-owned businesses located in the state; (IV) businesses located in areas in the state that have experienced a high rate of chronic unemployment; and (V) development of housing in the state for families and persons of low income. If, at the time of the making of any investment of a type described in item (i), (ii) or (iii) of the first sentence of this subsection, the aggregate amount of investments of the types described in clauses (I), (II), (III), (IV) and (V) of such sentence made by the insurer on or after the date on which this subdivision becomes effective and then held by the insurer is one percent or more of its admitted assets, then the forty percent figure in such sentence shall be deemed to be increased by an equal amount up to a maximum of forty-five percent, thus providing for a maximum of investments described in items (i), (ii) and (iii) herein of fifty percent of total admitted assets.

(e) No domestic life insurer shall hold a direct or indirect ownership interest in a risk retention group, as defined in article fifty-nine of this chapter, other than in a risk retention group all of whose members are insurance companies.

(f) Any investment may be denominated in a currency other than United States dollars, provided that the aggregate amount of all such investments (other than investments made pursuant to subparagraphs (A) and (B) of paragraph seven of subsection (a) of this section) that are not effectively hedged, substantially in their entirety, against the United States dollar, reduced, on a currency by currency basis, by the

amount of foreign-currency denominated insurance liabilities may not exceed four percent of the insurer's admitted assets. An investment shall be deemed to be effectively hedged, substantially in its entirety, if it has been hedged:

(1) for an insurer that has an approved derivative use plan under section one thousand four hundred ten of this article, pursuant to contracts or agreements entered into under and in accordance with that derivative use plan and subject to the counterparty exposure limits thereunder; or

(2) for any other insurer, pursuant to contracts or agreements (derivative transactions) which are cleared through a "derivatives clearinghouse" or entered into with a "qualified counterparty", as those terms are defined pursuant to subsection (f) of section one thousand four hundred ten of this article.

§ 1406. Policy loans. (a) Any life insurance company may lend to any policyholder upon the security of the value of his policy a sum not exceeding the legal reserve which it is required to maintain thereon.

(b) A fraternal benefit society may make similar loans subject to the provisions of article forty-five of this chapter.

§ 1407. Non-reserve and prohibited investments for property/casualty and certain other insurers. (a) Any insurer that makes investments under the authority of subsection (c) of section one thousand four hundred three of this article and meets the requirements of such subsection (c) and section one thousand four hundred two of this article may invest in, or otherwise acquire or loan upon, directly or indirectly, any of the types of investments described in section one thousand four hundred four of this article, but without having to meet the applicable qualitative standards or quantitative limitations which are set forth in subsection (a) of section one thousand four hundred four of this article, except the following prohibited investments:

(1) Obligations, shares or other securities of any institution which is insolvent at the time of the investment.

(2) Obligations secured by real property or real property or interest

therein, which are either not eligible under or which exceed the investment limitations under paragraph four or five of subsection (a) of section one thousand four hundred four of this article.

(3) Shares of stock of the investing insurer, except to the extent permitted by the provisions of subsection (d) of section one thousand four hundred eleven of this article.

(4) Obligations, shares or other securities (including certificates of deposit) issued by a parent corporation or a corporation which is an affiliate or will be an affiliate after direct or indirect acquisition by the insurer. Nothing in this paragraph shall be deemed to prevent any investment in obligations, shares or other securities of:

(A) another insurance corporation within the limitations prescribed in section one thousand four hundred eight of this article,

(B) a subsidiary organized to engage exclusively in the acquisition, ownership or management of investments of the type described in paragraphs one, two, three, six, seven, eight or ten of subsection (a) of section one thousand four hundred four of this article, provided such subsidiary is wholly-owned by two or more insurance companies domiciled in the United States who are members of the same holding company system, as such term is defined in article fifteen of this chapter. Furthermore, each individual insurer's share of the net investment made by such subsidiary shall be:

(i) computed in proportion to its equity interests in such subsidiary, and

(ii) included when computing any applicable investment limitations, or

(C) subsidiaries subject to and within the limitations prescribed in article sixteen of this chapter.

(5) Investments made under the leeway provision, as set forth in subsection (b) of section one thousand four hundred four of this article, if the aggregate amount of such investments exceed twelve percent of the insurer's invested assets as shown by its last statement on file with the superintendent; or if the aggregate amount of investments that are neither interest-bearing nor income-paying exceed three percent of the insurer's invested assets as shown by its last statement on file with the superintendent.

(6) Obligations, shares or other securities issued by a corporation, if a majority of the shares having voting powers of such issuing

corporation is owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer.

(7) Foreign investments, meaning obligations, shares or other securities of any person or governmental or business unit of or in a foreign country or of any person or business unit of or in a possession of the United States, except such as conform substantially with the limitations imposed by this section upon like domestic investments; but the aggregate amount of foreign investments including obligations of American institutions payable outside of the United States and cash deposited in a bank, trust company or thrift institution located outside of the United States held at any time by such insurer under this paragraph and under paragraph six of subsection (a) of section one thousand four hundred four of this article shall not exceed the greatest of (i) twelve percent of the insurer's admitted assets as shown by its last statement on file with the superintendent, (ii) fifteen percent of the insurer's invested assets as shown by its last statement on file with the superintendent, or (iii) one and one-half times the amount of its reserves and other obligations under its insurance and reinsurance contracts on risks resident or located in such foreign countries and subdivisions thereof. An investment in the shares of an alien insurer, which results in the control of such insurer by the investing insurer, shall not be included when calculating the limitations under this paragraph, but such an investment shall only be subject to the limitations of section one thousand four hundred eight of this article.

(8) A direct or indirect ownership interest in a risk retention group, as defined in article fifty-nine of this chapter, other than in a risk retention group all of whose members are insurance companies, in which case any investment in such a risk retention group shall be subject to the limitations prescribed in section one thousand four hundred eight of this article.

(9) Acquiring any interest in an investment through a partnership, other than an interest acquired as a limited partner in a limited partnership.

(10) Any investment found by the superintendent to be against public policy or designed to evade any prohibition of this chapter.

(b) This section shall not prohibit any such insurer from accepting securities, otherwise ineligible, which may be distributed pursuant to

any judicial or lawful non-judicial plan of reorganization or dissolution.

(c) Any investment pursuant to the provisions of this section shall be subject to other requirements of law (statutory or otherwise) that affect the standard of care of directors and officers of corporations, and in making investments under this section the insurer's directors and officers shall perform their duties in good faith and with that degree of care that an ordinarily prudent individual in a like position would use under similar circumstances.

§ 1408. Acquisition of insurance company shares; limitations thereon. (a) Any insurer which makes investments under the authority of subsection (c) of section one thousand four hundred three of this article and which meets the requirements of such subsection and section one thousand four hundred two of this article, may invest in, or otherwise acquire, the shares, including voting trust certificates, certificates of deposit, interim receipts and other similar instruments representing such shares, of any other insurance companies, including for purposes of this section any corporation having a majority of its assets invested in one or more insurance companies, in an amount which, together with its present holdings and with any indirect or proportionate interest in insurance company shares held by it through any intermediate subsidiary, shall not exceed in value thirty-five percent of the surplus to policyholders of such acquiring insurer, or fifty percent of its surplus over and above its liabilities and capital, whichever is greater. No United States branch of an alien insurer shall be permitted to acquire or hold any shares of any alien insurance corporation.

(b) This section shall not prohibit the acquisition of insurance company shares by the acceptance of a stock dividend nor prohibit the owner of previously lawfully acquired shares of an insurance company from making a contribution, with the approval of the superintendent, to such other insurance company's surplus. Notwithstanding any other provisions of this chapter, any domestic insurer or United States branch of an alien insurer, which, prior to January first, nineteen hundred forty, acquired shares of other insurance companies in accordance with

law in force at the time of such acquisition, may continue to hold them. In determining the financial condition of a domestic insurer shares of other insurance companies shall be valued in accordance with subsection (c) of section one thousand four hundred fourteen of this article but in no event shall their aggregate value be allowed as an admitted asset in excess of fifty per centum of the surplus to policyholders or sixty per centum of the surplus of such insurer, whichever is greater.

(c) In applying the formulas of this section, the initial calculation of surplus shall include voluntary reserves not required by law and the value of insurance company shares before adjustment for any excess holdings thereof.

(d) A United States branch of an alien insurer, other than one licensed to do in this state the business of life insurance, shall be subject to the foregoing limitations, except that its trusteed surplus statement shall be used in determining compliance. For the purpose of this section the surplus to policyholders of a United States branch shall be deemed to be its trusteed surplus and its surplus shall be deemed to be its trusteed surplus less an amount equal to the paid-in-capital specified in table one of paragraph one of subsection (a) of section four thousand one hundred three of this chapter for a domestic stock property/casualty insurance company licensed to do the same kinds of insurance except as such amount may be modified by paragraph five of subsection (a) of section four thousand one hundred three of this chapter.

§ 1409. Limitation of investments. (a) Except as more specifically provided in this chapter, no domestic insurer shall have more than ten percent of its admitted assets as shown by its last statement on file with the superintendent invested in, or loaned upon, the securities (including for this purpose certificates of deposit, partnership interests and other equity interests) of any one institution.

(b) The restriction of subsection (a) hereof shall not apply to the classes of governmental obligations (including obligations secured by mortgages upon real property guaranteed or insured under the National Housing Act, 12 U.S.C. §§ 1701-1750) eligible for minimum capital or surplus to policyholder investments pursuant to the provisions of

section one thousand four hundred two of this article nor to investments in shares of other insurance companies pursuant to the provisions of section one thousand four hundred eight of this article.

(c) The limitations of investments set forth in this section shall not apply to mortgage-related securities or securities issued or guaranteed by the Federal Home Loan Mortgage Corporation or the Federal National Mortgage Association; provided, however, that for an insurer maintaining an aggregate investment in excess of seventy percent of its admitted assets as shown by its last statement on file with the superintendent in such securities, the balance of such investments greater than seventy percent thereon shall be limited by and apportioned according to a ratio of one to two respectively, between investment in such securities and investment in government obligations, as that term is defined in paragraph one of subsection (a) of section fourteen hundred four of this chapter.

(d) The superintendent shall not promulgate any rules or regulations to limit or otherwise alter the provisions of paragraph two of subsection (a) of section fourteen hundred one of this article or subsection (c) of this section. The superintendent shall not promulgate any rules or regulations that limit the authority of any insurer to invest in mortgage related securities.

§ 1410. Derivative transactions and derivative instruments. (a) For purposes of this section, except subsection (k) of this section, an insurer shall mean a domestic life insurer, a domestic property/casualty insurer, a domestic reciprocal insurer, a domestic mortgage guaranty insurer, a domestic co-operative property/casualty insurance corporation or a domestic financial guaranty insurer.

(b) (1) An insurer may only engage in derivative transactions pursuant to and in compliance with the requirements of this section. Any insurer subject to the provisions of subsection (c) of section one thousand four hundred three of this article shall also comply with the requirements set forth in such subsection relative to derivative transactions authorized by this section.

(2) An insurer may use derivative instruments under this section to engage in hedging transactions, replication transactions, and for

certain limited income generation transactions authorized pursuant to this section.

(3) Prior to entering into any derivative transaction authorized pursuant to this section:

(A) the board of directors of the insurer or a committee thereof charged with the responsibility for supervising investments shall: (i) authorize such transactions, (ii) assure that all individuals conducting, monitoring, controlling and auditing derivative transactions are suitably qualified and have appropriate levels of knowledge and experience, and (iii) approve a derivative use plan for such transactions or an amendment to a previously adopted derivative use plan. If such determinations are made by a committee of such a board, the minutes of the committee reflecting such determinations shall be recorded and a report thereon shall be submitted to the board of directors for its review at such board's next meeting;

(B) the insurer shall submit a written derivative use plan or amendment thereto to the superintendent for approval; and

(C) the superintendent shall approve the insurer's written derivative plan for engaging in derivative transactions and investment practices related to derivative transactions. The plan shall specify guidelines as to the quality, maturity and diversification of derivative investments and other specifications, including investment strategies, asset/liability management practices, its liquidity needs and its capital and surplus as they relate to the derivative use plan. The board of directors or a committee thereof charged with the responsibility for supervising investments shall determine at least quarterly whether all derivative transactions have been made in accordance with delegations, standards, limitations and investment objectives prescribed in the insurer's derivatives use plan. If such determinations are made by a committee of such a board, the minutes of the committee reflecting such determinations shall be recorded and a report thereon shall be submitted to the board of directors for its review at such board's next meeting.

(D) (i) Within ninety days of receipt of a derivative use plan application, the superintendent shall, in writing, approve, submit a detailed list to the insurer requesting all additional information necessary to make a determination on the plan, or deny such plan; otherwise, such plan shall be deemed approved. Any denial issued by the

superintendent shall state the reasons for such disapproval. If an insurer does not provide the additional information requested by the superintendent, within forty-five days of receipt of such request, then such plan shall be deemed denied. Such forty-five day limit for providing such additional information may be extended at the option of the superintendent.

(ii) In the event that an insurer properly submits the additional information requested by the superintendent, then such plan shall be deemed approved sixty days after receipt of such information by the superintendent, unless the insurer is notified in writing prior to such date that the filing has been denied. Such denial shall state the reasons for such disapproval. Notwithstanding anything to the contrary in this section, the superintendent may, at any time, before a plan is approved, affirmatively approved or denied, raise objections to the plan that is based on the requirements of this chapter.

(iii) The superintendent shall, as soon as practicable, but no later than sixty days after receipt of a plan, notify the insurer if its filing is incomplete or fails to comply with applicable statutory or regulatory requirements. Such notice shall indicate that the filing is being returned with no action by the superintendent and that the period for the superintendent's substantive review has not commenced.

(4) An insurer which engages in hedging transactions or replication transactions as authorized pursuant to this section shall:

(A) only maintain its position in any outstanding derivative instrument used as part of a hedging transaction or replication transaction for as long as the hedging transaction or replication transaction, as the case may be, continues to be effective; and

(B) be able to demonstrate to the superintendent, upon request, that any derivative transaction entered into and involving a hedging transaction or replication transaction, at the point of inception is and, for as long as the derivative transaction remains outstanding, continues to be, an effective hedging or replication transaction.

(5) An insurer which enters into derivative transactions as authorized pursuant to this section shall be required to include, as part of the evaluation of accounting procedures and internal controls required to be filed pursuant to subsection (b) of section three hundred seven of this chapter, a statement describing the assessment by the independent

certified public accountant of the internal controls relative to derivative transactions. If the internal controls relative to derivative transactions are determined to be deficient, the insurer shall require the accountant to include in the evaluation a description of such deficiencies and the insurer shall append to the evaluation a description of any remedial actions taken or proposed to be taken to correct these deficiencies, if such actions are not already described in the accountant's report.

(c)(1) An insurer may enter into hedging transactions pursuant to this section if, as a result of and after giving effect to the transaction:

(A) the aggregate statement value of options, swaptions, caps, floors and warrants purchased pursuant to this section does not exceed seven and one-half percent of its admitted assets;

(B) the aggregate statement of value of options, swaptions, caps and floors written pursuant to this section does not exceed three percent of its admitted assets; and

(C) the aggregate potential exposure of collars, swaps, forwards and futures entered into and options, swaptions, caps and floors written pursuant to this section does not exceed six and one-half percent of its admitted assets.

(2) Transactions entered into to effectively hedge the currency risk of investments denominated in a currency other than United States dollars, pursuant to subsection (f) of section one thousand four hundred five of this article, shall not be included in the limits under paragraph one of this subsection.

(d) An insurer may enter into income generation transactions under this section only through the sale of call options on securities, provided that the insurer holds, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the underlying securities during the entire period the option is outstanding.

(e) An insurer may purchase or sell one or more derivative instruments to offset any derivative instrument previously purchased or sold, as the case may be, without regard to the quantitative limitations of subsection (c) of this section provided that such derivative instrument is an exact offset to the original derivative instrument being offset.

(f)(1) The counterparty exposure under an over the counter derivative

instrument entered into by an insurer authorized to engage in transactions pursuant to this section shall be deemed to be an obligation of the institution to which the insurer is exposed to credit risk and shall be included in determining compliance with any single or aggregate quantitative limitation on investments made by an insurer under this chapter.

(2) Notwithstanding any single or aggregate quantitative limitation on investments made by an insurer under this chapter, an insurer may only transact an over the counter derivative instrument with:

(A) a qualified counterparty; or

(B) a counterparty other than a "qualified counterparty" if, after giving effect to that transaction, the aggregate counterparty exposure of the insurer under one or more over the counter derivative instruments to:

(i) that non-qualified counterparty does not exceed one percent of the insurer's admitted assets; and

(ii) all counterparties, other than qualified counterparties, does not exceed three percent of the insurer's admitted assets.

(3) For purposes of this section:

(A) a "qualified counterparty" is a counterparty which has an investment grade rating from at least one nationally recognized statistical rating organization or a designation of one from the Securities Valuation Office of the National Association of Insurance Commissioners, or any successor office established by the National Association of Insurance Commissioners, and with which the insurer has entered into a master agreement, together with a credit support annex or other documentation providing for the collateralization of the counterparty's obligations to the insurer under the master agreement, if that collateral documentation provides for (i) daily margin and collateral settlement, in cash or investment grade securities, between the parties, (ii) a minimum transfer amount of no more than one million dollars, and (iii) a requirement that collateral be provided by the counterparty from the first dollar of exposure, subject to the minimum transfer amount;

(B) "aggregate counterparty exposure" means the sum of: (i) the aggregate statement value of options, swaptions, caps, floors, and warrants purchased; and (ii) the aggregate potential exposure of

collars, swaps, forwards and futures entered into;

(C) "over the counter derivative instrument" means a derivative instrument which is authorized under this chapter other than a derivative instrument (i) cleared through a United States or foreign derivatives clearinghouse, or (ii) traded on or through a United States or foreign exchange providing derivatives clearing services;

(D) "derivatives clearinghouse" means a derivatives clearing organization registered with the Commodity Futures Trading Commission or the Securities and Exchange Commission or, if not so registered, is a foreign clearinghouse regulated, supervised and examined by a regulatory authority in a foreign jurisdiction approved by the superintendent;

(E) "master agreement" means a written master agreement relating to derivatives transactions that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or if not within the United States, within a jurisdiction approved by the superintendent as eligible for netting; and

(F) "minimum transfer amount" means an amount below which a daily margin and collateral settlement is not required.

(g) For the purposes of this section, "admitted assets" means the assets, as shown on the insurer's last annual statement filed with the superintendent, which conform to the requirements of section one thousand three hundred one of this chapter, except that a domestic life insurer shall include assets held in separate accounts established under section four thousand two hundred forty of this chapter to the extent of amounts allocated to such separate accounts pursuant to paragraph three of subsection (a) of section four thousand two hundred forty of this chapter, and shall exclude investments in subsidiaries referred to in subsection (c) of section one thousand seven hundred four of this chapter.

(h) The superintendent shall promulgate regulations to:

(1) define terms used in this section that are not otherwise defined;

(2) establish the content of the derivative use plan to be submitted by an insurer to the superintendent pursuant to this section;

(3) establish effective management oversight standards, including quarterly reporting to the board of directors or a committee thereof charged with the responsibility for supervising investments, for

transactions authorized pursuant to this section;

(4) require that the insurer establish adequate systems of internal control and reporting to ensure that derivative transactions are properly supervised and that transactions are in accordance with the insurer's authorized policies and procedures;

(5) establish documentation and reporting requirements for transactions authorized pursuant to this section;

(6) establish appropriate accounting standards for derivative transactions authorized pursuant to this section; and

(7) the provisions of this section shall not be deemed to authorize the superintendent to promulgate any rule or regulation, circular letter or directive, that in any way expands the superintendent's authority to (i) approve or regulate an insurer's entire investment portfolio or investment strategy, or (ii) impose standards on corporate governance that are either stricter or contrary to the provisions contained in this article or the business corporation law.

(i) For purposes of other provisions of this chapter, derivative instruments and derivative transactions entered into under this section shall be deemed to be investments, provided that if this section conflicts with any other provisions of this chapter, the provisions of this section shall prevail.

(j) The superintendent may order an insurer to cease effecting and maintaining transactions authorized by this section upon a finding that continued operations hereunder could be detrimental to the best interests of the policyholders or the public.

(k) Any foreign insurer engaging in derivative transactions and derivative instruments shall be subject to and comply with all the provisions of this section. However, a foreign insurer may engage in derivative transactions not authorized by this section provided that: (1) such insurer is authorized to engage in such transactions pursuant to its domestic state law; (2) such insurer includes the intent to engage in such derivative transactions in the derivative use plan submitted to and approved by the superintendent pursuant to paragraph three of subsection (b) of this section; (3) the transactions are not deemed, by the superintendent, to be potentially detrimental to the policy holders or the public in this state; and (4) the insurer complies with subsection (a) of section one thousand four hundred thirteen of

this article after the surplus to policyholders is reduced by the amount of all derivative transactions not authorized by this section in accordance with the measurement standards of paragraph one of subsection (c) of this section. For purposes of this subsection, a foreign insurer shall include foreign insurers as defined in paragraph twenty-one of subsection (a) of section one hundred seven of this chapter, foreign fraternal benefit societies, and accredited reinsurers.

(l) An insurer may enter into replication transactions provided that:

(1) the insurer would otherwise be authorized to invest its funds under this chapter in the asset being replicated;

(2) the asset being replicated is subject to all provisions and limitations (including quantitative limits) on the making thereof specified in this chapter with respect to investments by the insurer, as if the transaction constituted a direct investment by the insurer in the asset being replicated; and

(3) as a result of giving effect to the replication transaction, the aggregate statement value of all assets being replicated does not exceed ten percent of the insurer's admitted assets.

§ 1411. Authorization of, and restrictions on, investments. (a) No domestic insurer shall make any loan or investment, except as provided in subsection (h) hereof, unless authorized or approved by its board of directors or a committee thereof responsible for supervising or making such investment or loan. The committee's minutes shall be recorded and a report submitted to the board of directors at its next meeting.

(b) No such insurer shall participate in any underwriting of the purchase or sale of securities in advance of their issuance. Any such insurer may enter into any agreement to sell or withhold from sale any of its property as long as the insurer is not participating in an underwriting. The disposition of its property shall be the responsibility of its board of directors, in accordance with its charter and by-laws.

(c) Except as otherwise specifically provided in this chapter, no domestic insurer shall pledge or transfer any securities as collateral for a loan (including a sale of securities subject to an unconditional obligation to repurchase the same) if such loan and all other

outstanding loans secured by pledge or deposit of its securities will exceed, when the loan is made, five percent of its admitted assets as shown by its last sworn statement to the superintendent, unless the superintendent shall first give his permission for such loan as necessary in the conduct of the insurer's business. No pledge or transfer of securities for a loan shall be made if the insurer does not receive the loan's proceeds. Nothing in this section shall be construed as prohibiting an insurer from selling or purchasing individually or on its account jointly with one or more of its subsidiaries the securities of any investment company to which the insurer or any of its subsidiaries renders management, investment advisory or sales services, nor from participating in such sales or purchases jointly with any person in the insurer's holding company system, as defined in section one thousand five hundred one of this chapter.

(d) No domestic stock insurer shall purchase its own capital shares except pursuant to section seven thousand three hundred two of this chapter or pursuant to a plan of stock redemption and retirement approved by the superintendent as reasonable and equitable. No domestic insurer shall enter into any agreement in connection with the sale of any property to repurchase such property or any part thereof, except that such an insurer may (subject to the provisions of subsection (b) of this section) sell securities subject to an unconditional obligation to repurchase the same on a date not more than one year from the date of sale. This subsection shall not apply to the purchase or sale of directors' qualifying shares.

(e) No director or officer of an insurer doing business in this state shall receive, in addition to his fixed salary or compensation, any money or valuable thing, directly or indirectly, or through any substantial interest in any other corporation or business unit, for negotiating, procuring, recommending or aiding in any purchase or sale of property, or loan, made by such insurer or any affiliate or subsidiary thereof; nor shall he be pecuniarily interested, as principal, co-principal, agent or beneficiary, directly or indirectly, or through any substantial interest in any other corporation or business unit, in any such purchase, sale or loan. This subsection shall not prohibit:

(1) a member of the board of directors of an insurer, other than life,

from receiving his share of the usual commission earnings of a stock exchange firm of which he is a partner;

(2) an insurer, other than life, or any life insurer all of whose shares (except directors' qualifying shares) is owned by any corporation organized primarily for, and engaged primarily in the business of, providing support, relief, pensions, annuities or insurance for the priests, clergy or ministers of any religious denomination or their dependents, from paying any corporation or partnership in which any director of the insurer has an interest or is an officer or director or partner, a reasonable fee for investment advice, provided such compensation is not in excess of the amounts customarily charged for the same type of service; or

(3) any transaction or class of transactions which comply with section one thousand five hundred five or article sixteen of this chapter.

(f) (1) No insurer doing business in this state shall, except as provided in subsection (h) hereof, make any loan to any of its directors or officers, directly or indirectly, or through its subsidiaries; nor shall any such director or officer accept any such loan directly or indirectly.

(2) No such insurer shall make any advance to any of its directors or officers for future services to be performed beyond a period of one year from the date of making such advance.

(g) No insurer doing business in this state, nor any affiliate or subsidiary thereof, shall directly or indirectly guarantee the financial obligation of any director or officer of such insurer, affiliate or subsidiary, and any such guaranty shall be void. In this subsection, "guarantee" shall not include the making of a contract of insurance of the kind specified in paragraphs thirteen, fourteen, fifteen or sixteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(h) Nothing contained in this chapter shall prohibit a life insurance company from making a policy loan upon its policy or contract in an amount not exceeding the net reserve value of the policy or contract, or any insurer from:

(1) Acquiring (i) in the case of an insurer making investments under the authority of section one thousand four hundred four of this article, such real property serving as the residence of a non-director officer as

may be acquired under the provisions of paragraph five of subsection (a) of section one thousand four hundred four of this article, or (ii) in the case of an insurer making investments under the authority of section one thousand four hundred five of this article, real property serving as the residence of a non-director officer, under the provisions of paragraph four of subsection (a) of section one thousand four hundred five of this article and with the approval of the superintendent in the case of domestic insurers, in connection with the relocation by the insurer of the place of employment of such officer (including any relocation in connection with initial employment), at a purchase price not exceeding the lesser of the value of such property as determined by an independent appraiser for the purpose of such acquisition or one hundred fifty thousand dollars, provided such officer has made reasonable efforts otherwise to dispose of such property for a period of not less than one month immediately prior to such acquisition; or

(2) Making a loan to a non-director officer secured by real property owned by such officer and improved with a one-family dwelling, which is to serve as such officer's residence, provided that (i) such loan qualifies under paragraph four of subsection (a) of section one thousand four hundred four (in the case of an insurer that makes investments under the authority of section one thousand four hundred four) or paragraph three of subsection (a) of section one thousand four hundred five (in the case of an insurer that makes investments under the authority of section one thousand four hundred five) of this article, (ii) such loan is made in connection with the relocation by the insurer of the place of employment of such officer (including any relocation in connection with initial employment), and (iii) in the case of a domestic insurer, such loan is approved by the superintendent.

For the purposes of paragraphs one and two of this subsection, paragraphs four and five of subsection (a) of section one thousand four hundred four and paragraphs three and four of subsection (a) of section one thousand four hundred five of this article, real property shall include a condominium unit and stock of a cooperative apartment corporation, if such stock entitles the holder thereof to a proprietary lease of a one-family apartment serving as the residence of the officer.

§ 1412. Disposal or deduction of investments unlawfully acquired. (a) Every domestic insurer shall forthwith dispose of any investment acquired in violation of the law in force at the date of acquisition.

(b) In determining the financial condition of any such insurer, the value of any wholly ineligible investments, and the value of any investment in excess of any limitation prescribed in this chapter, shall be deducted as a non-admitted asset of such insurer.

§ 1413. Investments of foreign and alien insurers. (a) The superintendent may refuse a new or renewal license to any foreign insurer, if he finds that its investments do not comply in substance with the investment requirements and limitations imposed by this chapter upon like domestic insurers hereafter organized to do the same kind or kinds of insurance business. For the purposes of this subsection, except for derivative transactions authorized pursuant to section one thousand four hundred ten of this article, a foreign insurer's investments shall be deemed to comply in substance with such requirements and limitations if, after disallowing as admitted assets in whole or in part any investments not in compliance therewith, the superintendent finds that such foreign insurer's adjusted surplus to policyholders is not less than an amount which is reasonable in relation to its outstanding liabilities and adequate to its financial needs, and at least equal to the minimum surplus to policyholders required on organization of a domestic insurer to do the same kind or kinds of insurance business. The superintendent may recognize like securities of a foreign insurer's home state as minimum capital or minimum surplus to policyholder investments in lieu of the securities specified in paragraphs two and four of subsection (b) of section one thousand four hundred two of this article. Foreign insurers engaging in derivative transactions pursuant to section one thousand four hundred ten of this article shall comply with subsection (k) of such section for the purposes of substantial compliance.

(b) No alien insurer shall be authorized to do business in this state unless its general state deposits and its trusteed assets comply with the requirements and limitations of this chapter applicable to like

foreign insurers hereafter licensed to do the same kind or kinds of insurance business, except that foreign investments shall be allowed to the following extent only:

(1) Obligations issued or guaranteed by the government of the country in which the alien insurer was organized or by any province or other major political subdivision thereof and not in default as to principal or interest, may be recognized as reserve investments under section one thousand four hundred four of this article (in the case of insurers making investments under section one thousand four hundred four of this article) or as investments under section one thousand four hundred five (in the case of insurers making investments under section one thousand four hundred five of this article) in an amount not exceeding the statutory deposit required by the provisions of section one thousand three hundred twenty of this chapter.

(2) Except as provided in paragraph one hereof, for an alien non-life insurer foreign investments that qualify as a reserve investment pursuant to the provisions of paragraph six of subsection (a) of section one thousand four hundred four of this article may be included in such alien insurer's trusteed assets in an aggregate amount not exceeding ten percent of the admitted assets of such insurer's United States branch as shown by its last statement on file with the superintendent, or, for an alien life insurer, foreign investments that qualify pursuant to the provisions of paragraph seven of subsection (a) of section one thousand four hundred five of this article may be included in such alien insurer's trusteed assets in an aggregate amount not exceeding the applicable quantitative limitations, as set forth in such paragraph seven.

(c) The superintendent may refuse a new or renewal license to any foreign or alien insurer which holds a direct or indirect ownership interest in a risk retention group, as defined in article fifty-nine of this chapter, other than in a risk retention group all of whose members are insurance companies.

(d) This section shall not relieve any foreign or alien insurer from compliance with any other provision of this chapter.

§ 1414. Valuation of investments. (a) (1) All obligations having a

fixed term and rate of interest and held by any life insurance company or fraternal benefit society authorized to do business in this state, if amply secured and not in default as to principal or interest, shall be valued as follows:

(A) if purchased at par, at the par value;

(B) if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and yield in the meantime the effective rate of interest at which the purchase was made, or, in the superintendent's discretion, on the basis of the method of calculation commonly known as the pro rata method.

(2) The purchase price shall in no case be taken at a higher figure than the actual market value at the time of acquisition.

(3) The superintendent shall have the power to determine the eligibility of any such investments for valuation on the basis of amortization, and may by regulation prescribe or limit the types of securities so eligible for amortization. All obligations which in the judgment of the superintendent are not amply secured shall not be eligible for amortization and shall be valued in accordance with subsection (b) hereof.

(4) The superintendent may, if he finds that the interests of policyholders so permit or require, by regulation permit or require any class of insurers, other than life insurance companies or fraternal benefit societies, authorized to do business in this state, to value their obligations in accordance with the foregoing rule.

(b) (1) Except securities subject to amortization and except as otherwise provided in this chapter, the investments (including any investments in an investment company) of all insurers authorized to do business in this state shall be valued, in the discretion of the superintendent, at their market value, or at their appraised value, or at prices determined by him as representing their fair market value.

(2) If the superintendent finds that in view of the character of investments of the insurer it would be prudent for such insurer to establish a special reserve for possible losses or fluctuations in the values of its investments, he may require that a reserve, reasonable in amount, be established and maintained and that it be reported in any statement or report of the financial condition of such insurer.

(3) The superintendent may, in connection with any examination or

required financial statement of the insurer, require it to furnish him a complete financial statement and audited report of the financial condition of any corporation whose securities are owned wholly or partly by such insurer and may cause an examination to be made of any subsidiary or affiliate of such insurer.

(c) (1) The shares of an insurance company which is not a subsidiary, or affiliate, including for purposes of this subsection any corporation having a majority of its assets invested in one or more insurance companies, shall be valued in accordance with subsection (b) of this section if such shares are registered on a national securities exchange, as provided in the federal Securities Exchange Act of 1934, 15 U.S.C. §§ 78a-78kk.

(2) Except as otherwise provided in section four thousand two hundred forty of this chapter, shares of an insurance company which is a subsidiary, or affiliate, shall be valued according to the methods approved by the National Association of Insurance Commissioners for the valuation of subsidiary, controlled and affiliated entities, or such other method that the superintendent in a regulation determines would be in the best interests of the policyholders and the people of this state.

(3) The book value of common shares of an insurance company shall be ascertained by dividing (i) the amount of the insurer's capital and surplus less the value of all its preferred shares, if any, outstanding, by (ii) the number of common shares outstanding.

(4) Notwithstanding the foregoing provisions, an insurer may, at its option, value its shares in a subsidiary insurance company in an amount not less than acquisition cost if it is less than the value determined as hereinbefore provided.

(d) Real property acquired by foreclosure or by deed in lieu thereof, in the absence of a recent appraisal deemed reliable by the superintendent, shall not be valued at an amount greater than the unpaid principal of the defaulted loan at the date of such acquisition, together with any taxes and expenses paid or incurred by such insurer at such time in connection with such acquisition (but not including any uncollected interest on such loan), and the cost of additions or improvements thereafter made by such insurer and any amounts thereafter paid by such insurer on any assessments levied for improvements in connection with the property.

(e) Purchase money mortgages received on dispositions of real property shall be valued in an amount not exceeding ninety percent of the value of such real property as determined by an appraisal made by an appraiser at or about the time of the disposition; provided that purchase money mortgages received on dispositions of real property acquired or held pursuant to paragraph five of subsection (a) of section one thousand four hundred four of this article or on dispositions of real property acquired or held under section one thousand four hundred five of this article in satisfaction of loans, mortgages, liens, judgments, decrees or other debts previously owing to such insurer in the course of its business shall in no event be valued in an amount exceeding its acquisition costs.

(f) The stock of a subsidiary of an insurer shall be valued on the basis of the greater of: (i) the value of only such assets of such subsidiary as would constitute lawful investments if acquired or held directly by the insurer; or (ii) such other value as may be determined pursuant to standards and cumulative limitations in regulations promulgated by the superintendent.

(g) Notwithstanding any provision contained in this section or elsewhere in this chapter, if the superintendent finds that the interests of policyholders so permit or require, he may permit or require any class of insurers authorized to do business in this state to value their investments or any class thereof as of any date heretofore or hereafter in accordance with any applicable valuation or method approved by the National Association of Insurance Commissioners.

§ 1415. Investments of domestic insurers in persons included on list of persons engaged in investment activities in Iran treated as nonadmitted assets. 1. As used in this section, the following definitions shall apply:

(a) "Iran" shall have the same definition as used in section one hundred sixty-five-a of the state finance law.

(b) "Person" shall have the same definition as used in section one hundred sixty-five-a of the state finance law.

(c) "Investment" shall mean any investment permitted under section fourteen hundred four or fourteen hundred five of this article.

2. Investments by a domestic insurer in persons which are included on the list of persons created by the office of general services pursuant to paragraph (b) of subdivision three of section one hundred sixty-five-a of the state finance law shall be treated as nonadmitted assets.

3. On or before December thirtieth, two thousand thirteen, and annually thereafter, the insurer shall determine what investments it had in the past calendar year, including any transfers or other transactions, in persons which are included on the list of persons created by the office of general services pursuant to paragraph (b) of subdivision three of section one hundred sixty-five-a of the state finance law.

4. On March first, two thousand fourteen, and annually thereafter, the insurer shall provide the department with a list of investments it had in the past calendar year, including any transfers or other transactions, in persons included on the list of persons created by the office of general services described in subdivision three of this section, including, but not limited to, the issuer, by name, of all the stock, bonds, securities, and other evidence of indebtedness.

5. This section shall cease to be operative if both of the following apply:

(a) Iran is removed from the United States department of state's list of countries that have been determined to repeatedly provide support for acts of international terrorism.

(b) Pursuant to the appropriate federal statute, the president of the United States determines and certifies to the appropriate committee of the congress of the United States that Iran has ceased its efforts to design, develop, manufacture, or acquire a nuclear explosive device or related materials and technology.

ARTICLE 15
HOLDING COMPANIES

Section 1501. Definitions; determinations.
1502. Exemptions.
1503. Registration.
1504. Reporting; examination; publication.
1505. Transactions within a holding company system affecting controlled insurers.
1506. Acquisition or retention of control of insurers.
1507. Management of controlled insurers.
1508. Acceptance of reports filed with government agencies.
1509. Prohibition of indirect action.
1510. Violations; penalties; jurisdiction over non-domiciliaries.
1511. Expenses for group-wide supervision.

§ 1501. Definitions; determinations. (a) In this article, unless the context shall otherwise require:

(1) "Person" means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity or any combination of the foregoing acting in concert.

(2) "Control", including the terms "controlling", "controlled by" and "under common control with", means the possession direct or indirect of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of his being an officer or director of such other person. Subject to subsection (c) hereof, control shall be presumed to exist if any person directly or indirectly owns, controls or holds with the power to vote ten percent or more of the voting securities of any other person.

(3) "Holding company" means any person who directly or indirectly controls any authorized insurer.

(4) "Controlled insurer" means an authorized insurer controlled directly or indirectly by a holding company.

(5) "Controlled person" means any person other than a controlled insurer, who is controlled directly or indirectly by a holding company.

(6) "Holding company system" means a holding company together with its controlled insurers and controlled persons.

(7) "Enterprise risk" means any activity, circumstance, event, or series of events involving the holding company system that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its holding company system, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section one thousand three hundred twenty-two or one thousand three hundred twenty-four of this chapter, or that would cause further transaction of business to be hazardous to the insurer's policyholders or creditors or the public.

(8) "Group capital calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such instructions conflict with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the holding company or insurer.

(9) "NAIC" means the National Association of Insurance Commissioners.

(10) "NAIC liquidity stress test framework" means an NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, such scope criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such instructions conflicts with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the holding company or insurer.

(11) "Scope criteria" means the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

(b) Notwithstanding the provisions of paragraph two of subsection (a) of this section, the superintendent may determine, after notice and

opportunity to be heard, that a person exercises directly or indirectly either alone or pursuant to an agreement with one or more other persons such a controlling influence over the management or policies of an authorized insurer as to make it necessary or appropriate in the public interest or for the protection of the insurer's policyholders or shareholders that the person be deemed to control the insurer.

(c) The superintendent may determine upon application that any person does not or will not upon the taking of some proposed action control another person. Such determination shall be made within thirty days or such further period as the superintendent may prescribe. The filing of the application in good faith by any person shall relieve the applicant from any obligation or liability imposed by this article with respect to the subject of the application, except as contained in section one thousand five hundred six of this article, until the superintendent has acted upon the application. The superintendent may prospectively revoke or modify his determination, after notice and opportunity to be heard, whenever in his judgment revocation or modification is consistent with this article.

(d) For the purposes of this article only, every foreign life insurer which is authorized to do business in this state which is controlled by a person not authorized to do an insurance business in this state, and which, during its three preceding fiscal years taken together, or during any lesser period of time if it has been licensed to transact its business in New York only for such lesser period of time, has written an average of more gross premiums in the state of New York than it has written in its state of domicile during the same period, and such gross premiums written constitute twenty percent or more of its total gross premiums written everywhere in the United States for such three year or lesser period, as reported in its three most recent annual statements, shall be deemed a domestic insurer, provided written notice of the applicability of this subsection is given to such company by the superintendent prior to this article being applicable.

§ 1502. Exemptions. (a) Notwithstanding any other provision of this article the following shall not be deemed holding companies:

(1) authorized insurers, including alien insurers transacting business

in this state through United States branches, or their subsidiaries; or

(2) the United States, a state or any political subdivision, agency or instrumentality thereof, or any corporation wholly owned directly or indirectly by one or more of the foregoing.

(b) The superintendent may conditionally or unconditionally exempt any specified person or class of persons from any obligation or liability under this article, if and to the extent he finds the exemption necessary or appropriate in the public interest or not adverse to the interests of policyholders or shareholders and consistent with the purposes of this article.

§ 1503. Registration. (a) Every person who becomes a controlled insurer shall, within thirty days thereafter register with the superintendent and shall amend the registration within thirty days following any change in the identity of its holding company or any other material change to the information provided in the registration. The registration shall be in such form and shall contain such matters as the superintendent prescribes. The superintendent may grant reasonable extensions of the time to register.

(b) A holding company that directly or indirectly controls an insurer shall adopt a formal enterprise risk management function and shall file an enterprise risk report with the superintendent by April thirtieth of each year. The report shall, to the best of the holding company's knowledge and belief, identify the material risks within the holding company system that could pose enterprise risk to the insurer.

(c) (1) An ultimate holding company shall file with the superintendent an annual group capital calculation by June thirtieth of each year when this state is the lead state of the holding company system as determined in accordance with the procedures within the financial analysis handbook adopted by the NAIC, as amended from time to time. When the lead state is not this state, an ultimate holding company shall file with the superintendent the annual group capital calculation as adopted by its lead state if the ultimate holding company has filed the annual group capital calculation with the lead state but the lead state is not willing or able to share the annual group capital calculation with the superintendent.

(2) When this state is the lead state, the ultimate holding company shall complete the annual group capital calculation in accordance with the group capital calculation instructions, which may permit the superintendent to allow a holding company that is not the ultimate holding company to file the annual group capital calculation.

(3) When this state is the lead state, an ultimate holding company shall be exempt from filing an annual group capital calculation if it is part of a holding company system that:

(A) has only one insurer within its system that only writes business and is only licensed in its domestic state and assumes no business from any other insurer;

(B) is required to perform a group capital calculation specified by the United States Federal Reserve Board, except that the holding company shall not be exempt if the superintendent requests the group capital calculation from the United States Federal Reserve Board under the terms of information sharing agreements in effect and the Federal Reserve Board cannot share the calculation with the superintendent;

(C) has a non-United States group-wide supervisor that is located within a reciprocal jurisdiction, as described in part one hundred twenty-five of title eleven of the official compilation of codes, rules and regulations of this state, that recognizes the United States state regulatory approach to group supervision and group capital; or

(D)(i) provides information to the superintendent, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the superintendent to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(ii) has a non-United States group-wide supervisor that is not in a reciprocal jurisdiction that recognizes and accepts, as specified by the superintendent in a regulation, the group capital calculation as the world-wide group capital assessment for United States holding company systems that operate in that jurisdiction.

(4) Notwithstanding subparagraphs (C) and (D) of paragraph three of this subsection, when this state is the lead state, the superintendent shall require the group capital calculation for United States operations of any non-United States-based holding company system where, after any necessary consultation with other supervisors or officials, it is deemed

appropriate by the superintendent for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(5) Notwithstanding the exemptions from filing the group capital calculation set forth in paragraph three of this subsection, when this state is the lead state, the superintendent has the discretion to exempt a holding company from filing an annual group capital calculation or accept a limited group capital calculation filing or report in accordance with criteria as specified by the superintendent in a regulation.

(6) When this state is the lead state, if the superintendent determines that a holding company no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this subsection, the holding company shall file the group capital calculation at the next annual filing date unless given an extension by the superintendent based on reasonable grounds shown.

(d)(1) An ultimate holding company that directly or indirectly controls an insurer subject to registration and that is scoped into the NAIC liquidity stress test framework shall file the results of a specific year's annual liquidity stress test with the superintendent when this state is the lead state of the holding company system as determined by the procedures within the financial analysis handbook adopted by the NAIC and as amended from time to time.

(2) When the lead state is not this state, an ultimate holding company shall file with the superintendent the results of a specific year's liquidity stress test as adopted by its lead state if the ultimate holding company has filed the results with the lead state but the lead state is not willing or able to share the results with the superintendent.

(3) When this state is the lead state, the performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test framework.

(4) When this state is the lead state, any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January first of the year following the calendar year when such changes are adopted.

(5) When this state is the lead state, an insurer meeting at least one

threshold of the scope criteria shall be considered scoped into the NAIC liquidity stress test framework for the specified data year unless the superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall not be scoped into the NAIC liquidity stress test framework for that data year.

(6) When this state is the lead state, an insurer that does not trigger at least one threshold of the scope criteria shall be considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall be scoped into the NAIC liquidity stress test framework for that data year.

(7) The superintendent, in consultation with the NAIC financial stability task force, or its successor, shall assess the concern of wishing to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis as part of the determination for an insurer.

(e) No insurer, insurance producer, or other person shall make, publish, disseminate, circulate, issue, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, issued, or placed before the public, in this state, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures for such test, or any component derived in the calculation thereof, of any insurer or holding company system, provided, however, that an insurer may publish, with the superintendent's prior approval, an announcement in a written publication to rebut any materially false statement with respect to the foregoing if the insurer is able to demonstrate to the superintendent with substantial proof the falsity of such statement or inappropriateness, as the case may be, and if the sole purpose of the announcement is to rebut the materially false statement.

§ 1504. Reporting; examination; publication. (a) (1) Every controlled insurer shall file with the superintendent such reports or material as the superintendent may direct for the purpose of disclosing information concerning the operations of persons within the holding company system that may materially affect the operations, management or financial condition of the insurer.

(2) To determine compliance with this article, the superintendent may order any controlled insurer to produce information not in the insurer's possession if the insurer can obtain access to the information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the superintendent, the insurer shall provide the superintendent a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the superintendent that the detailed explanation is without merit, in addition to any other penalty provided by law, the superintendent, after notice and an opportunity to be heard, may levy a penalty against the insurer not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response.

(b) Every holding company and every controlled person within a holding company system shall be subject to examination by order of the superintendent if the superintendent has cause to believe that the operations of such persons may materially affect the operations, management or financial condition of any controlled insurer within the system, including by posing enterprise risk to the insurer, and that the superintendent is unable to obtain relevant information from such controlled insurer. The grounds relied upon by the superintendent for such examination shall be stated in the superintendent's order. Such examination shall be confined to matters specified in the order. The cost of such examination shall be assessed against the person examined and no portion thereof shall thereafter be reimbursed to it directly or indirectly by the controlled insurer.

(c) (1) The contents of each report and filing made pursuant to this article and any information obtained in connection therewith shall be confidential and proprietary and shall not be subject to subpoena or discovery or admissible in evidence in any private civil action, and the

superintendent shall not make the same public without the prior written consent of the controlled insurer to which it pertains unless the superintendent, after notice and an opportunity to be heard, shall determine that the interests of policyholders, shareholders or the public will be served by the publication thereof. In any action or proceeding by the superintendent against the person examined or any other person within the same holding company system a report of such examination published by the superintendent shall be admissible as evidence of the facts stated therein.

(2) Neither the superintendent nor any person who received a report or filing made pursuant to this article and any information obtained in connection therewith, through examination or otherwise, while acting under the authority of the superintendent or with whom such report, filing, or information are shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning the report, filing, or information.

§ 1505. Transactions within a holding company system affecting controlled insurers. (a) Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:

(1) the terms shall be fair and equitable;

(2) charges or fees for services performed shall be reasonable; and

(3) expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied.

(b) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(c) The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year-end.

(d) The following transactions between a domestic controlled insurer

and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period:

(1) sales, purchases, exchanges, loans or extensions of credit, or investments involving less than five percent of the insurer's admitted assets at last year-end, provided the transactions are equal to or exceed:

(A) the lesser of three percent of the insurer's admitted assets or twenty-five percent of capital and surplus at last year-end, with regard to an accident and health insurance company or a corporation subject to article forty-three of this chapter;

(B) three percent of the insurer's admitted assets at last year-end, with regard to a life insurance company; or

(C) the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus to policyholders at last year-end, with regard to an insurer other than as specified in subparagraphs (A) and (B) of this paragraph;

(2) reinsurance treaties or agreements;

(3) rendering of services on a regular or systematic basis; or

(4) any material transaction, specified by regulation, that the superintendent determines may adversely affect the interests of the insurer's policyholders or shareholders.

Nothing herein contained shall be deemed to authorize or permit any transaction that, in the case of a non-controlled insurer, would be otherwise contrary to law.

(e) The superintendent, in reviewing transactions pursuant to subsections (c) and (d) hereof, shall consider whether they comply with the standards set forth in subsections (a) and (b) hereof and whether they may adversely affect the interests of policyholders.

(f) This section shall not apply to transactions subject to article sixteen or article seventeen or section one thousand four hundred eight or any sections of this chapter which impose notice or approval

requirements greater than those in this section.

§ 1506. Acquisition or retention of control of insurers. (a) No person, other than an authorized insurer, shall acquire control of any domestic insurer, whether by purchase of its securities or otherwise, unless:

(1) it gives twenty days written notice to the insurer, or such shorter period of notice as the superintendent permits, of its intention to acquire control, provided that the notice shall include an agreement by the person seeking to acquire control that the person will provide the annual report specified in section one thousand five hundred three of this article for so long as control exists; and

(2) it receives the superintendent's prior approval.

(b) The superintendent shall disapprove such acquisition if he determines, after notice and an opportunity to be heard, that such action is reasonably necessary to protect the interests of the people of this state. Only the following factors may be considered in making such determination:

(1) the financial condition of the acquiring person and the insurer;

(2) the trustworthiness of the acquiring person or any of its officers or directors;

(3) a plan for the proper and effective conduct of the insurer's operations;

(4) the source of the funds or assets for the acquisition;

(5) the fairness of any exchange of shares, assets, cash or other consideration for the shares or assets to be received;

(6) whether the effect of the acquisition may be substantially to lessen competition in any line of commerce in insurance or to tend to create a monopoly therein; and

(7) whether the acquisition is likely to be hazardous or prejudicial to the insurer's policyholders or shareholders.

(c) (1) The following conditions affecting any controlled insurer, regardless of when such control has been acquired, are violations of this article:

(A) the controlling person or any of its officers or directors have demonstrated untrustworthiness; and

(B) the effect of retention of control, in the case of a domestic controlled insurer, may be substantially to lessen competition in any line of commerce in insurance or to tend to create a monopoly therein, or, in the case of a foreign or alien controlled insurer, may be substantially to lessen competition in any line of commerce in insurance in this state or to tend to create a monopoly therein.

(2) If, after notice and an opportunity to be heard, the superintendent determines that any of the foregoing violations exists, he shall issue an order based on written findings and cause the same to be served upon the insurer and all persons affected thereby directing any person found to be in violation hereof to take appropriate action to cure such violation. Upon the failure of any such person to comply with such order, section one thousand five hundred ten of this article shall become applicable.

(d) The superintendent may require the submission of such information as he deems necessary to determine whether any acquisition or retention of control complies with this article and may require, as a condition of approval of such acquisition or retention of control, that all or any portion of such information be disclosed to the insurer's shareholders.

(e) Unless subject to registration under section one thousand five hundred three of this article, or unless acquisition of its control is subject to subsections (a) and (b) hereof, every authorized insurer shall, within thirty days after any event requiring notice hereunder, notify the superintendent in writing of the identity of any person whom the insurer then knows or has reason to believe controls, or has taken any action, other than preliminary negotiations or discussions, to acquire control of the insurer.

(f) Any holding company seeking to divest its controlling interest in a domestic insurer, in any manner, shall file with the superintendent, with a copy to the insurer, notice of its proposed divestiture at least thirty days prior to the cessation of control, provided, however that this subsection shall not apply if notice is provided as required by subsection (a) of this section.

§ 1507. Management of controlled insurers. (a) Notwithstanding the control of an authorized insurer by any person, the insurer's officers

and directors shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(b) Nothing herein shall preclude an authorized insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of subsection (a) of section one thousand five hundred five of this article.

§ 1508. Acceptance of reports filed with government agencies. To the extent that any information or material is set forth in forms or other matter on file with any government agency or in a registration form filed with the superintendent by another person within the same holding company system, the controlled insurer may comply with the registration or reporting requirements of this article by referring in its registration form or report to such other filed matter and attaching a copy thereof certified by the insurer as a true and complete copy, to such registration form or report or, if such other filed matter is on file with the superintendent, incorporating such matter by reference.

§ 1509. Prohibition of indirect action. No holding company or controlled person shall directly or indirectly or through another person do or cause to be done for or in behalf of the controlled insurer any act intended to affect the insurance operations of the insurer which, if done by the insurer, would violate section four thousand two hundred twenty-eight, four thousand two hundred twenty-nine, four thousand two hundred thirty or any sections specified in section two thousand four hundred two of this chapter.

§ 1510. Violations; penalties; jurisdiction over non-domiciliaries. (a) In addition to any other penalty provided by law, the superintendent may, upon the wilful failure of any person within a holding company system to comply with this article or any regulation or order

promulgated hereunder:

(1) proceed under article seventy-four of this chapter with respect to a domestic insurer within the holding company system;

(2) revoke or refuse to renew the authority to do business in this state of an authorized foreign or alien insurer within the holding company system or refuse to issue such authority to any other insurer in the system;

(3) request the attorney general to commence a proceeding utilizing the procedures of sections seven thousand four hundred seventeen and seven thousand four hundred eighteen of this chapter to enforce compliance or, where appropriate, for an order directing the termination of control of a domestic insurer; or

(4) direct that, in addition to any other penalty provided by law, such person forfeit to the people of this state a sum not exceeding five hundred dollars for a first violation and two thousand five hundred dollars for any subsequent violation. An additional sum not exceeding two thousand five hundred dollars shall be imposed for each month during which any such violation shall continue.

(b) If the superintendent finds after notice and opportunity to be heard that any domestic controlled insurer or any policyholder thereof has suffered any loss or damage because of the wilful violation of this article, or of any regulation or order promulgated hereunder, by any person within the insurer's holding company system, he may request the attorney general to maintain a civil action in the name of the people of the state or intervene in an action brought by or on behalf of the insurer or policyholder for the recovery of compensatory damages for the benefit of the insurer or policyholder or for other appropriate relief.

(c) As to any cause of action enumerated in this section a court may exercise personal jurisdiction over any non-domiciliary who controls or is an officer or director of a person who controls a domestic insurer.

(d) Whenever it appears to the superintendent that any person has committed a violation of section one thousand five hundred six of this article that prevents the full understanding of the enterprise risk posed to the insurer by the holding company system, the violation may serve as an independent basis for disapproving dividends or distributions or as grounds for rehabilitation or liquidation pursuant to article seventy-four of this chapter.

§ 1511. Expenses for group-wide supervision. A controlled insurer shall be liable for and shall pay the reasonable expenses of the superintendent's participation in the administration of group-wide supervision of internationally active insurance groups, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

ARTICLE 16
SUBSIDIARIES OF DOMESTIC PROPERTY/CASUALTY INSURANCE COMPANIES AND CERTAIN OTHER ENTITIES

Section 1601. Authority to invest in subsidiaries; businesses of subsidiaries.
1602. Minimum ownership of subsidiaries' shares.
1603. Notice of intent to acquire or divest.
1604. Registration.
1605. When corporation is deemed a subsidiary.
1606. Valuation of shares of subsidiary.
1607. Subsidiary's name not to mislead.
1608. Relationships and transactions between parent and subsidiary.
1609. Prohibitions on investments of subsidiaries.
1610. Authority to conduct certain business directly instead of through subsidiary.
1611. Aggregate limitations.
1612. Regulations.
1613. Expenses for group-wide supervision.
1614. Confidentiality of reports and filings.

§ 1601. Authority to invest in subsidiaries; businesses of subsidiaries. (a) (1) A domestic insurer authorized to make investments by subsection (c) of section one thousand four hundred three of this chapter may, subject to section one thousand two hundred eighteen of this chapter invest in, or otherwise acquire, subsidiaries engaged or

organized to engage in any business lawful under the laws of the jurisdiction in which such subsidiaries are organized.

(2) Notwithstanding the provisions of paragraph one of this subsection, no assessment corporation, as defined in subsection (b) of section six thousand six hundred two of this chapter, shall invest in or otherwise acquire, directly or indirectly, an insurance company if such investment or acquisition results in the control of such insurance company by the assessment corporation.

(b) Except as prohibited by paragraph two of subsection (a) of this section, subsidiaries engaged or organized to engage exclusively in owning or investing in insurers, directly or indirectly, are subject to the limitations set forth in sections one thousand two hundred eighteen and one thousand four hundred eight of this chapter.

§ 1602. Minimum ownership of subsidiaries' shares. A domestic insurer shall own not less than fifty-one percent of the issued and outstanding voting shares of each of its subsidiaries.

§ 1603. Notice of intent to acquire or divest. (a) A domestic insurer shall not acquire control of any other domestic insurer, whether by purchase of its securities or otherwise, unless:

(1) a notice of intention of such proposed acquisition shall have been filed with the superintendent not less than ninety days, or such shorter period as may be permitted by the superintendent, in advance of such proposed acquisition; and

(2) the insurer receives the superintendent's prior approval.

(b) The superintendent shall disapprove such acquisition if the superintendent determines that the proposed acquisition is contrary to law or determines that such proposed acquisition would be contrary to the best interests of the parent insurer's policyholders or of the people of this state. Only the following factors shall be considered in making the foregoing determination:

(1) the availability of the funds or assets required for such acquisition;

(2) the fairness of any exchange of shares, assets, cash or other

consideration for the shares or assets to be received;

(3) the impact of the new operation on the parent insurer's surplus and existing insurance business and the risks inherent in the parent insurer's investment portfolio and operations;

(4) the fairness and adequacy of the financing proposed for the subsidiary;

(5) the likelihood of undue concentration of economic power;

(6) whether the effect of the acquisition may be substantially to lessen competition in any line of commerce in insurance or to tend to create a monopoly therein; and

(7) whether the acquisition might result in an excessive proliferation of subsidiaries that would tend to unduly dilute management effectiveness or weaken financial strength, or otherwise be contrary to the best interests of the parent insurer's policyholders or of the people of this state.

(c) At any time after an acquisition the superintendent may order its disposition if the superintendent finds, after notice and an opportunity to be heard, that its continued retention is hazardous or prejudicial to the interests of the parent insurer's policyholders.

(d) Any domestic insurer seeking to divest its controlling interest in another domestic insurer, in any manner, shall file with the superintendent, with a copy to the insurer, notice of its proposed divestiture at least thirty days prior to the cessation of control, provided, however that this subsection shall not apply if notice is provided as required by subsection (a) of this section.

(e) The contents of each notice of intention of a proposed acquisition or divestiture filed hereunder and information pertaining thereto shall be kept confidential, shall not be subject to subpoena and shall not be made public unless after notice and opportunity to be heard the superintendent determines that the interests of policyholders, shareholders or the public will be served by publication.

§ 1604. Registration. (a) An authorized domestic insurer shall register with the superintendent within thirty days of becoming subject to registration and shall amend the registration within thirty days following any material change to the information provided in the

registration. The registration shall be in such form and shall contain such matters as the superintendent prescribes. The superintendent may grant reasonable extensions of the time to register.

(b)(1) An authorized domestic insurer, other than a domestic insurer required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, shall adopt a formal enterprise risk management function and shall file an enterprise risk report with the superintendent by April thirtieth of each year. The report shall, to the best of the insurer's knowledge and belief, identify the material risks within any subsidiary that could pose enterprise risk to the insurer.

(2) For the purposes of this article, "enterprise risk" means any activity, circumstance, event, or series of events involving one or more subsidiaries of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer, including anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section one thousand three hundred twenty-four of this chapter, or that would cause further transaction of business to be hazardous to the insurer's policyholders or creditors or the public.

(c) (1) An authorized domestic insurer, other than a domestic insurer required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, shall file with the superintendent an annual group capital calculation by June thirtieth of each year when this state is the lead state as determined in accordance with the procedures within the financial analysis handbook adopted by the NAIC, as amended from time to time.

(2) When the lead state is not this state, an authorized domestic insurer shall file with the superintendent the annual group capital calculation as adopted by its lead state if the authorized domestic insurer has filed the annual group capital calculation with the lead state but the lead state is not willing or able to share the annual group capital calculation with the superintendent.

(3) When this state is the lead state, the authorized domestic insurer shall complete the annual group capital calculation in accordance with the group capital calculation instructions, which may permit the superintendent to allow a subsidiary to file the annual group capital

calculation.

(4) When this state is the lead state, an authorized domestic insurer shall be exempt from filing an annual group capital calculation if it:

(A) has only one insurer subsidiary that only writes business and is only licensed in its domestic state and assumes no business from any other insurer;

(B) is required to perform a group capital calculation specified by the United States Federal Reserve Board, except that the authorized domestic insurer shall not be exempt if the superintendent requests the group capital calculation from the United States Federal Reserve Board under the terms of information sharing agreements in effect and the Federal Reserve Board cannot share the calculation with the superintendent;

(C) has a non-United States group-wide supervisor that is located within a reciprocal jurisdiction, as described in part one hundred twenty-five of title eleven of the official compilation of codes, rules and regulations of this state, that recognizes the United States state regulatory approach to group supervision and group capital; or

(D)(i) provides information to the superintendent, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the superintendent to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(ii) has a non-United States group-wide supervisor that is not in a reciprocal jurisdiction and that recognizes and accepts, as specified by the superintendent in a regulation, the group capital calculation as the world-wide group capital assessment for United States systems that operate in that jurisdiction.

(5) Notwithstanding subparagraphs (C) and (D) of paragraph four of this subsection, when this state is the lead state, the superintendent shall require the group capital calculation for United States operations of any non-United States-based system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the superintendent for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(6) Notwithstanding the exemptions from filing the group capital

calculation set forth in paragraph four of this subsection, when this state is the lead state, the superintendent has the discretion to exempt an authorized domestic insurer from filing an annual group capital calculation or accept a limited annual group capital calculation filing or report in accordance with criteria as specified by the superintendent in a regulation.

(7) When this state is the lead state, if the superintendent determines that an authorized domestic insurer no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this subsection, the authorized domestic insurer shall file the group capital calculation at the next annual filing date unless given an extension by the superintendent based on reasonable grounds shown.

(d)(1) An authorized domestic insurer, other than a domestic insurer required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, that has a subsidiary that is scoped into the NAIC liquidity stress test framework shall file the results of a specific year's annual liquidity stress test with the superintendent when this state is the lead state as determined by the procedures within the financial analysis handbook adopted by the NAIC and as amended from time to time.

(2) When the lead state is not this state, an authorized domestic insurer shall file with the superintendent the results of a specific year's liquidity stress test as adopted by its lead state if the authorized domestic insurer has filed the results with the lead state but the lead state is not willing or able to share the results with the superintendent.

(3) When this state is the lead state, the performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test framework.

(4) When this state is the lead state, any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January first of the year following the calendar year when such changes are adopted.

(5) When this state is the lead state, an insurer meeting at least one threshold of the scope criteria shall be considered scoped into the NAIC liquidity stress test framework for the specified data year unless the

superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall not be scoped into the NAIC liquidity stress test framework for that data year.

(6) When this state is the lead state, an insurer that does not trigger at least one threshold of the scope criteria shall be considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall be scoped into the NAIC liquidity stress test framework for that data year.

(7) The superintendent, in consultation with the NAIC financial stability task force, or its successor, shall assess the concern of wishing to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis as part of the determination for an insurer.

(e) No insurer, insurance producer, or other person shall make, publish, disseminate, circulate, issue, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, issued, or placed before the public, in this state, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures for such test, or any component derived in the calculation thereof, of any authorized domestic insurer or subsidiary thereof, provided, however, that an insurer may publish, with the superintendent's prior approval, announcements in a written publication to rebut any materially false statement with respect to the foregoing if the insurer is able to demonstrate to the superintendent with substantial proof the falsity of such statement or the inappropriateness, as the case may be, and if the sole purpose of the announcement is to rebut the materially false statement.

(f) For the purpose of this section:

(1) "Group capital calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the

NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such instructions conflict with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the domestic insurer or subsidiary.

(2) "NAIC" means the National Association of Insurance Commissioners.

(3) "NAIC liquidity stress test framework" means an NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, such scope criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such publication conflicts with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the domestic insurer or subsidiary.

(4) "Scope criteria" means the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

§ 1605. When corporation is deemed a subsidiary. (a) For the purposes of this article:

(1) any corporation a majority of whose outstanding voting shares is owned or controlled by another corporation shall be deemed the latter's subsidiary, and

(2) any corporation whose voting shares are held by a domestic insurance company pursuant to section one thousand six hundred two, one thousand six hundred three or one thousand six hundred four of this article shall be deemed the subsidiary of the insurer, provided that for purposes of section one thousand six hundred six of this article, a corporation shall be deemed the insurer's subsidiary only so long as the insurer owns a majority of the total voting shares or retains direct or indirect control of such subsidiary.

(b) For purposes of this article "voting shares" means shares of any

class having voting power for the election of the corporation's directors except shares having such power only by reason of the happening of a contingency.

§ 1606. Valuation of shares of subsidiary. In determining the financial condition of a domestic insurance company, all shares of its subsidiaries held pursuant to this article shall be valued in accordance with subsections (c), (f) and (g) of section one thousand four hundred fourteen of this chapter.

§ 1607. Subsidiary's name not to mislead. The name of any corporation which is a subsidiary of a domestic insurance company shall not be such as to mislead or deceive the public.

§ 1608. Relationships and transactions between parent and subsidiary. (a) The business operations, corporate proceedings and fiscal and accounting records of subsidiaries organized or acquired pursuant to this article shall be conducted or maintained so as to assure the separate legal and operating identities of the parent and subsidiary, but nothing herein shall preclude arrangements for common management or the cooperative or joint use of personnel, property or services otherwise consistent with this chapter.

(b) All transactions between the insurer and its subsidiaries shall be fair and equitable, charges or fees for services performed shall be reasonable and all expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied.

(c) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(d) The superintendent may promulgate regulations relating to such subsidiaries, their management and their relationships and transactions

with their parent insurance companies and their affiliates to the extent that the same may affect the operations, management or financial condition of domestic insurers. Subsidiaries that are persons within a holding company system, as such terms are defined in article fifteen of this chapter, shall be subject to the provisions of such article.

(e) The following transactions between a domestic insurer and any subsidiary may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period:

(1) sales, purchases, exchanges, loans, extensions of credit, or investments with a subsidy, provided the transactions are equal to or exceed the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus to policyholders at last year-end;

(2) loans or extensions of credit to any person who is not a subsidiary, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or make investments in, any subsidiary of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus to policyholders at last year-end;

(3) reinsurance treaties or agreements with a subsidiary that the insurer has not otherwise submitted to the superintendent, provided, however, the insurer need not submit a copy of a reinsurance agreement unless requested by the superintendent where the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, is less than five percent of the insurer's surplus to policyholders at last year-end. This shall include agreements that may require, as consideration, the transfer of assets from an insurer to a non-subsidiary, if an agreement or understanding exists between the insurer and non-subsidiary that any portion of the assets will be transferred to one or more subsidiaries of the insurer; and

(4) management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing arrangements.

§ 1609. Prohibitions on investments of subsidiaries. No subsidiary acquired by a domestic insurance company pursuant to this article shall make any investment prohibited by subsection (a) of section one thousand four hundred seven of this chapter except that an alien subsidiary may make investments in excess of the limitations described in paragraph seven of such subsection if found by the superintendent to be reasonably necessary to protect the interests of the parent corporation or those of its alien subsidiary and not prejudicial to the interests of the people of this state.

§ 1610. Authority to conduct certain business directly instead of through subsidiary. (a) A domestic insurance company subject to this article may, provided that it maintains books and records which separately account for such business, engage directly in any business referred to in paragraphs one, two and three of this subsection to the extent any such business is necessarily or properly incidental to the insurance business the insurer is authorized to do in this state:

(1) rendering investment advice;

(2) rendering services related to the functions involved in the operation of an insurance business including actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisals, collections and soliciting and engaging in the business of representing self-insurers pursuant to section fifty of the workers' compensation law; and

(3) acting as administrative agent for a government instrumentality which is performing an insurance function or is responsible for a health or welfare program.

(b) A domestic insurance company subject to this article may, provided that it maintains books and records which separately account for such business, engage directly in any other business activity reasonably ancillary to an insurance business to the extent any such business is approved by the superintendent and subject to any limitations he may

prescribe to protect the interests of the policyholders of the insurer after taking into account:

(1) the effect of such business on the insurer's existing insurance business and its surplus,

(2) the proposed allocation of the estimated cost of such business,

(3) the risks inherent in such business, and

(4) the relative advantages to the insurer and its policyholders of conducting such business directly instead of through a subsidiary.

§ 1611. Aggregate limitations. (a) The aggregate investment by the insurer and its subsidiaries in assets which are owned, managed or acquired pursuant to this article shall not exceed the limitations of this chapter otherwise applicable to such investments if held directly by the insurer.

(b) The aggregate amount of the insurer's investment in subsidiaries shall not exceed fifteen percent of the insurer's invested assets, as defined in subsection (a) of section one thousand four hundred one of this chapter and as shown by its last statement on file with the superintendent, but excluded from this limitation shall be any investment in a subsidiary which is an insurance company and any investment in a subsidiary of the type described in paragraph nine of subsection (a) of section one thousand four hundred four or subparagraph (B) of paragraph four of subsection (a) of section one thousand four hundred seven of this chapter.

§ 1612. Regulations. In addition to the powers expressly given by this article, the superintendent shall have the power to promulgate, from time to time, such regulations, not inconsistent with this chapter, as may be appropriate to carry out this article and, insofar as applicable to this article, other provisions of this chapter.

§ 1613. Expenses for group-wide supervision. An authorized domestic insurer shall be liable for and shall pay the reasonable expenses of the superintendent's participation in the administration of group-wide

supervision of internationally active insurance groups, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

§ 1614. Confidentiality of reports and filings. The contents of each report and filing submitted pursuant to this article and information pertaining thereto shall be kept confidential, shall not be subject to subpoena or discovery, shall not be admissible in evidence in any private civil action, and shall not be made public unless, after notice and opportunity to be heard, the superintendent determines that the interests of policyholders, subscribers, stockholders or the public will be served by the publication thereof. Neither the superintendent nor any person who received a report or filing submitted pursuant to this article and information pertaining thereto, through examination or otherwise, while acting under the authority of the superintendent or with whom such report or information are shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning the report, filing, or information.

ARTICLE 17

SUBSIDIARIES OF DOMESTIC LIFE INSURANCE COMPANIES AND CERTAIN OTHER ENTITIES

Section 1701. Authority to invest in subsidiaries; businesses of subsidiaries.
1702. Definitions.
1703. Standard of care for investments in subsidiaries.
1704. Exemptions applicable to subsidiaries; limitations generally.
1705. Quantitative limitations.
1706. Exemptions applicable to parent corporation.
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1710. Divestiture of control; superintendent's power to order disposition of subsidiaries.

1711. Subsidiary's name not to mislead.
1712. Relationships and transactions between parent corporation and subsidiary.
1713. Prohibitions on investments of subsidiaries.
1714. Authority to conduct certain business directly instead of through subsidiary.
1715. Valuation of shares of subsidiaries.
1716. Regulations.
1717. Registration.
1718. Expenses for group-wide supervision.

§ 1701. Authority to invest in subsidiaries; businesses of subsidiaries. Subject to the provisions of section one thousand two hundred eighteen of this chapter:

(a) A domestic life insurance company may, subject to the provisions of subsection (d) of section one thousand four hundred five of this chapter, invest in, or otherwise acquire, subsidiaries engaged or organized to engage in any business lawful under the laws of the jurisdictions in which such subsidiaries are organized;

(b) A domestic corporation subject to article forty-three of this chapter may invest in, or otherwise acquire, subsidiaries of the types described in subsection (b) of section one thousand seven hundred four of this article and subsidiaries engaged or organized to engage in (i) activities that such corporation could engage in directly, (ii) management or information services reasonably related to the provision of health insurance, (iii) the delivery or financing of health care, or (iv) any other business directly related to providing administration or sales of any employer provided or arranged employee health and welfare benefits, provided that notice of any such acquisition or investment shall be given to the superintendent within five days thereafter; and

(c) A domestic retirement system subject to article forty-six of this chapter may invest in, or otherwise acquire, subsidiaries of the types described in subsection (b) of section one thousand seven hundred four of this article and subsidiaries of the type authorized by article forty-six of this chapter.

§ 1702. Definitions. As used in this article: (a) "Subsidiary" means subsidiaries of the types described in subsection (b) of section one thousand seven hundred four of this article and subsidiaries acquired or held under this article, section one thousand four hundred five or section four thousand two hundred forty of this chapter, but shall not include a subsidiary acquired or held under section one thousand four hundred four of this chapter or a subsidiary acquired or held by an insurer authorized to make investments by subsection (c) of section one thousand four hundred three of this chapter.

(b) "Parent corporation" means a parent corporation of a type described in subsection (a), (b) or (c) of section one thousand seven hundred one of this article.

(c) "Holding company operating subsidiary" means a subsidiary (other than a separate account subsidiary) engaged or organized to engage in either or both of the following activities (1) the ownership and management of other subsidiaries, and (2) the raising of capital (debt or equity) that could be loaned to, or invested in, other subsidiaries or loaned to the parent corporation, provided that any such subsidiary may in addition engage in the ownership and management of assets authorized as investments for the parent corporation.

(d) "Investment subsidiary" means a subsidiary (other than a separate account subsidiary) engaged or organized to engage exclusively in the ownership and management of assets (other than equity securities of subsidiaries) authorized as investments for the parent corporation and of other investment subsidiaries.

(e) "Separate account subsidiary" means a subsidiary acquired or held under section four thousand two hundred forty of this chapter.

(f) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more subsidiaries of a parent corporation that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the parent corporation, including anything that would cause the parent corporation's risk-based capital to fall into company action level as set forth in section one thousand three hundred twenty-two of this chapter, or that would cause further transaction of business to be hazardous to the insurer's policyholders or creditors or the public.

(g) "Group capital calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such instructions conflict with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the parent corporation or subsidiary.

(h) "NAIC" means the National Association of Insurance Commissioners.

(i) "NAIC liquidity stress test framework" means an NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, such scope criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC, except where such instructions conflict with the laws of this state and subject to exceptions the superintendent may take in a regulation upon a written finding that the exceptions would not be unduly burdensome on the parent corporation or subsidiary.

(j) "Scope criteria" means the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

§ 1703. Standard of care for investments in subsidiaries. In addition to other requirements of law (statutory or otherwise) that affect the standard of care of directors and officers of corporations, directors and officers shall perform their duties in connection with investments in, or other acquisitions of, subsidiaries in good faith and with that degree of care that an ordinarily prudent individual in a like position would use under similar circumstances.

§ 1704. Exemptions applicable to subsidiaries; limitations generally. (a) Investments in separate account subsidiaries and in investment subsidiaries are exempt from the provisions of subsection (a) of section

one thousand seven hundred five of this article and separate account subsidiaries and investment subsidiaries are exempt from the provisions of item (ii) of section one thousand seven hundred ten of this article. Investments by the parent corporation in holding company operating subsidiaries are exempt from the provisions of paragraph two of subsection (a) of section one thousand seven hundred five of this article.

(b) Subsidiaries that become such as a result of (i) the acquisition of securities received as permitted by subsection (e) of section one thousand four hundred three of this chapter or (ii) the temporary assumption of control by the owners of securities upon the happening of a contingency are exempt from the provisions of section one thousand seven hundred eight and item (ii) of section one thousand seven hundred ten of this article for one year, and from the provisions of subsection (a) of section one thousand seven hundred five of this article for five years, after becoming subsidiaries.

(c) Investments in subsidiaries engaged or organized to engage in any kind of insurance business in which the parent corporation may engage, and investments in subsidiaries engaged or organized to engage exclusively in the ownership and management of such subsidiaries, are exempt from the provisions of subsection (a) of section one thousand seven hundred five of this article.

(d) Investments made or acquired by investment subsidiaries shall be deemed, for the purposes of this chapter, to be made or acquired directly by the parent corporation (pro rata, in the case of a subsidiary less than all of whose voting securities are owned by the parent corporation, in accordance with the parent corporation's investment in such subsidiary), and shall (to such extent) be subject to all the provisions and limitations (including quantitative limits) on the making thereof specified in this chapter with respect to investments by the parent corporation.

§ 1705. Quantitative limitations. * (a)(1) Unless the superintendent shall have given prior written approval, a parent corporation shall not make an investment for its own account in any subsidiary (not at the time exempt from the provisions of this section) if, after giving effect

to such investment, the aggregate investment value of all subsidiaries then directly invested in by the parent corporation (excluding investments in subsidiaries at the time exempted from this subsection) would be in excess of thirty percent (but not more than twenty percent with respect to subsidiaries not having their principal operations in this state, and, in the case of a parent corporation of the type described in subsection (b) of section one thousand seven hundred one of this article, not more than ten percent) of the parent corporation's admitted assets.

(2) Unless the superintendent shall have given prior written approval, neither the parent corporation nor any subsidiary (other than a separate account subsidiary or any subsidiary referred to in subsection (c) of section one thousand seven hundred four of this article) may make any investment in any subsidiary (not at the time exempt from this paragraph), if, after giving effect to such investment, the investment value of such subsidiary would aggregate more than fifteen percent (but not more than two percent in the case of a parent corporation of the type described in subsection (b) of section one thousand seven hundred one of this article) of the parent corporation's admitted assets.

* NB See other sub§ (a) (Sep. amended - cannot be put together)

* (a)(1) Unless the superintendent shall have given prior written approval, a parent corporation shall not make an investment for its own account in any subsidiary (not at the time exempt from the provisions of this section) if, after giving effect to such investment, the aggregate investment value of all subsidiaries then directly invested in by the parent corporation (excluding investments in subsidiaries at the time exempted from this subsection) would be in excess of thirty percent (but not more than twenty percent with respect to subsidiaries not having their principal operations in this state and, in the case of a parent corporation of the type described in subsection (b) of section one thousand seven hundred one of this article, not more than ten percent) of the parent corporation's admitted assets.

(2) Unless the superintendent shall have given prior written approval, neither the parent corporation nor any subsidiary (other than a separate account subsidiary or any subsidiary referred to in subsection (c) of section one thousand seven hundred four of this article) may make any investment in any subsidiary (not at the time exempt from this

paragraph), if, after giving effect to such investment, the investment value of such subsidiary would aggregate more than fifteen percent (but not more than two percent in the case of the parent corporation of the type described in subsection (b) of section one thousand seven hundred one of this article) of the parent corporation's admitted assets.

* NB See other sub§ (a) (Sep. amended - cannot be put together)

(b) "Admitted assets," for the purposes of this section, has the meaning ascribed to it by subparagraph (B) of paragraph one of subsection (b) of section one thousand four hundred five of this chapter.

(c) (1) For the purposes of computations under paragraph one of subsection (a) of this section, the aggregate investment value of all subsidiaries at any time directly invested in by the parent corporation (excluding investments in subsidiaries at the time exempted from subsection (a) of this section) shall mean the sum of (i) the minimum value of each such subsidiary of which equity securities (including partnership interests) are directly held by the parent corporation, (ii) indebtedness of such subsidiaries then outstanding to the extent guaranteed by the parent corporation, and (iii) the unpaid principal amount of loans and advances to such subsidiaries by the parent corporation or by any investment subsidiary of the parent corporation then outstanding (including the unpaid principal amount of bonds, notes or other evidences of indebtedness of such subsidiaries held by the parent corporation or by any such investment subsidiary). The minimum value of a subsidiary as of any date shall be the greater of (i) the net cost of the equity investment in such subsidiary by the parent corporation or (ii) the pro rata interest of the parent corporation in the net worth of such subsidiary.

(2) For purposes of computations under paragraph two of subsection (a) of this section, the investment value of a subsidiary at any time shall be an amount equal to the sum of (i) the minimum value of such subsidiary, (ii) indebtedness of such subsidiary then outstanding to the extent guaranteed by the parent corporation, and (iii) the unpaid principal amount of loans and advances to the subsidiary by the parent corporation or by any investment subsidiary of the parent corporation then outstanding (including the unpaid principal amount of bonds, notes or other evidences of indebtedness of the subsidiary held by the parent

corporation or by any such investment subsidiary). The minimum value of a subsidiary as of any date shall be the greater of (i) the net cost of the equity investment in such subsidiary by the parent corporation and its subsidiaries or (ii) the pro rata interest of the parent corporation and its subsidiaries in the net worth of such subsidiary.

(3) For purposes of this subsection, the "net cost of the equity investment" by any person in a subsidiary at any time shall mean the aggregate amount of contributions to and purchases of equity securities (including partnership interests) and other equity interests of such subsidiary (less repurchases of such equity securities and other equity interests) by such person at such time and the "net worth" of a subsidiary shall mean the net worth of the subsidiary determined in accordance with generally accepted accounting principles, as of the end of its most recent fiscal year. In determining the minimum value of a holding company operating subsidiary, there shall be taken into account the greater of the net cost of the equity investment of the holding company operating subsidiary in each subsidiary or the pro rata interest of the holding company operating subsidiary in the net worth of such subsidiary. The superintendent may require, by regulation, that parent corporations submit reports annually to the superintendent as to the aggregate investment value of all subsidiaries held by the parent corporation determined in accordance with paragraph one of this subsection or the investment value of any particular subsidiary or class of subsidiaries held by the parent corporation determined in accordance with paragraph two of this subsection, which values may be required to be audited by an independent public accountant in accordance with generally accepted auditing standards.

§ 1706. Exemptions applicable to parent corporation. Except as provided in subsection (d) of section one thousand four hundred five of this chapter and except for investments deemed to be made or acquired directly by the parent corporation (as provided in subsection (d) of section one thousand seven hundred four of this article), investments by parent corporations in subsidiaries are not subject to the limitations on the making of investments provided for in section one thousand four hundred three, section one thousand four hundred four (in the case of

insurers making investments under section one thousand four hundred four) or section one thousand four hundred five (in the case of insurers making investments under section one thousand four hundred five) of this chapter.

§ 1707. Regulations to restrict pyramiding. The superintendent may adopt regulations designed to prevent an insurer from pyramiding subsidiaries to a degree that, in the judgment of the superintendent, would be materially adverse to the interests of policyholders, subscribers or the people of this state.

§ 1708. Information reports. Every parent corporation that has acquired one or more subsidiaries shall (except to the extent exempted by section one thousand seven hundred four of this article) file an information report on or before May first of each year or on or before such other date as the superintendent may permit. The information report shall provide (i) a description of the activities of the subsidiary, (ii) a description of all material transactions between the subsidiary and such parent corporation and affiliates of such subsidiary, and (iii) such other information as the superintendent may by regulation prescribe.

§ 1709. Confidentiality of reports and filings. The contents of each report and filing submitted pursuant to this article and information pertaining thereto shall be kept confidential, shall not be subject to subpoena or discovery, shall not be admissible in evidence in any private civil action, and shall not be made public unless, after notice and opportunity to be heard, the superintendent determines that the interests of policyholders, subscribers, stockholders or the public will be served by the publication thereof. The provisions of this section shall not be applicable to any report or filing submitted pursuant to this article and any information pertaining thereto, if the parent corporation is a corporation subject to article forty-three of this chapter. Neither the superintendent nor any person who received a report

or filing submitted pursuant to this article and information pertaining thereto, through examination or otherwise, while acting under the authority of the superintendent or with whom such report or information are shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning the report, filing, or information.

§ 1710. Divestiture of control; superintendent's power to order disposition of subsidiaries.

(a) Any parent corporation seeking to divest its controlling interest in a domestic insurer, in any manner, shall file with the superintendent, with a copy to the insurer, notice of its proposed divestiture at least thirty days prior to the cessation of control, provided, however that this subsection shall not apply if notice is provided as required by subsection (b) of section one thousand seven hundred one of this article.

(b) In addition to the powers granted to the superintendent elsewhere in this chapter (including, without limitation, section one hundred nine of this chapter and section three hundred nine of the financial services law), the superintendent may, at any time, order a parent corporation to dispose of any subsidiary, if the superintendent finds, after notice and an opportunity to be heard, either:

(1) that its acquisition or continued retention is or was not permitted by the provisions of this article; or

(2) except in the case of a subsidiary then exempted by the provisions of subsection (a) or (b) of section one thousand seven hundred four of this article, that its continued retention is materially adverse to the interests of the parent corporation's policyholders or subscribers.

§ 1711. Subsidiary's name not to mislead. The name of any subsidiary shall not be such as to mislead or deceive the public.

§ 1712. Relationships and transactions between parent corporation and subsidiary. (a) The business operations, corporate proceedings and

fiscal and accounting records of subsidiaries shall be conducted or maintained so as to assure the separate legal and operating identities of the parent corporation and subsidiary, but nothing herein shall preclude arrangements for common management or the cooperative or joint use of personnel, property, or services, otherwise consistent with this chapter. All transactions between the parent corporation and its subsidiaries shall be fair and equitable, charges or fees for services performed shall be reasonable and all expenses incurred and payments received shall be allocated to the parent corporation on an equitable basis in conformity with customary insurance accounting practices consistently applied. The books, accounts and records of each party to all such transactions shall be so maintained as to disclose clearly and accurately the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(b) The following transactions between a parent corporation and any subsidiary may not be entered into unless the parent corporation has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or with regard to reinsurance treaties or agreements at least forty-five days prior thereto, or such shorter period as the superintendent may permit, and the superintendent has not disapproved it within such period:

(1) sales, purchases, exchanges, loans, extensions of credit, or investments with a subsidiary, provided the transactions are equal to or exceed:

(A) three percent of the parent corporation's admitted assets at last year-end, with regard to a domestic life insurance company; or

(B) the lesser of three percent of the parent corporation's admitted assets or twenty-five percent of capital and surplus at last year-end, with regard to a domestic corporation subject to article forty-three of this chapter; or

(2) loans or extensions of credit to any person who is not a subsidiary, where the parent corporation makes loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or make investments in, any subsidiary of the parent corporation making the

loans or extensions of credit, provided the transactions are equal to or exceed:

(A) three percent of the parent corporation's admitted assets at last year-end, with regard to a domestic life insurance company; or

(B) the lesser of three percent of the parent corporation's admitted assets or twenty-five percent of capital and surplus at last year-end, with regard to a domestic corporation subject to article forty-three of this chapter; or

(3) reinsurance treaties or agreements with a subsidiary that the parent corporation has not otherwise submitted to the superintendent. This shall include agreements that may require, as consideration, the transfer of assets from a parent corporation to a non-subsidiary, if an agreement or understanding exists between the parent corporation and non-subsidiary that any portion of the assets will be transferred to one or more subsidiaries of the parent corporation; and

(4) management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing arrangements.

§ 1713. Prohibitions on investments of subsidiaries. No subsidiary shall make any investment (i) in obligations, shares or other securities issued by a corporation, other than an insurance corporation, if a majority of the shares having voting powers of such issuing corporation is owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer or (ii) found by the superintendent to be against public policy or designed to evade any prohibition of this chapter or (iii) in the case of a subsidiary that is a property/casualty insurance company (other than an alien insurer), in any foreign investment that would be prohibited under paragraph seven of subsection (a) of section one thousand four hundred seven of this chapter.

§ 1714. Authority to conduct certain business directly instead of through subsidiary. (a) A domestic life insurance company may, if it maintains books and records that separately account for such business, engage directly in (i) any business, to the extent necessarily or properly incidental to the insurer's business, including rendering

investment advice, investment management services and services related to the functions involved in the operation of an insurance business, and (ii) any other business to the extent approved by the superintendent.

(b) In the case of approval pursuant to item (ii) of subsection (a) of this section, the superintendent may prescribe limitations for the protection of the interests of the policyholders of such company after taking into account the effect of such business on such company's existing insurance business and its surplus, the proposed allocation of the estimated cost of such business and the risks inherent in such business as well as the relative advantages to such company and its policyholders of conducting such business directly instead of through a subsidiary.

§ 1715. Valuation of shares of subsidiaries. In determining the financial condition of a parent corporation, all stock of its subsidiaries (except subsidiaries acquired or held under section four thousand two hundred forty of this chapter) shall be valued in accordance with subsections (c), (f) and (g) of section one thousand four hundred fourteen of this chapter. Stock of subsidiaries acquired or held under section four thousand two hundred forty of this chapter shall be valued as required by section four thousand two hundred forty of this chapter.

§ 1716. Regulations. In addition to the powers expressly given by this article, the superintendent shall have the power to promulgate, from time to time, such regulations, not inconsistent with the provisions of this chapter, as may be appropriate to carry out the provisions of this article and, insofar as applicable to this article, other provisions of this chapter.

§ 1717. Registration. (a) A parent corporation shall register with the superintendent within thirty days of becoming subject to registration and shall amend the registration within thirty days following any material change to the information provided in the registration. The

registration shall be in such form and shall contain such matters as the superintendent prescribes. The superintendent may grant reasonable extensions of the time to register.

(b) A parent corporation, other than a parent corporation required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, shall adopt a formal enterprise risk management function and shall file an enterprise risk report with the superintendent by April thirtieth of each year. The report shall, to the best of the parent corporation's knowledge and belief, identify the material risks within any subsidiary that could pose enterprise risk to the parent corporation.

(c) (1) A parent corporation, other than a parent corporation required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, shall file with the superintendent an annual group capital calculation by June thirtieth of each year when this state is the lead state as determined in accordance with the procedures within the financial analysis handbook adopted by the NAIC, as amended from time to time.

(2) When the lead state is not this state, a parent corporation shall file with the superintendent the annual group capital calculation as adopted by its lead state if the parent corporation has filed the annual group capital calculation with the lead state but the lead state is not willing or able to share the annual group capital calculation with the superintendent.

(3) When this state is the lead state, the parent corporation shall complete the annual group capital calculation in accordance with the group capital calculation instructions, which may permit the superintendent to allow a subsidiary to file the annual group capital calculation.

(4) When this state is the lead state, a parent corporation shall be exempt from filing an annual group capital calculation if it:

(A) has only one insurer subsidiary that only writes business and is only licensed in its domestic state and assumes no business from any other insurer;

(B) is required to perform a group capital calculation specified by the United States Federal Reserve Board, except that the parent corporation shall not be exempt if the superintendent requests the group

capital calculation from the United States Federal Reserve Board under the terms of information sharing agreements in effect and the Federal Reserve Board cannot share the calculation with the superintendent;

(C) has a non-United States group-wide supervisor that is located within a reciprocal jurisdiction, as described in part one hundred twenty-five of title eleven of the official compilation of codes, rules and regulations of this state, that recognizes the United States state regulatory approach to group supervision and group capital; or

(D)(i) provides information to the superintendent, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the superintendent to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(ii) has a non-United States group-wide supervisor that is not in a reciprocal jurisdiction that recognizes and accepts, as specified by the superintendent in a regulation, the group capital calculation as the world-wide group capital assessment for United States systems that operate in that jurisdiction.

(5) Notwithstanding subparagraphs (C) and (D) of paragraph four of this subsection, when this state is the lead state, the superintendent shall require the group capital calculation for United States operations of any non-United States-based system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the superintendent for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(6) Notwithstanding the exemptions from filing the group capital calculation set forth in paragraph four of this subsection, when this state is the lead state, the superintendent has the discretion to exempt a parent corporation from filing an annual group capital calculation or accept a limited annual group capital calculation filing or report in accordance with criteria as specified by the superintendent in a regulation.

(7) When this state is the lead state, if the superintendent determines that a parent corporation no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this subsection, the parent corporation shall file the group

capital calculation at the next annual filing date unless given an extension by the superintendent based on reasonable grounds shown.

(d)(1) A parent corporation, other than a parent corporation required to register as a controlled insurer pursuant to section one thousand five hundred three of this chapter, that has a subsidiary that is scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test with the superintendent when this state is the lead state as determined by the procedures within the financial analysis handbook adopted by the NAIC and as amended from time to time.

(2) When the lead state is not this state, a parent corporation shall file with the superintendent the results of a specific year's liquidity stress test as adopted by its lead state if the parent corporation has filed the results with the lead state but the lead state is not willing or able to share the results with the superintendent.

(3) When this state is the lead state, the performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test framework.

(4) When the lead state is this state, any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January first of the year following the calendar year when such changes are adopted.

(5) When this state is the lead state, an insurer meeting at least one threshold of the scope criteria shall be considered scoped into the NAIC liquidity stress test framework for the specified data year unless the superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall not be scoped into the NAIC liquidity stress test framework for that data year.

(6) When this state is the lead state, an insurer that does not trigger at least one threshold of the scope criteria shall be considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the superintendent, in consultation with the NAIC financial stability task force, or its successor, determines the insurer shall be scoped into the NAIC liquidity stress test framework for that data year.

(7) The superintendent, in consultation with the NAIC financial stability task force, or its successor, shall assess the concern of

wishing to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis as part of the determination for an insurer.

(e) No insurer, insurance producer, or other person shall make, publish, disseminate, circulate, issue, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, issued, or placed before the public, in this state, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, liquidity stress test results or supporting disclosures for such test, or any component derived in the calculation thereof, of any parent corporation or subsidiary thereof, provided, however, that a parent corporation may publish, with the superintendent's prior approval, announcements in a written publication to rebut any materially false statement with respect to the foregoing if the insurer is able to demonstrate to the superintendent with substantial proof the falsity of such statement or the inappropriateness, as the case may be, and if the sole purpose of the announcement is to rebut the materially false statement.

§ 1718. Expenses for group-wide supervision. A parent corporation shall be liable for and shall pay the reasonable expenses of the superintendent's participation in the administration of group-wide supervision of internationally active insurance groups, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

ARTICLE 21

AGENTS, BROKERS, ADJUSTERS, CONSULTANTS AND INTERMEDIARIES

Section 2101. Definitions.
2102. Acting without a license.
2103. Insurance agents; licensing.

2104. Insurance brokers; licensing.
2105. Excess line brokers; licensing.
2106. Reinsurance intermediaries; licensing.
2107. Insurance consultants; licensing and duties.
2108. Adjusters; licensing and duties.
2109. Agents and brokers; temporary license in case of death, service in armed forces or disability.
2110. Revocation or suspension of license of insurance producer, insurance consultant, adjuster or life settlement broker.
2111. Revoked licensees.
2112. Certificate of appointment of an insurance producer to act as an agent and notice of termination of an insurance producer.
2113. Title insurance agent commissions; disclosure.
2114. Life, accident and health insurance agents; commissions.
2115. Property/casualty insurance agents; commissions.
2116. Insurance brokers; commissions.
2117. Acting for or aiding unlicensed or unauthorized insurers or health maintenance organizations.
2118. Excess line brokers; duties.
2119. Insurance agents, brokers, consultants, life settlement brokers, and title insurance agents; written contract for compensation; excess charges prohibited.
2120. Fiduciary capacity of insurance agents, title insurance agents, insurance brokers and reinsurance intermediaries.
2121. Broker authorized to receive premium, when.
2122. Advertising by insurance producers.
2123. Misrepresentations, misleading statements and incomplete comparisons.
2124. Stay or suspension of superintendent's determination.
2125. Marine insurance; acting as agent, broker or insurer of persons without insurable interest.
2126. Impersonation at examinations prohibited.
2127. Penalties for violations.
2128. Commission and fee sharing prohibited.

2129. Duty to have an agent or broker at each place of business.
2130. Excess line association.
2131. Limited license for rental vehicle companies, peer-to-peer car sharing program administrators, wireless communications equipment vendors and self-service storage companies.
2132. Continuing education.
2133. Forged insurance identification cards.
2134. Change of address.
2135. Administration of certain functions.
2136. Reciprocity.
2137. Life settlement brokers; licensing.
2138. Health benefit exchange navigators.
2139. Title insurance agents; licensing.
2140. Restrictions on insurance producers procuring immigration bonds.

§ 2101. Definitions. (a) In this article, "insurance agent" means any authorized or acknowledged agent of an insurer, fraternal benefit society or health maintenance organization issued a certificate of authority pursuant to article forty-four of the public health law, and any sub-agent or other representative of such an agent, who acts as such in the solicitation of, negotiation for, or sale of, an insurance, health maintenance organization or annuity contract, other than as a licensed insurance broker, except that such term shall not include:

(1) any regular salaried officer or employee of a licensed insurer, fraternal benefit society or health maintenance organization or of a licensed insurance agent, who does not solicit or accept from the public, outside of an office of such insurer, health maintenance organization or agent, applications or orders for any such contract, if such officer or employee does not receive a commission or other compensation for his services which commission or other compensation is directly dependent upon the amount of business done;

(2) employees of insurers, fraternal benefit societies or health maintenance organizations or organizations employed by insurers, fraternal benefit societies or health maintenance organizations who are

engaging in the inspection, rating or classification of risks, or in the supervision of the training of licensed insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(3) any agent or representative of a fraternal benefit society, other than agents representing societies governed by section four thousand five hundred twenty-seven of this chapter, who devotes, or intends to devote, less than fifty percent of the person's time to the solicitation and negotiation or sale of insurance contracts for fraternal benefit societies and who receives or intends to receive any commission or other compensation directly dependent on the amount of insurance, provided that any person who in the preceding calendar year has solicited, negotiated or sold any of the following contracts of insurance on behalf of a fraternal benefit society is presumed to have devoted, or intended to devote, fifty percent of the person's time to the solicitation, negotiation and sale of insurance contracts;

(A) life insurance contracts that, in the aggregate, exceed two hundred thousand dollars of coverage for all lives insured for the preceding calendar year;

(B) a permanent life insurance contract offering more than ten thousand dollars of coverage on an individual life;

(C) a term life insurance contract offering more than fifty thousand dollars of coverage on an individual life;

(D) any insurance contracts other than life that the fraternal benefit society may write that insure the individual lives of more than twenty-five persons;

(E) any variable life insurance or variable annuity contract;

(4) any agent or other representative of any title insurance company;

(5) any service contract provider or any administrator or person designated by a service contract provider who in this state markets, sells, offers for sale, issues, makes, proposes to make or administer service contracts pursuant to article seventy-nine of this chapter;

(6) a person who secures and furnishes information for the purpose of group life insurance, group property/casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or performing

administrative services related to mass marketed property/casualty insurance, provided that no commission is paid to the person for the service;

(7) an employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, fraternal benefit society or health maintenance organization, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(8) a person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

(10) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission; or

(11) any person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, to act as a navigator, as such term is used in 42 U.S.C. § 18031(i), provided that the person: (A) has completed the training required by the health benefit exchange; (B)

does not sell insurance; (C) does not engage in any activity with respect to insurance not expressly permitted under 42 U.S.C. § 18031(i)(3) and regulations thereunder; and (D) does not receive any compensation for acting as a navigator directly or indirectly from an insured, insurance producer, or an insurer.

(b) In this article, "independent insurance agent" means an "insurance agent" who is not owned or controlled by any insurer, fraternal benefit society or health maintenance organization or group of such insurers and whose agency agreement does not prohibit the representation of other insurers or groups of insurers and which provides that upon termination of the agreement the agent's records and use and control of expirations remain the property of the agent. Only an "independent insurance agent" shall be represented to the public as an independent insurance agent or agency.

(c) In this article, "insurance broker" means any person, firm, association or corporation who or which for any compensation, commission or other thing of value acts or aids in any manner in soliciting, negotiating or selling, any insurance or annuity contract or in placing risks or taking out insurance, on behalf of an insured other than himself, herself or itself or on behalf of any licensed insurance broker, except that such term shall not include:

(1) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission;

(2) an officer, director or employee of a licensed insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(A) the officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or

(B) the officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) the officer, director or employee is acting in the capacity of a

special agent or agency supervisor assisting licensed insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(3) any foreign freight forwarder registered with the federal maritime commission or any custom house broker licensed by the United States treasury department, when such forwarder or broker negotiates, issues or delivers a certificate or other evidence of a contract of insurance under an open marine policy naming the forwarder or broker as the insured and covering exports or imports serviced by such forwarder or broker on behalf of others, provided that such forwarder or broker takes or receives no money or other thing of value when acting as hereinafter specified, from any insurer or representative thereof, unless the receipt of money or thing of value is authorized under this chapter;

(4) any service contract provider or any administrator or person designated by a service contract provider who in this state markets, sells, offers for sale, issues, makes, proposes to make or administers service contracts pursuant to article seventy-nine of this chapter;

(5) a person who secures and furnishes information for the purpose of group life insurance, group property/casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass marketed property/casualty insurance, where no commission is paid to the person for the service;

(6) an employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, fraternal benefit society or health maintenance organization, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(7) a person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through

communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(8) a person who is not a resident of this state who sells, solicits or negotiates a contract for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state; or

(10) any person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, to act as a navigator, as such term is used in 42 U.S.C. § 18031(i), including any person employed by a certified navigator, provided that the person: (A) has completed the training required by the health benefit exchange; (B) does not sell insurance; (C) does not engage in any activity with respect to insurance not expressly permitted under 42 U.S.C. § 18031(i)(3) and regulations thereunder; and (D) does not receive any compensation for acting as a navigator directly or indirectly from an insured, insurance producer, or an insurer.

(d) In this article, "non-resident insurance agent" means an individual who is a non-resident of this state and who is licensed or authorized to act as an insurance agent in the state in which he resides, or in which he or the firm or association of which he is a member or employee, or the corporation of which he is an officer, director, or employee maintains an office as an insurance agent.

(e) In this article, "non-resident insurance broker", means an

individual who is a non-resident of this state and who is licensed or authorized to act as an insurance broker in the state in which he resides, or in which he, or the firm or association of which he is a member or employee, or the corporation of which he is an officer, director or employee, maintains an office as an insurance broker.

(f) In this article, "reinsurance intermediary" means any person, firm, association or corporation who acts as broker in soliciting, negotiating or selling any reinsurance contract or binder, or acts as an agent in accepting any reinsurance contract or binder on behalf of an insurer, except that such term shall not include:

(1) licensed attorneys at law of this state acting in their professional capacity as such;

(2) regular salaried officers, employees or attorneys in fact of an authorized insurer or of an underwriting office of such insurer while acting in their capacity as such in discharging the duties of their employment or appointment;

(3) licensed insurance agents acting within the scope of their agency authority in the placement or acceptance of reinsurance on risks produced or managed by such agents; or

(4) licensed insurance brokers, in the placement of reinsurance on risks produced by such brokers.

(g) In this article, "adjuster" means any "independent adjuster" or "public adjuster" as defined below:

(1) The term "independent adjuster" means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer and who performs such duties required by such insurer as are incidental to such claims and also includes any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster, except that such term shall not include:

(A) any officer, director or regular salaried employee of an authorized insurer or entity licensed pursuant to article forty-four of the public health law providing comprehensive health service plans (as used in this paragraph, a "health maintenance organization"), or any manager thereof, individual or corporate, or the manager, agent or

general agent of any department thereof, individual or corporate, or attorney in fact of any reciprocal insurer or Lloyds underwriter, or marine underwriting office, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

(B) any officer, director or regular salaried employee of an insurer authorized to write accident and health insurance, a corporation licensed under article forty-three of this chapter (collectively, as used in this paragraph, a "health insurer") or a health maintenance organization, or any manager thereof, individual or corporate, when the claim to be adjusted is issued or administered by another health insurer or health maintenance organization within the same holding company system as the health insurer or health maintenance organization adjusting the claim;

(C) any officer, director or regular salaried employee of an article fifteen holding company or a controlled person within such holding company system providing administrative services within that holding company, or any manager thereof, individual or corporate, when the claim to be adjusted is submitted for payment under a health benefit plan that is issued or administered by a health insurer or health maintenance organization within that same holding company system;

(D) any officer, director or regular salaried employee of an authorized insurer that is licensed to write the kind of insurance to be adjusted, or any manager thereof, individual or corporate, when the claim to be adjusted is pursuant to a policy that is issued or administered by another insurer within the same holding company system as the authorized insurer adjusting the claim, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

(E) any officer, director or regular salaried employee of an authorized life insurance company, or any manager thereof, individual or corporate, or the manager, agent or general agent of any department thereof, individual or corporate, when the claim to be adjusted is submitted under an insurance contract issued by another insurer and the claim: (i) is within the scope of a contract of reinsurance between the two insurers for all of the underlying risks and none of the underlying risks are later reinsured back to the ceding insurer; and (ii) relates to a kind of insurance that the authorized life insurance company adjusting the claim is licensed to write;

(F) any adjustment bureau or association owned and maintained by insurers to adjust or investigate losses, or any regular salaried employee or manager thereof who devotes substantially all of his time to the business of such bureau or association, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

(G) any licensed agent of an authorized insurer who adjusts losses for such insurer solely under policies issued through his or its agency, provided the agent receives no compensation for such services in excess of fifty dollars per loss adjusted;

(H) any licensed attorney at law of this state;

(I) any average adjuster or adjuster of maritime losses; or

(J) any agent or other representative of an insurer authorized to issue life and annuity contracts, provided he receives no compensation for such services.

(2) "Public adjuster" means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts or aids in any manner on behalf of an insured in negotiating for, or effecting, the settlement of a claim or claims for loss or damage to property of the insured in this state caused by, or resulting from, any of the risks as enumerated in paragraphs four, five, six, seven, eight, nine and ten and subparagraphs (B) and (C) of paragraph twenty of subsection (a) of section one thousand one hundred thirteen of this chapter, not including loss or damage to persons under subparagraph (B) of paragraph twenty of subsection (a) of such section or who, or which, advertises for, or solicits employment as an adjuster of such claims, and shall also include any person who, for money, commission or any other thing of value, solicits, investigates, or adjusts such claims on behalf of any such public adjuster, except that such term shall not include:

(A) any employee, agent or other representative of any authorized insurer who acts as such in the adjustment of any claim or any licensed insurance broker who acts as an adjuster for a client of such broker, without any compensation for such services as adjuster if such insurer's representative or such licensed insurance broker does not advertise or publicly solicit the adjustment of claims in such a way as is likely to mislead the public into believing that he is offering his services as a public adjuster;

(B) any licensed attorney at law of this state who acts or aids in adjusting insurance claims as an incident to the practice of his profession and who does not advertise himself as a public adjuster;

(C) any licensed insurance broker who acts as an adjuster with respect to any loss involving insurance contracts under which he was the broker of record in placing the insurance, whether or not designated in writing to act for the insured; or

(D) any other licensed insurance broker who has been designated to act for the insured in writing before a loss occurs.

(h) In this chapter, "licensed insurance broker," means an insurance broker who is the licensee or a sub-licensee named in a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article and in full force and effect.

(i) In this chapter, "limited licensee" shall mean a person authorized to sell certain coverages relating to the rental of motor vehicles pursuant to the provisions of section two thousand one hundred thirty-one of this article.

(j) In this article, "auto body repair estimator" means any officer, director or regular salaried employee of an authorized insurer or of any adjustment bureau or association owned and maintained by insurers, who writes, or who directly supervises the writing of, any motor vehicle body repair estimate in this state, on behalf of such insurer in the work of diagnosing or estimating motor vehicle repair costs or procedures relative to appraising, investigating or adjusting claims for motor vehicle body repair work pursuant to an insurance contract.

(k) In this article, "insurance producer" means an insurance agent, title insurance agent, insurance broker, reinsurance intermediary, excess lines broker, or any other person required to be licensed under the laws of this state to sell, solicit or negotiate insurance. Such term shall not include:

(1) an officer, director or employee of a licensed insurer, fraternal benefit society or health maintenance organization or of a licensed insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(A) the officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are

only indirectly related to the sale, solicitation or negotiation of insurance; or

(B) the officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) the officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting licensed insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(2) employees of insurers, fraternal benefit societies or health maintenance organizations or organizations employed by insurers, fraternal benefit societies or health maintenance organizations who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of licensed insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(3) any agent or representative of a fraternal benefit society, other than agents representing societies governed by section four thousand five hundred twenty-seven of this chapter, who devotes, or intends to devote, less than fifty percent of the person's time to the solicitation, negotiation or sale of insurance contracts for fraternal benefit societies and who receives or intends to receive any commission or other compensation directly dependent on the amount of insurance, provided that any person who in the preceding calendar year has solicited, negotiated or sold any of the following contracts of insurance on behalf of a fraternal benefit society is presumed to have devoted, or intended to devote, fifty percent of the person's time to the solicitation, negotiation or sale of insurance contracts:

(A) life insurance contracts that, in the aggregate, exceed two hundred thousand dollars of coverage for all lives insured for the preceding calendar year;

(B) a permanent life insurance contract offering more than ten thousand dollars of coverage on an individual life;

(C) a term life insurance contract offering more than fifty thousand dollars of coverage on an individual life;

(D) any insurance contracts other than life that the fraternal benefit

society may write that insure the individual lives of more than twenty-five persons;

(E) any variable life insurance or variable annuity contract; or

(4) any service contract provider or any administrator or person designated by a service contract provider who in this state markets, sells, offers for sale, issues, makes, proposes to make or administer service contracts pursuant to article seventy-nine of this chapter;

(5) a person who secures and furnishes information for the purpose of group life insurance, group property/casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass marketed property/casualty insurance, where no commission is paid to the person for the service;

(6) an employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, fraternal benefit society or health maintenance organization, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(7) a person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(8) a person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business

and the contract of insurance insures risks located in that state;

(9) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission;

(10) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state; or

(11) any person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031 to act as a navigator, as such term is used in 42 U.S.C. § 18031(i), including any person employed by a certified navigator, provided that the person: (A) has completed the training required by the health benefit exchange; (B) does not sell insurance; (C) does not engage in any activity with respect to insurance not expressly permitted under 42 U.S.C. § 18031 (i) (3) and regulations thereunder; and (D) does not receive any compensation for acting as a navigator directly or indirectly from an insured, insurance producer, or an insurer.

(l) In this article, "home state" means the District of Columbia or any state or territory of the United States in which an insurance producer maintains his, her or its principal place of residence or principal place of business and is licensed to act as an insurance producer.

(m) In this article, "negotiate" or "negotiation" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from licensed insurers, fraternal benefit societies or health maintenance organizations for purchasers.

(n) In this article, "sell" or "sale" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of a

licensed insurer, fraternal benefit society or health maintenance organization.

(o) In this article, "solicit" or "solicitation" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular licensed insurer, fraternal benefit society or health maintenance organization.

(p) In this article, "business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(q) In this article, "person" means an individual or a business entity.

(r) In this article, "line of authority" means any of the following:

(1) life: insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(2) accident and health or sickness: insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(3) property: insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) casualty: insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

(5) variable life and variable annuity products: insurance coverage provided under variable life insurance contracts and variable annuities;

(6) personal lines: property/casualty insurance coverage sold to individuals and families for primarily noncommercial purposes; and

(7) any other line of insurance permitted pursuant to this chapter.

(s) In this article, "controlled person" shall have the meaning set forth in paragraph five of subsection (a) of section one thousand five hundred one of this chapter.

(t) In this article, "holding company" shall have the meaning set forth in paragraph three of subsection (a) of section one thousand five hundred one of this chapter.

(u) In this article, "holding company system" shall have the meaning set forth in paragraph six of subsection (a) of section one thousand five hundred one of this chapter.

(v) In this article, "life settlement broker" shall have the meaning contained in subsection (j) of section seven thousand eight hundred two of this chapter.

(w) In this article, "state" means the District of Columbia or any state or territory of the United States.

(x) In this article, with respect to excess line insurance and excess line brokers:

(1) With respect to an insured's home state, "affiliated group" means any group of entities that are all affiliated. For the purposes of this paragraph:

(A) "affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured; and

(B) an entity has control over another entity if the entity:

(i) directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent or more of any class of voting securities of the other entity; or

(ii) controls in any manner the election of a majority of the directors or trustees of the other entity;

(2) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(A) the person employs or retains a qualified risk manager to negotiate insurance coverage;

(B) the person has paid aggregate nationwide commercial property/casualty insurance premiums in excess of one hundred thousand dollars in the immediately preceding twelve months; and

(C) (i) the person meets at least one of the following criteria:

(I) the person possesses a net worth in excess of twenty million dollars, as such amount is adjusted pursuant to item (ii) of this subparagraph;

(II) the person generates annual revenues in excess of fifty million dollars, as such amount is adjusted pursuant to item (ii) of this subparagraph;

(III) the person employs more than five hundred full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand employees in the

aggregate;

(IV) the person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars, as such amount is adjusted pursuant to item (ii) of this subparagraph; or

(V) the person is a municipality with a population in excess of fifty thousand persons;

(ii) Effective on the fifth January first occurring after July twenty-first, two thousand ten and each fifth January first occurring thereafter, the amounts in clauses (I), (II), and (IV) of item (i) of this subparagraph shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Unites States Department of Labor;

(3) "Insured's home state" means:

(A) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence;

(B) if one hundred percent of the insured risk is located outside of the state referred to in subparagraph (A) of this paragraph, then the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated;

(C) if more than one insured from an affiliated group are named insureds on a single insurance contract, then the insured's home state, as determined pursuant to subparagraph (A) of this paragraph, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract; or

(D) in the case of a group policy:

(i) when the group policyholder pays one hundred percent of the premium from its own funds, then the insured's home state, as determined pursuant to subparagraph (A) of this paragraph, of the group policyholder; or

(ii) when the group policyholder does not pay one hundred percent of the premium from its own funds, then the home state, as determined pursuant to subparagraph (A) of this paragraph, of the group member;

(4) With respect to determining an insured's home state, "principal place of business" means the state where:

(A) the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities; or

(B) if the insured's high-level officers direct, control, and coordinate the business activities in more than one state, or if the insured's principal place of business is located outside any state, then the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated;

(5) With respect to determining an insured's home state, "principal residence" means the state:

(A) where the individual resides for the greatest number of days during a calendar year; or

(B) if the insured's principal residence is located outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated;

(6) "Property/casualty insurance" means any kind of insurance as specified in subsection (a) of section one thousand one hundred thirteen of this chapter, except insurance issued pursuant to paragraph one, two, three, fifteen, eighteen or thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter or insurance substantially similar thereto; and

(7) With respect to an exempt commercial purchaser, "qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(A) the person is an employee of, or third-party consultant retained by, the commercial policyholder;

(B) the person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance;

(C) the person:

(i)(I) has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the superintendent to demonstrate minimum competence in risk management; and

(II)(aa) has three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance; or

(bb) has:

(aaa) a designation as a chartered property and casualty underwriter (in this clause referred to as a "CPCU") issued by the American Institute for CPCU/Insurance Institute of America;

(bbb) a designation as an associate in risk management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;

(ccc) a designation as certified risk manager (CRM) issued by the National Alliance for Insurance Education & Research;

(ddd) a designation as a Risk and Insurance Management Society (RIMS) fellow (RF) issued by the Global Risk Management Institute; or

(eee) any other designation, certification, or license determined by the superintendent to demonstrate minimum competency in risk management;

(ii) (I) has at least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and

(II) has any one of the designations specified in subclauses (aaa) through (eee) of subitem (bb) of clause (II) of item (i) of this subparagraph;

(iii) has at least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(iv) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the superintendent to demonstrate minimum competence in risk management.

(y)(1) In this chapter, "title insurance agent" means any authorized or acknowledged agent of a title insurance corporation, and any subagent or other representative of such an agent, who or which for commission, compensation, or any other thing of value, performs the following acts in conjunction with the issuance of a title insurance policy:

(A) sells, or negotiates the sale of a title insurance policy;

(B) evaluates the insurability of title, based upon the performance or review of a title search; and

(C) performs one or more of the following functions:

(i) collects, remits or disburses title insurance premiums, escrows or other related funds;

(ii) prepares, amends, marks up or delivers a title insurance

commitment or certificate of title for the purpose of the issuance of a title insurance policy by a title insurance corporation;

(iii) prepares, amends or delivers a title insurance policy on behalf of a title insurance corporation; or

(iv) negotiates the clearance of title exceptions, in connection with the issuance of a title insurance policy.

(2) Such term shall not include any regular salaried officer or employee of an authorized title insurance corporation or of a licensed title insurance agent, who does not receive a commission or other compensation for services, which commission or other compensation is directly dependent upon the amount of title insurance business done.

§ 2102. Acting without a license. (a) (1) (A) No person, firm, association or corporation shall act as an insurance producer, insurance adjuster or life settlement broker in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter.

(B) No person, firm, association or corporation shall act as an excess line broker in this state without having authority to do so by virtue of a license issued and in force pursuant to section two thousand one hundred five of this article, provided, however, that such person, firm, association or corporation shall not be required to be licensed as an excess line broker where the insured's home state is a state other than this state and such person, firm, association or corporation is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state.

(2) Any person, firm, association or corporation who or which acts as a reinsurance intermediary in violation of paragraph one hereof shall, in addition to other penalties prescribed by law, be subject to a penalty not to exceed five thousand dollars for each transaction.

(b) (1) Unless licensed as an insurance agent, insurance broker or insurance consultant, no person, firm, association or corporation shall in this state identify or hold himself or itself out to be an insurance advisor, insurance consultant or insurance counselor.

(2) No person, firm, association or corporation shall use any other designation or title which is likely to mislead the public or shall hold

himself or itself out in any manner as having particular insurance qualifications other than those for which he may be otherwise licensed or otherwise qualified.

(3) Unless licensed as an insurance agent, insurance broker or insurance consultant with respect to the relevant kinds of insurance, no person, firm, association or corporation shall receive any money, fee, commission or thing of value for examining, appraising, reviewing or evaluating any insurance policy, annuity or pension contract, plan or program or shall make recommendations or give advice with regard to any of the above.

(4) This subsection shall not apply to:

(A) licensed attorneys at law of this state acting in their professional capacity as such;

(B) actuaries or certified public accountants who provide information, recommendations, advice or services in their professional capacity, if neither they nor their employer receive any compensation directly or indirectly on account of any insurance, bond, annuity or pension contract that results in whole or part from such information, recommendation, advice or services; or

(C) regular salaried officers or employees of an insurer who devote substantially all of their services to activities other than the rendering of consulting services to the insuring public while acting in their capacity as such in discharging the duties of their employment.

(5) Paragraphs one and three of this subsection shall not apply to any person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the Affordable Care Act, 42 U.S.C. § 18031 (i), including persons employed by certified navigators; provided that the person: (A) has completed the training required by the health benefit exchange; (B) does not sell insurance; (C) does not engage in any activity with respect to insurance not expressly permitted under 42 U.S.C. § 18031 (i) (3) and regulations thereunder; and (D) does not receive any compensation for acting as a navigator directly or indirectly from an insured, insurance producer, or an insurer.

(c) Unless licensed as a reinsurance intermediary, no person, firm, association or corporation shall in this state act as a reinsurance intermediary or use any other designation or title which is likely to

mislead the public or hold himself or itself out in any manner as a reinsurance intermediary.

(d) Notwithstanding the foregoing, any membership corporation or voluntary association organized and operating in this state prior to January first, nineteen hundred thirty-nine may, as part of its operations, continue as theretofore to obtain for its members, from a property/casualty insurance company licensed to do business in this state and having a certificate of qualification from the superintendent, the surety bonds or insurance policies required to be filed by such members pursuant to section three hundred seventy of the vehicle and traffic law and may, without being licensed as an insurance broker, receive compensation from such members or from such insurer for such services.

(e)(1) No person shall accept any commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this article and is not so licensed.

(2) Renewal or other deferred commissions may be paid to a person or other entity for selling, soliciting or negotiating insurance in this state if the person or other entity was required to be licensed under this article at the time of the sale, solicitation or negotiation and was so licensed at that time.

(3) An insurer, fraternal benefit society, health maintenance organization or licensed insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance producer or to persons who do not sell, solicit or negotiate a contract of insurance in this state, unless the payment would violate any provision of this chapter.

(f) Every licensee shall notify the superintendent upon changing his, her or its legal name. Except for an individual licensee's own legal name, no licensee shall use any name, in conducting a business regulated by this article that has not been previously approved by the superintendent.

(g) Any person, firm, association or corporation who or that violates this section shall be subject to a penalty not to exceed five hundred dollars for each transaction, except as provided in paragraph two of subsection (a) of this section.

§ 2103. Insurance agents; licensing. (a) The superintendent may issue a license to any person, firm or corporation who or which has complied with the requirements of this chapter, authorizing such licensee to act as an insurance agent with respect to the lines of authority for life insurance, variable life and variable annuity products, or accident and health insurance and sickness or any other line of authority deemed to be similar by the superintendent, including for this purpose, health maintenance organization contracts, legal services insurance or with respect to any combination of the above, as specified in such license, on behalf of any insurer, fraternal benefit society or health maintenance organization, which is authorized to do such kind or kinds of insurance or health maintenance organization business in this state.

(b) The superintendent may issue a license to any person, firm, association or corporation who or which has complied with the requirements of this chapter, authorizing the licensee to act as agent of any authorized insurer, other than an insurer specified in subsection (b) of section two thousand one hundred fifteen of this article, with respect to the lines of authority for accident and health or sickness, property, casualty, personal lines or any other line of authority granted other than life, and variable life and variable annuity products, which such insurer is authorized to do in this state.

(c) Any such license issued to a firm or association shall authorize only the members thereof, named in such license as sub-licensees, to act individually as agents thereunder, and any such license issued to a corporation shall authorize only the officers and directors thereof, named in such license as sub-licensees, to act individually as agents thereunder. Every sub-licensee, acting as insurance agent pursuant to such a license shall be authorized so to act only in the name of the licensee.

(d) Every individual applicant for a license under this section and every proposed sub-licensee shall be eighteen years of age or over at the time of the issuance of such license.

(e) Before any original insurance agent's license is issued there shall be on file in the office of the superintendent an application by the prospective licensee in such form or forms and supplements, and

containing information the superintendent prescribes and for each business entity, the sub-licensee or sub-licensees named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(f) (1) The superintendent shall, in order to determine the competency of every individual applicant and of every proposed sub-licensee to have the kind of license applied for, require such individual to submit to a personal written examination and to pass the same to the satisfaction of the superintendent. Such examination shall be held at such times and places as the superintendent shall from time to time determine. Every individual applying to take any written examination shall, at the time of applying therefor, pay to the superintendent, or, at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an amount which is the actual documented administrative cost of conducting said qualifying examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable. The superintendent may accept, in lieu of any such examination, the result of any previous written examination, given by the superintendent, which in his judgment is equivalent to the examination for which it is substituted.

(2) The superintendent may from time to time make reasonable classifications of the kinds of insurance and may prescribe the following types of examinations:

(A) For individuals seeking to qualify to obtain a license under subsection (a) of this section, one examination adapted to test the qualifications for a life insurance agent's license, another adapted to test the qualifications for an accident and health insurance agent's license and another adapted to test the qualifications for a legal services insurance license. Each such individual shall be required to pass the type or types of examination prescribed by the superintendent for the line or lines of authority, as specified in subsection (a) of this section, for which the license is sought. No individual shall be deemed qualified to take the examination or examinations unless he shall have successfully completed a course or courses, approved as to method and content by the superintendent, covering the principal branches and contracts of life insurance, annuity contracts, disability insurance,

accident and health insurance and related insurance and requiring not less than forty hours of classroom work or the equivalent in correspondence work or similar instruction, provided, however, that, at the discretion of the superintendent, insurance subject material may be eliminated from course content, with a corresponding reduction in course hours, if an insurer is not authorized to transact such kind or kinds of insurance in this state. Such course or courses either shall have been given by a degree conferring college or university which has, when such course is taken by such individual, a curriculum or curricula registered with the state education department, whether such course be given as part of any such curricula or separately, or by any other institution or life or accident and health insurer which maintains equivalent standards of instruction, and which shall have been approved for such purpose by the superintendent.

(B) For individuals seeking to qualify to obtain a license under subsection (b) of this section, not more than six types of examinations, each adapted to test the qualifications of an individual with respect to the kinds of insurance business specified in such classification. Every such individual shall be required to pass the type or types of examination prescribed by the superintendent for the line or lines of authority for which the license is sought. No individual shall be deemed qualified to take the examination unless he shall have successfully completed a course or courses, approved as to method and content by the superintendent, covering the principal branches of the insurance business and requiring not less than ninety hours of classroom work or the equivalent in correspondence work, a course offered over the internet or a similar institution, in institutions of learning meeting the standards prescribed by paragraph one of subsection (a) of section two thousand one hundred four of this article; provided, however, with respect to a license issued pursuant to subsection (b) of this section for a personal line of authority, there shall be required not less than forty hours of such classroom work or the equivalent in correspondence work, a course offered over the internet or a similar institution.

(3) The superintendent shall require that all written examinations request the applicant to set forth: (i) his or her full name, age, residence address, business address and mailing address; (ii) the applicant's gender; (iii) the applicant's native language; (iv) the

applicant's highest level of education achieved; and (v) the applicant's race or ethnicity. This section of the examination shall include a clear and unambiguous statement that the applicant is not required to disclose his or her race or ethnicity, gender, native language or level of education, that he or she will not be penalized for failing to do so, and that the department will use this information solely for statistical purposes that will then be studied in order to ensure continued quality and fairness of the examination.

(g) No such written examination shall be required:

(1) as a prerequisite to the issuance of a baggage or accident and health insurance agent's license to any ticket selling agent or representative of a railroad company, steamship company, carrier by air, or public bus carrier, who shall act thereunder as insurance agent only in reference to the issuance of baggage or accident insurance tickets primarily for the purpose of covering risk of travel;

(2) in the discretion of the superintendent, of any individual whose license has been revoked or suspended;

(3) of any individual seeking to be named as a licensee or sub-licensee, under subsection (a) hereof, to represent a fraternal benefit society as its agent;

(4) in connection with any certificate of appointment for an additional insurer, provided the certificate of appointment does not include any additional kind of insurance;

(5) in the discretion of the superintendent, of any individual seeking to be named as a licensee or sub-licensee who is a non-resident insurance agent;

(6) of any person who received a license effective the first day of July, nineteen hundred eighty-seven to represent any assessment corporation which was limited on that date to the kinds of insurance specified in subsection (a) of section six thousand six hundred five of this chapter, and whose license is limited to those kinds of insurance, in connection with any certificate of appointment to represent another such assessment corporation, provided the certificate of appointment does not include any additional kind of insurance.

(7) of any applicant who has passed the written examination given by the superintendent for an insurance agent's license and was licensed as such or of an applicant who was licensed as an insurance agent but did

not pass such an examination, provided the applicant applies within two years following the date of termination of his license;

(8) of any person who was appointed prior to the first day of July, nineteen hundred fifty-seven, to represent any domestic assessment co-operative property/casualty insurance company which shall be licensed to do the business permitted under subsection (b) of section six thousand six hundred five of this chapter, provided such person within three months after that date files with the superintendent an application for a license in such form as the superintendent shall prescribe;

(9) in the discretion of the superintendent, as to all or any part of the written examination or the prerequisite minimum forty hour course specified in subparagraph (A) of paragraph two of subsection (f) of this section, of any individual seeking to be named a licensee or sub-licensee, upon whom has been conferred the Chartered Life Underwriter (C.L.U.) or Chartered Life Underwriter Associate designation by The American College;

(10) in the discretion of the superintendent, as to all or any part of the written examination or the prerequisite minimum ninety hour course specified in subparagraph (B) of paragraph two of subsection (f) of this section, of any individual seeking to be named a licensee or sublicensee, upon whom has been conferred the Chartered Property Casualty Underwriter (C.P.C.U.) designation by the American Institute for Property and Liability Underwriters; or

(11) of any individual who applies for an insurance agent license in this state who was previously licensed for the same line or lines of authority in another state, provided, however, that the applicant's home state grants non-resident licenses to residents of this state on the same basis. Such individual shall also not be required to complete any prelicensing education. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the date of cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good

standing for the line of authority requested. An individual or entity licensed in another state who moves to this state shall make an application within ninety days of establishing legal residence to become a resident licensee. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the superintendent determines otherwise by regulation.

(h) The superintendent may refuse to issue any insurance agent's license if, in his judgment, the proposed licensee or any sub-licensee is not trustworthy and competent to act as such agent, or has given cause for the revocation or suspension of such a license, or has failed to comply with any prerequisite for the issuance of such license.

(i) (1) The superintendent may require from every applicant and from every proposed sub-licensee, before or after issuing any such license, a statement subscribed and affirmed as true by the applicant under the penalties of perjury as to the ownership of any interest in an applicant firm, association or corporation and as to facts indicating whether any applicant has been by reason of an existing license, if any, or will be by reason of the license applied for, receiving any benefit or advantage in violation of section two thousand three hundred twenty-four of this chapter, and also as to such facts as he may deem pertinent to the requirements of this subsection. The superintendent may refuse to issue, suspend or revoke a license, as the case may be, to or of any applicant if he finds that such applicant has been or will be, as aforesaid, receiving any benefit or advantage in violation of section two thousand three hundred twenty-four of this chapter, or if he finds that more than ten percent of the aggregate net commissions, received during the twelve month period immediately preceding, if any, or to be received during the ensuing twelve months, by the applicant, resulted or will result from insurance on the property and risks:

(A) of the spouse of an individual applicant; and of any corporation of which such individual applicant or his or her spouse or both own more than fifty percent of the shares; and of any affiliated or subsidiary corporations of such corporation; and of the members of any firm or association and their spouses, of which firm or association the individual applicant or his or her spouse is a member;

(B) of the members of an applicant firm or association and their

respective spouses, and of the owners of any interest in such firm or association and their respective spouses, and of any corporation of which such firm or association or the members or owners and their respective spouses, either individually or in the aggregate, own more than fifty percent of the shares, and of any affiliated or subsidiary corporations of such corporation, and of any other firm and the members thereof and their respective spouses, of which other firm a member or members of the applicant firm or association and their respective spouses are members or owners; and

(C) of the shareholders of an applicant corporation and their respective spouses, and of any affiliated and subsidiary corporations of such applicant corporation, and of any subsidiary and affiliated corporations of a corporation owning any interest in such applicant corporation, and of any firm or association and the members thereof and their respective spouses which either individually or collectively own more than fifty percent of the shares of the applicant corporation, and of any corporation of which such firm or association and its members and their respective spouses, either individually or in the aggregate, own more than fifty percent of the shares, and of any affiliated or subsidiary corporation of such corporation.

(2) Nothing herein disqualifies any applicant by reason of acts done or facts existing at a time when the same did not, under the law then in force, constitute or contribute to constituting such a disqualification.

(3) The word "applicant" in this subsection, includes a licensee or sub-licensee.

(j) (1) Any license currently in force issued to an insurance agent of any insurer, fraternal benefit society or health maintenance organization pursuant to subsection (a) of this section shall be deemed terminated as of June thirtieth, nineteen hundred eighty-five. Any license currently in force issued to an insurance agent of any insurer pursuant to subsection (b) of this section without an expiration date shall be deemed terminated as of June thirtieth, nineteen hundred eighty-six.

(2) Every license issued to a business entity pursuant to subsection (a) of this section shall expire on June thirtieth of odd numbered years. Every license issued to a business entity pursuant to subsection (b) of this section shall expire on June thirtieth of odd numbered

years. On and after January first, two thousand seven, every license issued pursuant to this section to an individual, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual, who was born in an odd numbered year, shall expire on the individual's birthday in each odd numbered year. On and after January first, two thousand seven, every license issued pursuant to this section to an individual, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual, who was born in an even numbered year, shall expire on the individual's birthday in each even numbered year. Every such license may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection. The superintendent may issue such rules and regulations as the superintendent deems necessary to implement the terms of this subsection including regulations providing that, prior to July first, two thousand twenty-three, the registration fees and continuing education requirements for the renewal of any license issued to a business entity pursuant to this subsection for a period that is more than twenty-four months may be increased in proportion to the length of the period of licensure.

(3) In the case of a license issued to a new applicant, the superintendent may issue a license for a term of more than two years, provided however, such term shall not exceed thirty months.

(4) Any license shall be considered in good standing within the license term unless:

(A) revoked or suspended by the superintendent pursuant to this article.

(B) all certificates of appointment have been terminated by the insurers, at which time the license becomes inactive.

(C) if at the expiration date of the license term, provided the license was in good standing during the term, the licensee fails to file a renewal application.

(5) Before the renewal of any insurance agent's license shall be issued, the following requirements shall have been met:

(A) The licensee shall have filed a completed renewal application in such form or forms and supplements thereto and containing such information as the superintendent may prescribe.

(B) The licensee shall have paid such fees as are prescribed in this section.

(6) If the agent's license is deemed to be in an inactive status at the time of renewal, a renewal application may be completed and filed with the superintendent for the ensuing term of a license; however, if a certificate of appointment is not filed on the agent's behalf within the term of the renewal, the license will expire and will not be renewed at the end of the license term. During the term of the license for which no certificate of appointment was on file, it shall be deemed to be inactive.

(7) If an application for a renewal license shall have been filed with the superintendent before the expiration of such license, the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant and to each proposed sub-licensee. Before refusing to renew any such license, except on the ground of failure to pass a written examination, the superintendent shall notify the applicant of his intention to do so and shall give such applicant a hearing.

(8) (A) The superintendent may in issuing a renewal license dispense with the requirements of a verified application by any individual licensee or sub-licensee who, by reason of being engaged in any military service for the United States, is unable to make personal application for such renewal license, upon the filing of an application on behalf of such individual, in such form as the superintendent shall prescribe, by some person or persons who in his judgment have knowledge of the facts and who make affidavit showing such military service and the inability of such insurance agent to make personal application.

(B) An individual licensee or sub-licensee who is unable to comply with license renewal procedures due to other extenuating circumstances, such as a long-term medical disability, may request a waiver of such procedures, in such form as the superintendent shall prescribe. The licensee or sub-licensee may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(9) In addition to any examination fee required by subsection (f) of

this section, there shall be paid to the superintendent for each individual license applicant and each proposed sub-licensee the sum of forty dollars for each year or fraction of a year in which a license shall be valid. If, however, the license applicant or a proposed sub-licensee should withdraw the application or the superintendent should deny the application before the license applied for is issued, the superintendent may refund the fee paid by the applicant for the license applied for with the exception of any examination fees required pursuant to subsection (f) of this section.

(10) An application for the renewal of a license shall be filed with the superintendent not less than sixty days prior to the date the license expires or the applicant shall be subject to a further fee for late filing of ten dollars.

(11) No license fee shall be required of any person who served as a member of the armed forces of the United States at any time and who (A) shall have been discharged therefrom, under conditions other than dishonorable, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, in a current licensing period, for the duration of such period.

(12) Except where a corporation, association or firm licensed as an insurance agent is applying to add a sub-licensee, or the date of the expiration of the license is changed, there shall be no fee required for the issuance of an amended license.

(13) The license shall contain the licensee's name, address, personal identification number, the date of issuance, the licensee's lines of authority, the expiration date and any other information the superintendent deems necessary.

(k) If the superintendent deems it necessary he may require any licensed agent to submit a new application at any time.

(l) Any licensee may at any time while such license is in force apply to the superintendent for an additional license authorizing such licensee, and the sub-licensees named in such existing license, to act as insurance agents for additional insurers. The superintendent may,

after the requirements of this chapter have been complied with, issue such additional license.

(m) An agent appointed for an insurer authorized to transact business in this state may transact business for any subsidiaries or affiliates of said insurer that are licensed in this state for the same line or lines of insurance without such insurers submitting additional appointments, provided a certified copy of a resolution adopted by the board of directors of each of the insurers requesting such authority is filed with the superintendent by each of the insurers and renewed and refiled whenever deemed necessary by the superintendent. The resolution shall also designate the primary insurer for which all of the company's agents must be appointed pursuant to subsection (a) or (b) of this section, and said appointment must be in full force and effect in order to transact business for any of the affiliated or subsidiary insurers.

(n) Any insurance agent licensed pursuant to subsection (b) of this section is hereby authorized while so licensed, to act in the sale, solicitation or negotiation for an insurance contract providing solely for disability benefits written to meet minimum requirements of article nine of the workers' compensation law.

(o) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 2104. Insurance brokers; licensing. (a) (1) The superintendent may issue an insurance broker's license to any individual, firm, association or corporation, hereinafter designated as "licensee," who or which is deemed by him trustworthy and competent to act as a broker in such manner as to safeguard the interests of the insured, and who or which is otherwise qualified as herein required, and who or which has complied with the prerequisites herein prescribed.

(2) The purpose of this section is to protect the public by requiring and maintaining professional standards of conduct on the part of all insurance brokers acting as such within this state.

(b) (1) Such license shall confer upon the licensee authority to act in this state as insurance broker, and upon every natural person named as sub-licensee in such license authority to act in this state as insurance broker in the name of and on behalf of such licensee, with respect to the following lines of authority:

(A) life insurance, variable life and variable annuity products, accident and health insurance and sickness or any other line of authority deemed to be similar by the superintendent, including for this purpose, health maintenance organization contracts and legal services insurance; or

(B) any and every line of authority, except life insurance and variable life and variable annuity products.

(2) A license issued to a corporation may name as sub-licensees only the officers and directors of such corporation, and a license issued to a firm or association may name as sub-licensees only the individual members of such firm or association. Each sub-licensee named in such license must be qualified to obtain a license as an insurance broker, and for each such sub-licensee a fee must be paid at the times and at the rates hereinafter specified.

(3) The license shall contain the licensee's name, address, personal identification number, the date of issuance, the licensee's lines of authority, the expiration date and any other information the superintendent deems necessary.

(c) (1) Every individual applicant for such license and every proposed sub-licensee shall be of the age of eighteen years or over at the time of the issuance of such license. No individual shall be deemed qualified to obtain such license or to be named as sub-licensee therein unless he shall comply with the requirements of subparagraph (A), (B) or (C) following:

(A) He shall have successfully completed a course or courses, approved as to method and content by the superintendent, covering the principal branches of the insurance business and requiring, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, not less than ninety hours, and in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section, not less than forty hours of classroom work or the equivalent thereof in correspondence work. Such course or courses either were given

by a degree conferring college or university which has, when such course is taken by such individual, a curriculum or curricula registered with the state education department, whether such course be given as a part of any such curriculum or separately, or were given by the The College of Insurance, or by any other institution which maintains equivalent standards of instruction, which has been continuously in existence for not less than five years prior to the taking of such course by such individual, and which shall have been approved for such purpose by the superintendent.

(B) He shall have been regularly employed by an insurance company or an insurance agent or an insurance broker, for a period or periods aggregating not less than one year during the three years next preceding the date of application, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, in responsible insurance duties relating to the underwriting or adjusting of losses in any one or more of the following branches of insurance: fire, marine, liability and workers' compensation, and fidelity and surety; in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section in responsible insurance duties relating to the use of life insurance, accident and health insurance and annuity contracts in the design and administration of plans for estate conservation and distribution, employee benefits and business continuation; and he shall submit with his application a statement subscribed and affirmed as true under the penalties of perjury by such employer or employers stating facts which show compliance with this requirement.

(C) He shall have been regularly employed by an insurance company or an insurance agent or an insurance broker, for a period or periods aggregating not less than one year, during the three years next preceding the date of entrance into the service of the armed forces of the United States or immediately following his discharge therefrom, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, in responsible insurance duties relating to the underwriting or adjusting of losses in any one or more of the following branches of insurance: fire, marine, liability and workers' compensation, and fidelity and surety; in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section in responsible insurance duties relating to the use of life insurance,

accident and health insurance and annuity contracts in the design and administration of plans for estate conservation and distribution, employee benefits and business continuation; provided the application for such license is filed within one year from the date of discharge; and he shall submit with his application a statement subscribed and affirmed as true under the penalties of perjury by such employer or employers stating facts which show compliance with this requirement.

(2) The requirements of subparagraphs (A), (B) and (C) of paragraph one hereof shall not apply to any non-resident insurance broker.

(d) (1) Before any such license shall be issued by the superintendent and before each renewal, there shall be filed in his office a written application therefor by the proposed licensee and by each proposed sub-licensee. Such application shall be in the form or forms and supplements prescribed by the superintendent and contain such information as he or she shall require and for each business entity, the sub-licensee or sub-licensees named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state. In connection with any such application the superintendent shall have power to examine under oath any person who has or appears to have relevant information, and to make an examination of the books, records and affairs of any such applicant.

(2) The superintendent may require from every applicant and from every proposed sub-licensee, before issuing any such license or renewal license, a statement subscribed and affirmed by the applicant and proposed sub-licensee as true under the penalties of perjury as to the ownership of any interest in an applicant firm, association or corporation and as to facts indicating whether any applicant has been by reason of an existing license, if any, or will be by reason of the license applied for, receiving any benefit or advantage in violation of section two thousand three hundred twenty-four of this chapter, and also as to such facts as he may deem pertinent to the requirements of this subsection.

(3) The superintendent may refuse to issue a license or renewal license, as the case may be, to any applicant if he finds that such applicant has been or will be, as aforesaid, receiving any benefit or advantage in violation of section two thousand three hundred twenty-four

of this chapter, or if he finds that more than ten percent of the aggregate net commissions, received during the term of the existing license, if any, or to be received during the term of the license applied for, by the applicant, resulted or will result from insurance on the property and risks set forth in subparagraphs (A), (B) and (C) of paragraph one of subsection (i) of section two thousand one hundred three of this article.

(4) Nothing herein shall be deemed to disqualify any applicant by reason of acts done or facts existing at a time when the same did not, under the law then in force, constitute or contribute to constituting such a disqualification.

(e) (1) (A) The superintendent shall, in order to determine the competency of each applicant for an insurance broker's license, other than a renewal license, and of each proposed sub-licensee, to act as insurance broker, require every such person to submit to, and pass to the satisfaction of the superintendent, a personal written examination on the branches of the insurance business relevant to such license. Such examination shall be held at such times and places as the superintendent shall from time to time determine.

(B) An exemption may be granted, at the discretion of the superintendent, as to all or any part of the written examination or the prerequisite course specified in subparagraph (A) of paragraph one of subsection (c) of this section, of any individual seeking to be named a licensee or sub-licensee, upon whom has been conferred, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, the Chartered Property Casualty Underwriter (C.P.C.U.) designation by the American Institute for Property and Liability Underwriters, or on whom has been conferred, in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section, the Chartered Life Underwriter (C.L.U.), Chartered Financial Consultant (Ch.F.C.) or the Master of Science in Financial Services (M.S.F.S.) designations by the American College of Financial Service Professionals.

(2) Every individual applying to take any written examination shall, at the time of applying therefor, pay to the superintendent, or, at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an

amount which is the actual documented administrative cost of conducting said qualifying examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable. The superintendent may, whenever in his judgment it appears advisable in order to determine the competency of any applicant for a renewal license, or of any proposed sub-licensee to be named therein, require such person to pass to the satisfaction of the superintendent, a similar written examination.

(3) The superintendent may issue a license to any person seeking to be named as licensee or sub-licensee who:

(A) has since July first, nineteen hundred twenty-eight, passed the examination given by the superintendent for that insurance broker's license and was licensed as such;

(B) within three years from the date of the receipt of his application was a similarly licensed insurance broker;

(C) within ten years from the date of the receipt of his application was, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, a similarly licensed insurance broker and during the period of three years next preceding the receipt of his application was licensed as a property/casualty insurance agent and, in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section, was a similarly licensed insurance broker and during the period of three years next preceding the receipt of his application was licensed as a life and accident and health insurance agent;

(D) has regularly and continuously acted, in the case of a license under subparagraph (B) of paragraph one of subsection (b) of this section, as a licensed resident property/casualty and accident and health insurance agent and, in the case of a license under subparagraph (A) of paragraph one of subsection (b) of this section, acted as a licensed life and accident and health insurance agent for a period of at least five years immediately preceding the date of receipt of his application;

(E) is a non-resident insurance broker for similar lines;

(F) served as a member of the armed forces of the United States at any time, and shall (i) have been discharged under conditions other than dishonorable, or (ii) has a qualifying condition, as defined in section

one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (iii) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, and who within three years prior to his or her entry into the armed forces held a license as insurance broker for similar lines, provided his or her application for such license is filed before one year from the date of final discharge; or

(G) was previously licensed for the same line or lines of authority in another state, provided, however, that the applicant's home state grants non-resident licenses to residents of this state on the same basis. Such individual shall also not be required to complete any prelicensing education. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the date of cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested. An individual or entity licensed in another state who moves to this state shall make an application within ninety days of establishing legal residence to become a resident licensee. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the superintendent determines otherwise by regulation.

(f) (1) At the time of application for every such license, and for every biennial renewal thereof, there shall be paid to the superintendent for each individual applicant and for each proposed sub-licensee the sum of forty dollars for each year or fraction of a year in which a license shall be valid. If, however, the applicant or a proposed sub-licensee should withdraw his or its application or the superintendent should deny his or its application before the license applied for is issued, the superintendent may refund the fee paid by the applicant for the license applied for, excepting any examination fees required pursuant to subsection (e) of this section.

(2) No license fee shall be required of any person who served as a

member of the armed forces of the United States at any time, and who (A) shall have been discharged, under conditions other than dishonorable, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, in a current licensing period, for the duration of such period.

(g) (1) Every insurance broker's license issued pursuant to this section to a business entity shall be for a term expiring on the thirtieth day of June of odd-numbered years. On and after January first, two thousand seven, every license issued pursuant to this section to an individual, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual, who was born in an odd numbered year, shall expire on the individual's birthday in each odd numbered year. On and after January first, two thousand seven, every license issued pursuant to this section to an individual, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual, who was born in an even numbered year, shall expire on the individual's birthday in each even numbered year. Every such license may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this section. In the case of a license issued to a new applicant, the superintendent may issue a license for a term of more than two years, provided however, such term shall not exceed thirty months. The superintendent may issue such rules and regulations as the superintendent deems necessary to implement the terms of this subsection including regulations providing that, prior to July first, two thousand twenty-three, the registration fees and continuing education requirements for the renewal of any license issued to a business entity pursuant to this subsection for a period that is more than twenty-four months may be increased in proportion to the length of the period of licensure.

(2) An application for a renewal license shall be filed with the superintendent not less than sixty days prior to the date the license expires or the applicant shall be required to pay, in addition to the

fee required in subsection (f) of this section, a further fee for late filing of ten dollars.

(3) If an application for a renewal license shall have been filed with the superintendent before the expiration of such license, the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant and to each proposed sub-licensee.

(4) Before refusing to renew any such license, except on the ground of failure to pass a written examination required pursuant to subsection (e) hereof, the superintendent shall notify the applicant of his intention so to do and shall give such applicant a hearing.

(5) (A) The superintendent may in issuing a renewal license dispense with the requirement of a verified application by any individual licensee or sub-licensee who, by reason of being engaged in any military service for the United States, is unable to make personal application for such renewal license, upon the filing of an application on behalf of such individual, in such form as the superintendent shall prescribe, by some person or persons who in his judgment have knowledge of the facts and who make affidavit showing such military service and the inability of such insurance broker to make personal application.

(B) An individual licensee or sub-licensee who is unable to comply with license renewal procedures due to other extenuating circumstances, such as a long-term medical disability, may request a waiver of such procedures, in such form as the superintendent shall prescribe. The licensee or sub-licensee may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(h) Any corporation, association or firm licensed as an insurance broker under this section may at any time make an application to the superintendent for the issuance of a supplemental license authorizing additional officers or directors of such corporation, or additional members of such firm or association, as the case may be, to act as sub-licensees, and, if the requirements of this section are fully complied with as to each of such proposed sub-licensees, the superintendent may issue to such licensee a supplemental license naming

such additional person or persons as sub-licensees.

(i) If an application for a license under this section be rejected, or if such a license be suspended or revoked by the superintendent, he shall forthwith give notice thereof to the applicant, or to the licensee.

(j) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 2105. Excess line brokers; licensing. (a) The superintendent may issue an excess line broker's license to any person, firm, association or corporation who or which is licensed as an insurance broker under section two thousand one hundred four of this article, or who or which is licensed as an excess line broker in the licensee's home state, provided, however, that the applicant's home state grants non-resident licenses to residents of this state on the same basis, except that reciprocity is not required in regard to the placement of liability insurance on behalf of a purchasing group or any of its members; authorizing such person, firm, association or corporation to procure, subject to the restrictions herein provided, policies of insurance from insurers that are not authorized to transact business in this state of the kind or kinds of insurance specified in paragraphs four through fourteen, sixteen, seventeen, nineteen, twenty, twenty-two, twenty-seven, twenty-eight, thirty-one, thirty-two, thirty-three, and thirty-four of subsection (a) of section one thousand one hundred thirteen of this chapter and in subsection (h) of this section, provided, however, that the provisions of this section and section two thousand one hundred eighteen of this article shall not apply to ocean marine insurance and other contracts of insurance enumerated in subsections (b) and (c) of section two thousand one hundred seventeen of this article. Such license may be suspended or revoked by the superintendent whenever in the superintendent's judgment such suspension or revocation will best promote the interests of the people of this

state.

(b) Before the superintendent issues any such license or renewal, there shall be filed in the superintendent's office an application by the person, firm, association or corporation desiring such license, in such form or forms, and supplements thereto, and containing information the superintendent prescribes. For each business entity, the sub-licensee or sub-licensees named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state. A person or entity licensed as an excess line broker in his, her or its home state may receive a non-resident excess line broker license pursuant to subsection (a) of this section with the submission of the application.

(c) (1) At the time of application for every such license, and for every renewal, each applicant shall pay the superintendent the following fees:

(A) Two hundred dollars for each year or fraction of a year in which a license shall be valid, if the applicant maintains an office in, or acts as an excess line broker in placing insurance on risks located in, any county in this state having a population of one hundred thousand or more inhabitants.

(B) Twenty-five dollars for each year or fraction of a year in which a license shall be valid in all other cases.

(2) The population of any county shall be determined by the most recent official census, whether by the United States or by this state.

(d) Every license issued pursuant to this section shall be for a term expiring with the expiration of the qualifying broker license and may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with subsection (b) of this section and paying the fee prescribed by subsection (c) of this section. In the case of a license issued to a new applicant, the superintendent may issue a license for a term of more than two years, provided however, such term shall not exceed thirty months.

(e) Any such license issued to a firm, association or corporation shall authorize as sub-licensee only the sub-licensees named in its license as insurance broker, and each such sub-licensee may act thereunder only in the name of and on behalf of the licensee.

(g) The superintendent may issue a replacement for a currently in

force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

(h) Pursuant to subsection (a) of this section, an excess line broker may procure policies of insurance from insurers which are not authorized to transact business in this state for personal accident insurance and accident disability insurance, in which the insured is a non-resident of this state, and the nature of the risk to be insured is related to the operation of motor vehicles at high speeds for the enjoyment of spectators, is unusual and difficult to place and where such broker, after diligent effort, could not procure substantially similar coverage from an insurer authorized to do business in this state.

(i) Pursuant to subsection (a) of this section, an excess line broker may procure policies of salary protection insurance from insurers that are not authorized to transact business in this state.

§ 2106. Reinsurance intermediaries; licensing. (a) (1) The superintendent may issue a reinsurance intermediary's license to any person, firm, association or corporation who or which has complied with the requirements of this chapter.

(2) Any such license issued to a firm or association shall authorize all of the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and supplements thereto.

(3) Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and supplements thereto.

(4) For each business entity, the officer or officers and director or directors named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(b) (1) Before a resident reinsurance intermediary's license shall be

issued or renewed the prospective licensee shall properly file in the office of the superintendent a written application therefor in such form or forms and supplements thereto as the superintendent prescribes, and pay a fee of five hundred dollars for each year or fraction of a year in which a license shall be valid.

(2) Every resident reinsurance intermediary's license issued to a business entity pursuant to this section shall expire on the thirty-first day of August of even-numbered years. On and after January first, two thousand seven, every license issued pursuant to this section to an individual resident reinsurance intermediary, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual resident reinsurance intermediary, who was born in an odd numbered year, shall expire on the individual's birthday in each odd numbered year. On and after January first, two thousand seven, every license issued pursuant to this section to an individual resident reinsurance intermediary, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual resident reinsurance intermediary, who was born in an even numbered year, shall expire on the individual's birthday in each even numbered year. Every license issued pursuant to this section may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection.

(c) (1) If an application for a renewal license shall have been filed with the superintendent before September first of the year of expiration, the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant.

(2) Before refusing to renew any such license the superintendent shall notify the applicant of his intention so to do and shall give such applicant a hearing.

(d) (1) The superintendent may refuse to issue a reinsurance intermediary's license if, in his judgment, the applicant or any member, principal, officer or director of such applicant, is not trustworthy and competent to act as a reinsurance intermediary, or that any controlling

person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(2) For the purposes of this section a "controlling person" is any person who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of the reinsurance intermediary.

(e) Licensees under this section shall be subject to examination by the superintendent as often as he may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and sections two thousand one hundred two and two thousand one hundred twenty of this article.

(f) (1) (A) The provisions of this section and of section two thousand one hundred two, subsection (a) of section two thousand one hundred ten and section two thousand one hundred twenty of this article shall apply to resident and non-resident reinsurance intermediaries; provided, however, that the provisions of this subsection shall be specifically applicable with respect to non-resident reinsurance intermediaries.

(B) A "non-resident reinsurance intermediary" means a person who is a non-resident of this state and who is licensed to act as a reinsurance intermediary in their home state.

(2) (A) Before a non-resident reinsurance intermediary's license shall be issued or renewed, the prospective licensee shall properly file in the office of the superintendent a written application therefor in such form or forms and supplements as the superintendent prescribes, and pay a fee of five hundred dollars for each year or fraction of a year in which a license shall be valid.

(B) Every non-resident reinsurance intermediary's license issued to a business entity pursuant to this section shall expire on the thirty-first day of August of even-numbered years. On and after January first, two thousand seven, every license issued pursuant to this section to an individual non-resident reinsurance intermediary, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual non-resident reinsurance intermediary, who was born in an odd numbered year, shall

expire on the individual's birthday in each odd numbered year. On and after January first, two thousand seven, every license issued pursuant to this section to an individual non-resident reinsurance intermediary, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual non-resident reinsurance intermediary, who was born in an even numbered year, shall expire on the individual's birthday in each even numbered year. Every such license issued pursuant to this subparagraph may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection.

(g) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 2107. Insurance consultants; licensing and duties. (a) (1) The superintendent may issue an insurance consultant's license to any person, firm, association or corporation who or which has complied with the requirements of this chapter with respect to either: life insurance, meaning all of those kinds of insurance authorized in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter; or general insurance, meaning all of those kinds of insurance authorized in paragraphs four through twenty-three of such subsection, as specified in such license.

(2) Any such license issued to a firm or association shall authorize only the members of such firm or association named in such license as sub-licensees to act individually as consultants thereunder, and any such license issued to a corporation shall authorize only the officers and directors thereof named in such license as sub-licensees to act individually as consultants thereunder. Each sub-licensee named in such license must be qualified to obtain a license as an insurance consultant, and for each such sub-licensee the fee specified in subsection (b) of this section must be paid. Every sub-licensee acting individually as a consultant pursuant to a license issued to a firm,

association or corporation shall be authorized to act only in the name of such firm, association or corporation.

(b) (1) Before an insurance consultant's license shall be issued or renewed the prospective licensee shall properly file in the office of the superintendent an application therefor in such form or forms and supplements that the superintendent prescribes, and pay a fee of fifty dollars for each year or fraction of a year in which a license shall be valid and pay an additional fee of fifty dollars for each year or fraction of a year in which a license shall be valid for each sub-licensee. Every consultant's license issued pursuant to this section to a business entity shall expire on the thirty-first day of March, with respect to (A) life insurance in the odd year and (B) general insurance in the even year, next following the date of issue. On and after January first, two thousand seven, every license issued pursuant to this section to an individual consultant, and every license in effect prior to January first two thousand seven that was issued pursuant to this section to an individual consultant, who was born in an odd numbered year, shall expire on the individual's birthday in each odd numbered year. On and after January first, two thousand seven, every license issued pursuant to this section to an individual consultant, and every license in effect prior to January first, two thousand seven that was issued pursuant to this section to an individual consultant, who was born in an even numbered year, shall expire on the individual's birthday in each even numbered year. Every license issued pursuant to this section may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection. In the case of a license issued to a new applicant, the superintendent may issue a license for a term of more than two years, provided however, such term shall not exceed thirty months.

(2) (A) If an application for a renewal license shall have been filed with the superintendent before the expiration of such license, the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant.

(B) Before refusing to renew any such license, except on the ground of

failure to pass a written examination required pursuant to subsection (c) of this section, the superintendent shall notify the applicant of his intention so to do and shall give such applicant a hearing.

(c) (1) The superintendent shall, in order to determine the competency of every applicant for license as an insurance consultant, require such applicant to submit to and pass to his satisfaction a personal, written examination concerning the kinds of insurance specified in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter for a life insurance consultant's license and paragraphs four through twenty-three of such subsection for a general insurance consultant's license. The fee for each such examination taken shall be fifty dollars.

(2) The superintendent may accept, in lieu of any part or all of such examination, the result of any previous written examination given by the superintendent, The American College, the American College of Property and Liability Underwriters, the Society of Actuaries, the Casualty Actuarial Society, the American Academy of Actuaries or any similar organization which administers professional examinations.

(d) The superintendent may refuse to issue an insurance consultant's license if, in his judgment, the applicant or any proposed sub-licensee is not trustworthy and competent to act as a consultant, or has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(e) No person licensed as an insurance consultant under this section may be an executive in or employee of or own any shares which give him a substantial interest, direct or indirect, in any authorized insurer. No such consultant may recommend or encourage the purchase of insurance, annuities or securities from any authorized insurer in which any member of his immediate family holds an executive position or holds a substantial interest.

(f) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 2108. Adjusters; licensing and duties. (a) (1) Adjusters shall be licensed as independent adjusters or as public adjusters.

(2) The superintendent may prescribe the types of independent adjusters' licenses according to the kind or kinds of insurance claims which the licensee is to be authorized to investigate and adjust.

(3) No adjuster shall act on behalf of an insurer unless licensed as an independent adjuster, and no adjuster shall act on behalf of an insured unless licensed as a public adjuster.

(4) No insurer, agent or other representative of an insurer shall pay any fees or other compensation to any person, firm, association or corporation for acting as an independent adjuster except to a licensed independent adjuster or to a person excepted from the licensing requirement pursuant to subsection (g) of section two thousand one hundred one of this article.

(b) The holder of a license under this section may act as an adjuster without any other or additional license.

(c) (1) The superintendent may issue an independent adjuster's license or a public adjuster's license to any person, firm, association or corporation, hereinafter designated as licensee, who, or which, is trustworthy and competent to act as an adjuster in such manner as to safeguard the interests of the people of this state and who, or which, has complied with the prerequisites herein prescribed.

(2) A license issued to a corporation may name as sub-licensees only the officers and directors of such corporation, and a license issued to a firm or association may name as sub-licensees only the individual members of such firm or association. Each sub-licensee named as such in the license issued to a firm, association or corporation must be qualified to obtain a license as an independent adjuster or as a public adjuster, as the case may be, and for each such sub-licensee a fee must be paid at the times and at the rate hereinafter specified. Each such sub-licensee shall be authorized, pursuant to such license, to act as an independent adjuster or as a public adjuster, as the case may be, only on behalf of the licensee.

(3) Every individual applicant for a license under this section and every proposed sub-licensee shall be eighteen years of age or over at the time of the issuance of such license.

(d) (1) Before any such license or any renewal thereof shall be issued by the superintendent there shall be filed in his office a written application therefor. Such application shall be in the form or forms and supplements and contain information the superintendent prescribes.

(2) Each person or individual signing such application shall, with such application, submit to the superintendent fingerprints of his two hands recorded in such manner as may be specified by the superintendent or his authorized representative. Before approving such application it shall be the duty of the superintendent or his authorized representative to compare such fingerprints with fingerprints filed with the division of criminal justice services. Such fingerprints may also be submitted to the federal bureau of investigation for a national criminal history record check.

(3) Except in the case of an application for a license to act as an independent adjuster, such application shall be approved, as to each person or individual so signing the same, by not less than five reputable citizens of the community in which such applicant resides or transacts business, each of whom shall certify that he or she has personally known the person or individual for a period of at least five years prior to the filing of such application, that he or she has read such application and believes each of the statements made therein to be true, that such person is honest, of good character and competent, and not related or connected to the person so certifying by blood or marriage. The certificate of approval shall be subscribed by such reputable citizens and affirmed by them as true under the penalties of perjury.

(e) (1) The superintendent shall, in order to determine the trustworthiness and competency to act as a public adjuster of each individual applicant for such license, and of each proposed sub-licensee, except in the case of a renewal license, require every such individual to take and pass, to the satisfaction of the superintendent, a personal written examination. No individual shall be deemed qualified to take the examination without having demonstrated by evidence satisfactory to the superintendent that (A) the applicant possesses a minimum of one year experience in the insurance business, with involvement in sales, underwriting or claims or other experience considered sufficient by the superintendent, or (B) the applicant

successfully completed forty hours of formal training in a course, program of instruction or seminars approved by the superintendent.

(2) The superintendent may, in his discretion and on such terms as he prescribes, dispense with such examination in the case of any individual applicant or proposed sub-licensee who shall previously have held a public adjuster's license issued subsequent to January first, nineteen hundred thirty-six.

(f) (1) The superintendent shall, in order to determine the trustworthiness and competency to act as an independent adjuster of each individual applicant for such license, and of each proposed sub-licensee, except in the case of a renewal license, require every such individual to take and pass, to the satisfaction of the superintendent, a personal written examination. The superintendent may prescribe the types of written examinations according to the kind or kinds of insurance claims which the applicant is to be licensed to investigate and adjust.

(2) Any person who at any time served with the armed forces of the United States, and who immediately prior to entering such military service had been continuously engaged in bona fide operation in this state as an independent adjuster for a period of five years, may within one year after the termination of such military service file with the superintendent an application in such form as he prescribes, and upon the payment of the requisite license fee may be licensed by the superintendent as an independent adjuster without being required to take and pass such examination.

(3) The superintendent may also, in the superintendent's discretion and on such terms the superintendent prescribes, dispense with such examination in the case of any individual applicant or proposed sub-licensee who shall previously have held an independent adjuster's license provided the applicant applies within two years following the date of termination of such license.

(g) The superintendent may, in his discretion require an applicant for a license under this section to present evidence, in such form as he prescribes, that such applicant has been employed, for a period which he deems reasonable, by an insurer, an independent adjuster or a public adjuster, in the performance of duties which in his opinion would provide the applicant with a satisfactory preliminary training for the

duties and responsibilities which would devolve upon him as a licensee under this section.

(h) (1) Any person who has had at least five years experience in adjusting claims as an employee of an authorized insurer and has made application for a license as an independent adjuster, or any person holding a valid estimator's license issued by the commissioner of motor vehicles and has made application for a license as an independent adjuster within ninety days of the expiration of the estimator's license, may file with the superintendent, in such form as the superintendent prescribes, a written application for a temporary permit to adjust claims, during the pendency of the application for a license as an independent adjuster, as:

(i) an employee of a licensed independent adjuster; or

(ii) in the case of an auto body repair estimator, an employee of an authorized insurer or any adjustment bureau or association owned and maintained by insurers to adjust or investigate motor vehicle body damage losses.

(2) Notwithstanding the requirement of subsection (f) of this section that each individual applicant for an independent adjuster's license or sub-license shall take and pass a personal written examination in order to satisfy the superintendent as to trustworthiness and competency, the superintendent may in the superintendent's discretion, if satisfied that the person applying for such temporary permit has in all other respects met the requirements of this section with respect to the licensing of independent adjusters and is qualified by training and experience to adjust claims as an employee of a licensed independent adjuster, authorized insurer, or any adjustment bureau or association owned and maintained by insurers to adjust or investigate motor vehicle body damage losses, issue such temporary permit to be effective for such period of time as the superintendent may specify therein but, in no event, for a period in excess of one hundred twenty days. The superintendent may summarily suspend or revoke any temporary permit issued pursuant to this subsection upon ten days' notice in writing to the permittee of the superintendent's intention to do so, which notice shall be given in accordance with the applicable provisions of subsections (a) and (d) of section three hundred four of the financial services law.

(i) (1) At the time of application for every adjuster's license and for every renewal thereof, there shall be paid to the superintendent by each individual applicant and by each proposed sub-licensee a fee of fifty dollars for each year or fraction of a year in which a license shall be valid; except that amounts paid to the commissioner of motor vehicles pursuant to subdivision five of section three hundred ninety-eight-d of the vehicle and traffic law, by any person who held an auto body repair estimator license prior to January first, nineteen hundred ninety-six shall be considered by the superintendent.

(2) No license fee shall be required of any person who served as a member of the armed forces of the United States at any time and who (A) shall have been discharged, under conditions other than dishonorable, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, in a current licensing period, for the duration of such period.

(3) A license fee of fifty dollars for each year or fraction of a year in which a license shall be valid for an independent adjuster's license shall cover any one or more of the various types of independent adjusters' licenses issued by the department.

(4) Every individual applying to take any written examination shall at the time of applying therefor pay to the superintendent, or at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an amount which is the actual documented administrative cost of conducting said qualifying examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable. If, however, the applicant or a proposed sub-licensee should withdraw his or its application or the superintendent should deny his or its application before the license applied for is issued, the superintendent may refund the fee paid by the applicant for the license applied for, excepting any examination fees required pursuant to this subsection.

(j) (1) Every adjuster's license issued pursuant to this section shall

be for a term expiring on the thirty-first day of December of even numbered years, and may be renewed for the ensuing two calendar years upon the filing of an application in conformity with subsection (d) hereof. In the case of a license issued to a new applicant, the superintendent may issue a license for a term of more than two years, provided however, such term shall not exceed thirty months.

(2) If an application for a renewal license shall have been filed with the superintendent by December thirty-first of the year of expiration, the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant and to all proposed sub-licensees named in such application.

(3) If such refusal is based on any grounds other than failure to pass a written examination and if the applicant or any proposed sub-licensee shall within thirty days after such notice is given notify the superintendent of his or its request for a hearing on such refusal, the superintendent shall within a reasonable time after receipt of such notice grant such a hearing, and he may, in his discretion, reinstate such license.

(k) Any firm, association or corporation licensed as an adjuster under this section may at any time make an application to the superintendent for the issuance of a supplemental license authorizing additional officers or directors of such corporation or additional members of such firm or association, as the case may be, to act as sub-licensees, and, if the requirements of this section are fully complied with as to each of such proposed sub-licensees, the superintendent may thereupon issue to such licensee a supplemental license naming such additional person, or persons, as sub-licensees.

(l) (1) No adjuster's license or renewal license, other than an independent adjuster's license, shall be issued to any applicant unless there shall be on file with the superintendent of financial services a bond, executed by such applicant and by approved sureties, in the penal sum of one thousand dollars conditioned on the faithful performance by such licensee and by all sub-licensees named in such license, of their duties as such adjusters.

(2) Such bond shall be approved as to form by the attorney general and as to sufficiency of security by the superintendent.

(3) Such bond shall be made to the state of New York and shall specifically authorize recovery by the state of the penal sum provided therein in case the adjuster or any sub-licensee shall have been guilty of fraudulent or dishonest practices in connection with the transaction of his or its business as such adjuster or shall have been convicted under any of the sections contained in article one hundred fifty of the penal law.

(m) If an application for a license under this section be rejected by the superintendent, he shall forthwith give notice to the applicant, or to the licensee, as the case may be.

(n) Notwithstanding the provisions of this section, the superintendent, in order to facilitate the settlement of claims under insurance contracts involving widespread property losses arising out of a conflagration or catastrophe common to all such losses, may issue a temporary permit for a term not exceeding one hundred twenty days to any person, whether he be a resident of this state or a non-resident, to act as an independent adjuster on behalf of an authorized insurer or insurers, provided any such insurer shall execute and file in the office of the superintendent a written application for the permit in the form prescribed by the superintendent, which application shall contain such information as he may require and shall certify that the person named therein to be designated in the temporary permit is qualified by experience and training to adjust claims arising under insurance contracts issued by any insurer. The superintendent may in his discretion renew such permit for an additional term or terms as may be necessary to adjust such claims.

(o) No licensee shall in connection with the transaction of his business as an adjuster make any misrepresentation of facts or advise any person on questions of law.

(p) No adjuster shall have any right to compensation from any insured for or on account of services rendered to such insured as a public adjuster unless such right to compensation is based upon a written memorandum, signed by the party to be charged, and specifying or clearly defining the amount or extent of such compensation. The superintendent shall establish and prescribe regulations:

(1) to provide for a standard form and terms of said written memorandum for compensation, including the maximum amount to be charged;

(2) to provide for compliance with article ten-A of the personal property law relating to door to door sales; however, for the purpose of this section, "door to door sale" in addition to the definition thereof contained in subdivision one of section four hundred twenty-six of the personal property law, shall include any contract entered into by a public adjuster to adjust losses;

(3) to provide for maintenance of appropriate books and records to be maintained by public adjusters which shall be kept subject to inspection and examination by the superintendent; and

(4) to provide for such other regulations that are deemed necessary by the superintendent for the proper and adequate supervision of public adjusters.

(q) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

(r) (1) The following continuing education requirements shall apply to resident and non-resident persons licensed as public adjusters.

(2) Resident and non-resident persons licensed as public adjusters and any person previously so licensed whose license was not in effect on the effective date of this subsection and who has subsequently been relicensed pursuant to the provisions of this article, shall biennially satisfactorily complete such courses or programs as may be approved by the superintendent, as follows:

(A) Any person holding a license as a public adjuster shall, during each full biennial licensing period, satisfactorily complete courses or programs of instruction or attend seminars as may be approved by the superintendent equivalent to fifteen credit hours of instruction.

(B) During the same calendar year biennial licensing period, a licensee may use accumulated continuing education credits to meet the requirements of similar classes of licenses including those authorized by subsection (b) of section two thousand one hundred three, section two thousand one hundred four, section two thousand one hundred seven of

this article with respect to general insurance consultants, and section two thousand one hundred eight of this article with respect to public adjusters.

(C) Excess credit hours accumulated during any biennial licensing period shall not carry forward to the next biennial licensing period for that same class of license.

(3) (A) The courses or programs of instruction successfully completed, which shall be deemed to meet the superintendent's standards for continuing education shall be:

(i) Courses, programs of instruction or seminars, approved as to method and content by the superintendent, covering portions of the principal branches of insurance related to the kinds of insurance covered by the public adjusting license, and given by a degree conferring college or university whose curriculum is registered with the state education department at the time the person takes the course, whether such course be given as part of such curriculum or separately, or by any other institution, association, trade association or insurer, which maintains equivalent standards of instruction and which shall have been approved for such purpose by the superintendent.

(ii) Continuing education as required by the state in which a non-resident licensee resides and maintains an office, provided the superintendent deems them equivalent to New York continuing education requirements. If the state in which the non-resident licensee resides and maintains an office has no continuing education requirements, or the superintendent does not deem them equivalent, the licensee must satisfy New York continuing education requirements.

(B) The number of credit hours assigned to each of the courses or programs of instruction set forth in paragraph one of this subsection shall be determined by the superintendent.

(4) A person who teaches any approved course of instruction or who lectures at any approved seminar, and who is subject to these continuing education requirements shall be granted the same number of credit hours as would be granted to a person taking and successfully completing such course, seminar or program, provided that such credit hours shall be credited only once per approved course during any biennial licensing period.

(5) Every person subject to these continuing education requirements

shall furnish, in a form satisfactory to the superintendent, written certification attesting to the course or programs of instruction taken and successfully completed by such person, and executed by the sponsoring organization or its authorizing representative.

(6) (A) Any person failing to meet applicable continuing education requirements shall not be eligible to renew the license.

(B) Any person whose license was not renewed shall not be eligible to become relicensed during the next biennial licensing period until that person has demonstrated to the satisfaction of the superintendent that continuing education requirements for the last biennial licensing period were met.

(C) Any person whose license was not renewed pursuant to subparagraph (A) of this paragraph, who accumulates sufficient credit hours for the prior licensing period to qualify for relicensing in the biennial period following such non-renewal, may not apply those same credit hours toward the continuing education requirements for the current biennial licensing period.

(7) (A) Any entity eligible to provide continuing education courses, programs of instruction, or seminars shall file for approval by the superintendent on a biennial basis, to conform with its areas of instruction, a provider organization application and a course submission application for each course, program, and seminar.

(B) The provider organization application shall include the names of all instructors to be used during the contract period, and instructors may be added during the period by notifying the superintendent and paying the appropriate filing fee.

(C) The completed applications shall be returned in a timely manner, as specified by the superintendent with a non-refundable filing fee of two hundred dollars per organization, fifty dollars per course, program, and seminar, and fifty dollars per instructor.

(D) Approval of the application shall be at the discretion of the superintendent.

(8) Each licensee shall pay a biennial fee of ten dollars per license, for continuing education certificate filing and recording charges, to the superintendent, or, at the direction of the superintendent, directly to an organization under contract to provide continuing education administrative services.

(s) (1) Every public adjuster shall have an affirmative duty to act on behalf and in the best interests of the insured when negotiating for or effecting the settlement of an insurance claim for the insured or otherwise acting as a public adjuster.

(2) (A) No public adjuster shall receive any compensation, either directly or indirectly, for a referral of the insured to an individual or entity for services, work or repairs, relating to any insurance claim for which the public adjuster represents the insured or has negotiated or effected a settlement, unless the compensation is prominently and clearly disclosed to the insured in the written memorandum described in subsection (p) of this section. Any such compensation received shall be deemed to be compensation from the insured and, in combination with any other compensation received from the insured, shall not exceed the maximum amount that the adjuster may charge in accordance with the regulations required pursuant to subsection (p) of this section.

(B) No public adjuster who has a financial or ownership interest in the individual or entity that performs the services, work, or repairs, shall refer the insured to the individual or entity unless the financial or ownership interest is prominently and clearly disclosed to the insured in the written memorandum described in subsection (p) of this section. If a public adjuster refers an insured to an individual who is related to the individual by blood or affinity to the second degree of consanguinity, or to an entity owned or controlled by such an individual, for services, work, or repairs, relating to any insurance claim for which the public adjuster represents the insured or has negotiated or effected a settlement, then the public adjuster shall disclose the relationship to the insured in the written memorandum described in subsection (p) of this section.

§ 2109. Agents and brokers; temporary license in case of death, service in armed forces or disability. (a) The superintendent may issue a temporary insurance agent's license, title insurance agent's license or insurance broker's license, or both an insurance agent's and insurance broker's license, without requiring the applicant to pass a written examination or to satisfy the requirements of subsection (c) of section two thousand one hundred four of this article except as to age,

in the case of a license issued pursuant to paragraph two of this subsection, in the following cases:

(1) in the case of the death of a person who at the time of his death was a licensed accident and health insurance agent under subsection (a) of section two thousand one hundred three of this article, a licensed insurance agent or licensed title insurance agent under subsection (b) of such section or a licensed insurance broker:

(A) to the executor or administrator of the estate of such deceased agent or broker;

(B) to a surviving next of kin of such deceased agent or broker, where no administrator of his estate has been appointed and no executor has qualified under his duly probated will;

(C) to the surviving member or members of a firm or association, which at the time of the death of a member was such a licensed insurance agent, licensed title insurance agent or licensed insurance broker; or

(D) to an officer or director of a corporation upon the death of the only officer or director who was qualified as a sub-licensee or to the executor or administrator of the estate of such deceased officer or director;

(2) to any person who may be designated by a person licensed pursuant to this chapter as an insurance agent, title insurance agent or an insurance broker, or both an insurance agent and insurance broker, and who is absent because of service in any branch of the armed forces of the United States, including a partnership or corporation that is licensed pursuant to this chapter as an insurance agent, title insurance agent or as an insurance broker, or both an insurance agent and insurance broker, in a case where the sub-licensee or all sub-licensees, if more than one, named in the license or licenses issued to such partnership or corporation is or are absent because of service in any branch of the armed forces of the United States; and

(3) to the next of kin of a person who has become totally disabled and prevented from pursuing any of the duties of his or her occupation, and who at the commencement of his or her disability was a licensed accident and health insurance agent under subsection (a) of section two thousand one hundred three of this article, a licensed insurance agent under subsection (b) of such section, a licensed title insurance agent or a licensed insurance broker.

(b) (1) Before any such license or licenses shall be issued, there shall be filed in the office of the superintendent a written application by the person or persons desiring such license or licenses, together with a written designation of such person or persons, in the case of a license issued pursuant to paragraph two of subsection (a) hereof, in such form or forms and supplements thereto, and containing such information, as the superintendent prescribes.

(2) No fee shall be charged for any such license or any renewal thereof, except that fees for the renewals of any license issued pursuant to paragraph two of subsection (a) hereof shall be one-half of the fees otherwise required by this chapter for such license.

(c) Such license or licenses shall authorize the person or persons named therein to renew the business of the deceased, absent or disabled insurance agent, title insurance agent, or insurance broker, or both an insurance agent and insurance broker, as the case may be, or of the firm or, in the case of a license issued pursuant to paragraph one or three of subsection (a) of this section, the association whose business is being continued thereunder, each such agent or broker being referred to in this section as "original licensee", expiring during the period in which such temporary license or licenses are in force, to collect premiums due and payable to the original licensee or, in the case of a license issued pursuant to paragraph one of subsection (a) of this section, to his or her estate, and to perform such other acts as an insurance agent, a title insurance agent or an insurance broker, or both an insurance agent or insurance broker, as the case may be, as are incidental to the continuance of the insurance business of such original licensee.

(d) A person eligible for such a temporary agent's license may be licensed only as an agent of the insurer or insurers which such original licensee was licensed to represent at the time of such death, entrance upon military or naval duty or disability.

(e) (1) In the case of a license or licenses issued pursuant to paragraph one of subsection (a) of this section, the license or licenses may be issued for a term not exceeding ninety days from the death of such deceased, and the superintendent may in his discretion renew such license or licenses for an additional term or terms of ninety days each, not exceeding in the aggregate fifteen months.

(2) The superintendent may issue renewal licenses for an additional term or terms of ninety days each exceeding the aggregate period of fifteen months when in his judgment it will best serve the interests of any person serving in the armed forces of the United States.

(3) A license issued to the next of kin shall not be renewed if, before the expiration of its term, an administrator or executor of the deceased shall have applied for and qualified for such a license.

(4) No person or persons so licensed shall, by virtue of such license, be authorized to solicit, negotiate or sell new insurance.

(f) (1) In the case of a license or licenses issued pursuant to paragraph two of subsection (a) hereof, the license or licenses may be issued for a term not exceeding six months, and the superintendent may in his discretion renew such license or licenses for an additional term or terms of six months each.

(2) The term of any such license or renewal shall in no event extend beyond sixty days after the final discharge of such absent insurance producer from military or naval duty, and each such license or renewal shall expire on such day as if that were the day specified therein for the expiration thereof.

(3) No person so licensed shall solicit new business under such license.

(g) (1) In the case of a license or licenses issued pursuant to paragraph three of subsection (a) hereof, the license or licenses may be issued for a term not exceeding ninety days from the disability of such person, and the superintendent may in his discretion renew such license or licenses for an additional term or terms of ninety days each, not exceeding in the aggregate fifteen months.

(2) No person or persons so licensed shall, by virtue of such license, be authorized to solicit, negotiate or sell new insurance.

(h) (1) In the case of a person seeking a temporary license to act as a title insurance agent pursuant to subsection (a) of this section, the superintendent may issue a license for a term not to exceed one hundred eighty days to such person provided the person:

(A) demonstrates to the satisfaction of the superintendent that a title insurance corporation is willing to appoint him or her;

(B) submits to the next available title insurance agent examination; and

(C) demonstrates to the satisfaction of the superintendent that he or she is qualified, competent, experienced and trustworthy to act as a title insurance agent.

(2) Any person issued a license pursuant to this subsection shall, by virtue of such license, be authorized to solicit, negotiate or sell new policies of title insurance.

§ 2110. Revocation or suspension of license of insurance producer, insurance consultant, adjuster or life settlement broker. (a) The superintendent may refuse to renew, revoke, or may suspend for a period the superintendent determines the license of any insurance producer, insurance consultant, adjuster or life settlement broker, if, after notice and hearing, the superintendent determines that the licensee or any sub-licensee has:

(1) violated any insurance laws, or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of his or her dealings in such capacity;

(2) provided materially incorrect, materially misleading, materially incomplete or materially untrue information in the license application;

(3) obtained or attempted to obtain a license through misrepresentation or fraud;

(4)(A) used fraudulent, coercive or dishonest practices;

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

(D) demonstrated financial irresponsibility in the conduct of business in this state or elsewhere;

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

(6) intentionally misrepresented the terms of an actual or proposed insurance contract, life settlement contract or application for insurance;

(7) has been convicted of a felony;

(8) admitted or been found to have committed any insurance unfair trade practice or fraud;

(9) had an insurance producer license, a life settlement broker license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(10) forged another's name to an application for insurance or life settlement contract or to any document related to an insurance or life settlement transaction;

(11) improperly used notes or any other reference material to complete an examination for an insurance license or life settlement broker license;

(12) knowingly accepted insurance business from an individual who is not licensed;

(13) failed to comply with an administrative or court order imposing a child support obligation;

(14) failed to pay state income tax or comply with any administrative or court order directing payment of state income tax;

(15) while acting as a public adjuster, the licensee has failed to act on behalf and in the best interests of the insured when negotiating for or effecting the settlement of an insurance claim for such insured or otherwise acting as a public adjuster, or has failed to make the disclosures required by paragraph two of subsection (s) of section two thousand one hundred eight of this article;

(16) while acting as a life settlement broker, failed to protect the privacy of the insured or owner or other person for whom the life settlement broker was required to provide protection pursuant to article seventy-eight of this chapter; or

(17) ceased to meet the requirements for licensure under this chapter.

(b) Before revoking or suspending the license of any insurance producer, life settlement broker or other licensee pursuant to the provisions of this article, the superintendent shall, except when proceeding pursuant to subsection (f) of this section, give notice to the licensee and to every sub-licensee and shall hold, or cause to be held, a hearing not less than ten days after the giving of such notice.

(c) If an insurance producer's license or other licensee's license pursuant to the provisions of this article is revoked or suspended by the superintendent, he shall forthwith give notice to the licensee.

(d) The revocation or suspension of any insurance producer's license or other licensee's license pursuant to the provisions of this article

shall terminate forthwith such producer's license or other licensee's license and the authority conferred thereby upon all sub-licensees.

(e) (1) No individual, corporation, firm or association whose license as an insurance producer or other licensee subject to subsection (a) of this section has been revoked, and no firm or association of which such individual is a member, and no corporation of which such individual is an officer or director, shall be entitled to obtain any license under the provisions of this chapter for a period of one year after such revocation, or, if such revocation be judicially reviewed, for one year after the final determination thereof affirming the action of the superintendent in revoking such license.

(2) If any such license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation shall be entitled to obtain any license, or to be named as a sub-licensee in any such license, for the same period of time, unless the superintendent determines, after notice and hearing, that such member, officer or director was not personally at fault in the matter on account of which such license was revoked.

(f) (1) As used in this subsection, "non-resident insurance producer's license or sub-license" means a license or sub-license in such capacity issued pursuant to paragraph five of subsection (g) of section two thousand one hundred three or subsection (e) of section two thousand one hundred four of this article.

(2) A non-resident insurance producer's license or sub-license may be summarily revoked in the event that the licensee's license as an agent, broker, adjuster or in any other capacity under the insurance law of the licensee's home state of domicile or such license of the firm or association of which the licensee is a member, employee or sub-licensee, or such license of the corporation of which the licensee is an officer, director, employee or sub-licensee has been suspended or revoked or renewal thereof denied in the licensee's home state of domicile by a procedure affording to the licensee or it a statutory right to a hearing, for action or conduct which, if it had been established upon a hearing before the superintendent, would have constituted grounds for revocation of a license under subsection (a) of this section.

(3) Before revoking the license of any non-resident insurance producer in accordance with this section, the superintendent shall give ten days'

notice in writing to such producer of the action proposed to be taken, which notice shall be given in accordance with the applicable provisions of subsections (a) and (d) of section three hundred four of the financial services law.

(4) Upon submission to the superintendent of satisfactory proof that a suspension or revocation of a license issued by a home state to act as an insurance agent, insurance broker, adjuster or in another licensed capacity under the insurance law of such other state or a denial of renewal thereof has been duly withdrawn, set aside, reversed or voided, the superintendent shall thereupon reinstate and restore any and all licenses revoked in accordance with the provisions of this subsection.

(g) If any licensed insurance producer or any person aggrieved shall file with the superintendent a verified complaint setting forth facts tending to show sufficient ground for the revocation or suspension of any insurance producer's license, or if any licensed adjuster or any person aggrieved files with the superintendent a verified complaint setting forth facts showing sufficient grounds for the suspension or revocation of any adjuster's license, the superintendent shall, after notice and a hearing, determine whether such license shall be suspended or revoked.

(h) The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter against any person or entity who is under investigation for or charged with a violation of this chapter, even if the person's or entity's license or registration has been surrendered, or has expired or has lapsed by operation of law.

(i) A licensee subject to this article shall report to the superintendent any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

(j) Within thirty days of the initial pretrial hearing date, a licensee subject to this article shall report to the superintendent any criminal prosecution of the licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

§ 2111. Revoked licensees. (a) (1) No individual, corporation, partnership, association, firm or entity subject to the provisions of this chapter whose license under this article has been revoked, or whose license to engage in the business of insurance in any capacity has been revoked by any other state or territory of the United States shall become employed or appointed as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(2) No individual, corporation, partnership, association, firm or entity subject to the provisions of this chapter shall knowingly employ or appoint any person or entity whose license issued under this article has been revoked, or whose license to engage in the business of insurance in any capacity has been revoked by any other state or territory of the United States, as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(3) No corporation or partnership subject to the provisions of this chapter shall knowingly permit any person whose license issued under this article has been revoked, or whose license to engage in the business of insurance in any capacity has been revoked by any other state, or territory of the United States, to be a shareholder or have an interest in such corporation or partnership, nor shall any such person become a shareholder or partner in such corporation or partnership, without the prior written approval of the superintendent.

(4) For the purpose of this section a "controlling person" is any person who or which, directly or indirectly, has the power to direct or cause to be directed the management, control or activities of such licensee.

(b) The superintendent may approve the employment, appointment or participation of any such person whose license has been revoked:

(1) if he determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other

licensees, or the licensee proposing employment or appointment of such person; or

(2) if such person has filed an application for relicensing pursuant to this article and the application for relicensing has not been approved or denied within one hundred twenty days following the filing thereof, unless the superintendent determines within the said time that employment or appointment of such person by a licensee in the conduct of an insurance business would not be in the public interest.

(c) The provisions of this section shall not apply to the ownership of shares of any corporation licensed pursuant to this article if the shares of such corporation are publicly held and traded in the over-the-counter market or upon any national or regional securities exchange.

(d) The provisions of this section shall apply to relationships created or proposed on or after September first, nineteen hundred eighty-two, as well as to any person whose license is revoked on or after such date.

(e) The provisions of section one hundred thirty of the former insurance law, as added by chapter four hundred twenty-seven of the laws of nineteen hundred eighty and repealed and added by chapter four hundred eighty-four of the laws of nineteen hundred eighty-two, shall be deemed to be and remain in full force and effect and be so applicable with respect to relationships created or proposed, and germain to such section prior to September first, nineteen hundred eighty-two, as well as to any person whose license was revoked on or before such date.

§ 2112. Certificate of appointment of an insurance producer to act as an agent and notice of termination of an insurance producer. (a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents or, in the case of a title insurance corporation, title insurance agents, to represent such insurer, fraternal benefit society or health maintenance organization.

(b) To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within

fifteen days from the date the agency contract is executed or the first insurance application is submitted.

(c) Certificates of appointment shall be valid until (1) terminated by the appointing insurer or title insurance agent after a termination in accordance with the provisions of the agency contract; (2) the license is suspended or revoked by the superintendent; or (3) the license expires and is not renewed.

(d) Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent, or title insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall provide, within fifteen days after notification has been sent to the superintendent, a copy of the statement filed with the superintendent to the insurance producer at his, or her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Every statement made pursuant to this subsection shall be deemed a privileged communication.

(e) The insurer, fraternal benefit society, health maintenance organization, insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall promptly notify the superintendent in a format acceptable to the superintendent if, upon further review or investigation, the insurer, fraternal benefit society, health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health

maintenance organization or insurance producer discovers additional information that would have been reportable to the superintendent had the insurer then known of its existence. Every statement made pursuant to this subsection shall be deemed a privileged communication.

(f)(1) Within fifteen days after making the notification required by subsection (e) of this section the insurer, fraternal benefit society, health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer shall mail a copy of the notification to the insurance producer at his, her or its last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty days after the insurance producer has received the original or additional notification, the insurance producer may file written comments concerning the substance of the notification with the superintendent. The insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, fraternal benefit society, health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer and the comments shall become a part of the superintendent's file and accompany every copy of a report distributed or disclosed for any reason about the insurance producer as permitted by section one hundred ten of this chapter.

(g)(1) In the absence of fraud, bad faith or gross negligence, an insurer, fraternal benefit society or health maintenance organization, or the authorized representative of the insurer, fraternal benefit society or health maintenance organization, an insurance producer, the superintendent, or an organization of which the superintendent is a member and that compiles the information and makes it available to other insurance superintendents or commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the superintendent, from an insurer, fraternal

benefit society or health maintenance organization or the authorized representative of the insurer, or insurance producer, or a statement by a terminating insurer, fraternal benefit society or health maintenance organization or the authorized representative of the insurer, fraternal benefit society or health maintenance organization, or insurance producer to an insurer, fraternal benefit society or health maintenance organization or the authorized representative of the insurer, fraternal benefit society or health maintenance organization, or insurance producer, limited solely and exclusively to whether a termination for cause was reported to the superintendent, provided that the propriety of any termination for cause is certified in writing by an officer or authorized representative of the insurer, fraternal benefit society or health maintenance organization or the authorized representative of the insurer, fraternal benefit society or health maintenance organization or insurance producer terminating the relationship.

(2) In any action brought against a person that may have immunity under paragraph one of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the superintendent, the party bringing the action shall plead specifically in any allegation that paragraph one of this subsection does not apply because the person making the statement or providing the information did so fraudulently, in bad faith or through gross negligence.

(3) Paragraphs one and two of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

(h) (1) Any documents, materials or other information in the control or possession of the superintendent that is furnished by an insurer, fraternal benefit society or health maintenance organization, the authorized representative of the insurer, fraternal benefit society or health maintenance organization, or insurance producer, or an employee or agent thereof acting on behalf of the insurer, fraternal benefit society or health maintenance organization, authorized representative of the insurer, fraternal benefit society or health maintenance organization or insurance producer relating to the termination of an insurance producer pursuant to this section or obtained by the superintendent in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to freedom of

information requests, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the superintendent is authorized to use the documents, materials or other information in furtherance of any regulatory or legal action brought as a part of the superintendent's duties. Further, this paragraph shall not apply to any documents, materials or other information in the control or possession of any person or entity other than the superintendent or the department, regardless of whether or not such documents, materials or other information are identical or similar to documents, materials or other information in the superintendent's control or possession to which the confidentiality restrictions of this paragraph apply.

(2) Neither the superintendent nor any person who received documents, materials or other information while acting under the authority of the superintendent shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to the provisions of paragraph one of this subsection.

(3) Nothing in this article shall prohibit the superintendent from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to article six of the public officers law to a data base or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(i) An insurer, fraternal benefit society or health maintenance organization, authorized representative of an insurer, fraternal benefit society or health maintenance organization or an insurance producer that fails to report as required under the provisions of this section or that is found to have reported fraudulently, in bad faith or through gross negligence by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with the provisions of this chapter, provided, however, that an insurer may be fined up to five thousand dollars. In the case of a domestic insurer, the provisions of article seventy-four of this chapter shall all also apply.

§ 2113. Title insurance agent commissions; disclosure. (a) No insurer doing business in this state, and no agent or other representative thereof, shall pay any commission or other compensation to any person, firm, association or corporation for acting as a title insurance agent in this state, except to a licensed title insurance agent.

(b) At the time of the application, a title insurance agent shall provide to every applicant for insurance, a written good faith estimate of the premium on the policy or policies to be issued and a breakdown of the amount of all fees and service costs, including all filing fees, recording charges, and closing costs, and any other ancillary or discretionary charges to be incurred, and the amount of any commission or other compensation to be paid to such agent by the title insurance corporation. If no title insurance agent is utilized, the title insurer shall provide the disclosures. If the applicant is represented by an attorney, the written good faith estimate shall be provided to the attorney.

(c) Nothing in this chapter shall be deemed to or be construed in a manner to authorize or permit any activity or practice, with respect to the business of title insurance, that is prohibited by section four hundred eighty-four or four hundred ninety-five of the judiciary law, or otherwise prohibited by law, including the unauthorized practice of law.

(d) Except as provided in subsection (f) of this section, no person or entity who acts as an agent, representative, attorney, or employee of the owner, lessee, or mortgagee, or of the prospective owner, lessee, or mortgagee of the real property or any interest therein and who or whose spouse also is a member, employee, or director of a title insurance agent, owns any interest in a title insurance agent, or is a subsidiary or affiliate of any title insurance agent, shall refer an applicant for insurance to such agent, and no such title insurance agent shall accept any such referral of title insurance business, unless the referral is made in accordance with section six thousand four hundred nine of this chapter and such person or entity, at the time of making a referral, provides, at a minimum, the following written disclosure to the applicant:

(1) the nature of the relationship between the person or entity and the title insurance agent;

(2) that the applicant is not required to use the services of the

title insurance agent or the title insurance corporation to which the applicant is being referred;

(3) that any money or other thing of value directly or indirectly paid by the title insurance agent or title insurance corporation to the person or entity is based on the person or entity's financial interest in the title insurance agent, and is not related to the amount of title insurance business the person or entity refers to the title insurance agent;

(4) that the person or entity is not required to refer a specified amount of title insurance business to the title insurance agency;

(5) the amount or value of any compensation or other thing of value that the person or entity expects to receive in connection with the services to be provided by the title insurance agent or the title insurance corporation to which the party is being referred; and

(6) any relevant disclosures required by the federal real estate settlement procedures act of 1974, as amended.

(e) For the purposes of this chapter, an attorney or his or her law firm may represent a client in a matter and may also act as a title insurance agent in such matter subject to applicable law.

(f) Where a licensed attorney represents an applicant in a real estate transaction and the applicant also retains the attorney as the title insurance agent, the attorney shall not be required to make the written disclosure required by subsection (d) of this section provided the attorney advises the client that the client is not required to use the attorney as the title insurance agent.

(g) As used in this section, "applicant" means the person, firm, limited liability company or corporation for whom the purchase of the property that is the subject of the title insurance policy is financed or to whom a mortgage loan is made or who owns the property, or to a person who is an attorney-in-fact for such person.

(h) The superintendent shall promulgate regulations to enforce the disclosure requirements of subdivision (d) of this section and in doing so shall consider the relevant standards of the federal real estate settlement procedures act of 1974, as amended.

§ 2114. Life, accident and health insurance agents; commissions. (a)

(1) No insurer or fraternal benefit society doing business in this state shall pay any commission or other compensation to any person, firm or corporation, for any services in obtaining in this state any new contract of life insurance or any new annuity contract, except to a licensed life insurance agent of such insurer or of such society or to an insurance broker licensed under subparagraph (A) of paragraph one of subsection (b) of section two thousand one hundred four of this article, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article.

(2) No agent or other representative of any such life insurer or fraternal benefit society shall pay any commission or other compensation to any person for any services of the kind specified in paragraph one hereof, except to a licensed life insurance agent of such insurer or of such society as the case may be.

(3) No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article.

* (4) Services of the kind specified in this subsection shall not include the referral of a person to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions and where the compensation for referral is not based upon the purchase of insurance by such person.

* NB Repealed September 10, 2029

(b) If any licensed life insurance agent who or which has received an application for a life insurance or annuity contract is unable after reasonable diligence to obtain all or any part of such insurance from the life insurer or insurers which he or it is licensed to represent, such agent may solicit, negotiate or sell such insurance, to the extent to which it is declined by such insurer or insurers, from any other

authorized life insurer or insurers, with the consent of the person making such application; but no such agent shall receive any commission or other compensation for his services in connection therewith from any insurer unless he is licensed as agent of such insurer at the time when he receives such compensation.

§ 2115. Property/casualty insurance agents; commissions. (a) * (1) No insurer doing business in this state, and no agent or other representative thereof, except as provided in subsection (b) hereof, shall pay any commission or other compensation to any person, firm, association or corporation for acting as insurance agent in this state, except to a licensed insurance agent of such insurer or to a person described in paragraph two or four of subsection (a) of section two thousand one hundred one of this article or except as provided in subsection (c) of this section. For the purposes of this section, "acting as insurance agent" shall not include the referral of a person to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions and where the compensation for referral is not based upon the purchase of insurance by such person.

* NB Effective until September 10, 2029

* (1) No insurer doing business in this state, and no agent or other representative thereof, except as provided in subsection (b) hereof, shall pay any commission or other compensation to any person, firm, association or corporation for acting as insurance agent in this state, except to a licensed insurance agent of such insurer or to a person described in paragraph two or four of subsection (a) of section two thousand one hundred one of this article or except as provided in subsection (c) of this section.

* NB Effective September 10, 2029

(2) The term "licensed insurance agent" as used in this subsection includes any agent authorized to act as such by a license issued and in force pursuant to the provisions of subsection (b) of section two thousand one hundred three of this article or authorized to act as such in connection with contracts for disability benefits pursuant to the provisions of subsection (n) of such section.

(b) This section shall not apply to any life insurance company, fraternal benefit society, accident and health insurance company, health maintenance organization, title insurance company nor to any agent or representative of any such insurer, society or health maintenance organization, acting as such.

(c) An insurer participating in a plan for assignment of personal injury liability insurance or property damage liability insurance pursuant to article fifty-three of this chapter, or participating in a reinsurance agreement for the writing of bonds to the state of New York under the alcoholic beverage control law, which plan or reinsurance agreement has been approved by the superintendent, may pay a commission to an adequately qualified agent who is licensed to act as agent for any insurer participating in such plan or reinsurance agreement when such agent is designated by the assured as the producer of record under the automobile assigned risk plan pursuant to which a policy is issued, or where such agent submits an application for a bond pursuant to which such bond is issued under such reinsurance agreement.

*** § 2116. Insurance brokers; commissions.** No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article. For the purposes of this section, "acting as insurance broker" shall not include the referral of a person to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions and where the compensation for referral is not based upon the purchase of insurance by such person.

* NB Effective until September 10, 2029

* § 2116. Insurance brokers; commissions. No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its

acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article.

* NB Effective September 10, 2029

§ 2117. Acting for or aiding unlicensed or unauthorized insurers or health maintenance organizations. (a) No person, firm, association or corporation shall in this state act as agent for any insurer or health maintenance organization which is not licensed or authorized to do an insurance or health maintenance organization business in this state, in the doing of any insurance or health maintenance organization business in this state or in soliciting, negotiating or effectuating any insurance, health maintenance organization or annuity contract or shall in this state act as insurance broker in soliciting, negotiating or in any way effectuating any insurance, health maintenance organization or annuity contract of, or in placing risks with, any such insurer or health maintenance organization, or shall in this state in any way or manner aid any such insurer or health maintenance organization in effecting any insurance, health maintenance organization or annuity contract.

(b) Notwithstanding the provisions of subsection (a) hereof, any insurance broker licensed under subparagraph (B) of paragraph one of subsection (b) of section two thousand one hundred four of this article may negotiate a contract of insurance, or place insurance, in an insurer not authorized to do business in this state, as follows:

(1) a contract of reinsurance on risks produced by such broker;

(2) insurance against loss of or damage to property having a permanent situs outside of this state; and

(3) marine insurance of the following kind or kinds, where it is reasonable so to do with due regard to the interests of all concerned and whether or not, at the time of such negotiation, the subject matter of such insurance is within or without this state:

(A) insurance against perils of navigation, transit or transportation upon hulls, freights or disbursements, or other shipowner interests, goods, wares, merchandise and all other personal property and interests

therein, in course of exportation from or importation into any country, or transportation coastwise, including transportation by land or water from point of origin to final destination and including war risks and marine builders' risks; and

(B) insurance in connection with ocean going vessels against any of the risks specified in paragraph twenty-one of subsection (a) of section one thousand one hundred thirteen of this chapter.

(c) Notwithstanding the provisions of subsection (a) hereof, any insurance broker licensed under subparagraph (B) of paragraph one of subsection (b) of section two thousand one hundred four of this article may negotiate a contract of insurance or place insurance in an unauthorized insurer as follows:

(1) insurance against legal liability arising out of the ownership, operation or maintenance of any motor vehicle or aircraft which is neither principally garaged nor principally used in this state, arising out of any activity carried on wholly outside of this state or arising out of the ownership, operation or maintenance of any property having a permanent situs outside of this state, but in case such property or risk is located in any other state, then only in an insurer authorized to do such business in such state or in an insurer in which a licensed insurance broker of such state may lawfully place such insurance; and

(2) fidelity bonds guaranteeing the fidelity of persons holding or exercising positions of public or private trust wholly outside of this state, and surety bonds guaranteeing or assuming the performance of any contract or other obligation of the kind included under subparagraphs (B) and (C) of paragraph sixteen of subsection (a) of section one thousand one hundred thirteen of this chapter, to be performed wholly outside of this state; but if such positions are held or exercised in another state or if such contract or other obligation is to be performed wholly or partly in another state, then only if such insurance is placed in an insurer authorized to do such business in such state, or in which a licensed broker of such state may lawfully place such insurance.

(d) Notwithstanding the provisions of subsection (a) hereof, any licensed reinsurance intermediary may negotiate a contract of reinsurance, or place reinsurance, in an insurer not authorized to do business in this state.

(e) This section shall not authorize any person, firm, association or

corporation to guarantee or otherwise validate or secure the performance or legality of any agreement, instrument or policy of insurance or annuity contract of any insurer not authorized to do business in this state, or to bind risks, validate, effect by countersignature, endorsement or otherwise, any binder, memorandum, cover note, slip, certificate, policy or other instrument of insurance of any insurer not authorized or licensed to do business in this state, or to make binding declarations of risks thereunder, or permit any unauthorized insurer to do any insurance business by its agent acting within this state; but licensed insurance brokers acting pursuant to subsections (b) and (c) hereof may issue to their clients, the insureds, confirmation of insurance so lawfully placed.

(f) This chapter shall not prohibit or prevent an attorney and counsellor at law from representing an unauthorized insurer in litigation or settlement of claims in this state.

(g) Any person, firm, association or corporation violating any provision of this section shall, in addition to any other penalty provided by law, forfeit to the people of the state the sum of five hundred dollars for each transaction.

(h) (1) This section shall not prohibit any person, firm, association or corporation from acting within the scope of the authority conferred by section two thousand one hundred five of this article.

(2) Notwithstanding subsection (a) of this section, a licensed insurance broker may deliver to the insured an insurance policy or contract procured by any person, firm, association or corporation acting pursuant to the authority conferred by section two thousand one hundred five of this article.

(3) Notwithstanding subsection (a) of this section and any other provision of law to the contrary, any excess line broker licensed pursuant to section two thousand one hundred five of this article may exercise binding authority and execute an authority to bind coverage on behalf of an insurer not licensed or authorized to do business in this state pursuant to the provisions of subsection (f) of section two thousand one hundred eighteen of this article.

(i) Notwithstanding subsection (a) of this section, a licensed insurer may provide, from its office in the state, services to support the insurance business of an unauthorized insurer with which it is

affiliated, provided that the unauthorized insurer has satisfied all applicable requirements for placements by excess line brokers as set forth in section two thousand one hundred eighteen of this article. Such services may include, but shall not be limited to, computer operations, clerical and staffing support, underwriting, negotiating contract terms, quoting premiums, binding coverage, drafting and issuing policies and claims handling, investigation and payment, among other incidental services. Services expressly prohibited under this section include the marketing, soliciting or advertising by the unauthorized insurer directly to policyholders. Notwithstanding paragraph two of subsection (a) of section two thousand one hundred twenty-two of this article, such unauthorized insurers shall be permitted to advertise to, and market and solicit through, excess line brokers licensed pursuant to section two thousand one hundred five of this article, from an office within the state. All obligations of such licensee under this article shall remain in full force and effect. Any document issued by an unauthorized insurer that indicates any location within this state in which it conducts its operations shall include a prominent notice that the insurer is not licensed by the state of New York, in no smaller than 10 point type, in accordance with regulations as may be promulgated by the superintendent.

(j) Nothing in this section shall prohibit a person who is not a resident of this state from selling, soliciting or negotiating a property/casualty insurance contract of an insurer not authorized to do business in this state, provided that: (1) the insured's home state is a state other than this state; and (2) the person is licensed to sell, solicit or negotiate excess line insurance in the insured's home state.

(k)(1) Notwithstanding subsection (a) of this section, any insurance broker licensed under subparagraph (A) of paragraph one of subsection (b) of section two thousand one hundred four of this article with respect to life insurance or annuities, subparagraph (A) or (B) of paragraph one of subsection (b) of such section with respect to accident and health insurance, or subparagraph (B) of this paragraph with respect to property/casualty insurance may engage in the activities specified in paragraph two of this subsection with respect to an alien insurer not authorized to do an insurance business in this state, provided that:

(A) the activities relate to a policy or contract of group life, group annuity, group accident and health insurance, or property/casualty

insurance where the policyholder or proposed policyholder is a multinational entity resident outside the United States, the policy or contract covers the multinational entity's liabilities, properties, employees and their dependents, and the liabilities arise, or the properties and employees reside outside of the United States, except that the policy or contract may provide coverage to employees who are temporarily inside the United States;

(B) the policy or contract shall not be underwritten or negotiated in this state or issued or delivered in the United States;

(C) the alien insurer is authorized to transact the kinds of insurance business in the jurisdictions where the policies or contracts will be issued or delivered and the policies or contracts are issued in conformance with the laws of such jurisdictions;

(D) before engaging in any of the activities specified in paragraph two of this subsection, the licensed insurance broker provides written notice to the multinational entity that the alien insurer is not licensed in or authorized to do business in this state; the policy or contract is not protected by the New York state guaranty funds; the policy or contract has not been approved by the superintendent; and the policy or contract may not be subject to all of the laws of this state;

(E) the alien insurer shall not maintain any office in this state; and

(F) except as specifically provided in this section, the licensed insurance broker shall not call attention to the alien insurer by any advertisement or public announcement in this state.

(2) Subject to paragraph one of this subsection, the licensed insurance broker may engage in this state in only the following activities with respect to the alien insurer:

(A) provide information to the multinational entity with respect to a policy or contract of group life, group annuity, group accident and health insurance, or a property/casualty insurance policy issued or delivered or that will be issued or delivered by the alien insurer;

(B) meet and discuss insurance needs with the multinational entity, including providing information directly to the entity in person or otherwise about the policies or contracts offered by the alien insurer; and facilitating introductions with the multinational entity's human resources and benefits manager in each country in which the multinational entity has employee benefit needs;

(C) refer the multinational entity to the alien insurer and provide information to the multinational entity about the alien insurer;

(D) respond to requests for information by representatives of the multinational entity concerning quotes and any other specific terms and conditions of a group life, group annuity, group accident and health insurance, or property/casualty insurance policy or contract being negotiated in the jurisdiction where the policy or contract will be issued or delivered by the alien insurer;

(E) provide information concerning renewals of existing policies or contracts of group life, group annuity, group accident and health insurance, or a property/casualty insurance policy issued by the alien insurer; and

(F) manage the employee benefits program of the multinational entity, including aggregating and reporting employee benefits and financial information about the program.

(3) Any activity in which a licensed insurance broker engages with respect to an alien insurer pursuant to this subsection shall be deemed to be included within the meaning of "any other transaction of business" for the purposes of section one thousand two hundred thirteen of this article.

(4) For purposes of this subsection:

(A) "multinational entity" shall mean an institution that is a member of a multinational group of institutions operating globally where: (i) at least one institution in the group is formed under the laws of the United States or has significant operations in the United States; and (ii) at least one institution in the group has offices outside the United States; and

(B) "group of institutions" shall mean a parent corporation and its subsidiaries.

§ 2118. Excess line brokers; duties. (a) (1) Every licensee licensed pursuant to section two thousand one hundred five of this article shall be required to use due care in selecting the unauthorized insurer from whom policies are procured under his license.

(2) (A) No policy of insurance may be procured by a licensee from any foreign or alien insurer which is controlled, by a foreign government or

by a political subdivision thereof, or which is an agency of any such government or subdivision if the superintendent determines that: (i) such insurer receives a subsidy or other competitive advantage, as a result of such control or status, that would enable it to compete unfairly with similarly situated insurers which are not so controlled or constituted; (ii) such insurer is entitled to claim sovereign immunity as a result of such control and the insurer has not waived the sovereign immunity; or (iii) the use of such insurer would be detrimental to the interests of the people of this state.

(B) No licensee shall be deemed to be in noncompliance with this subsection unless: (i) the superintendent has made a prior determination that the foreign or alien insurer from which the licensee procured a policy of insurance should not be used as an excess line insurer in this state in accordance with the provisions of this subsection; or (ii) the licensee knew or should have known that such insurer should not be used as an excess line insurer in accordance with the provisions of this subsection. The superintendent may promulgate regulations to provide guidance to the licensee.

(C) Every such insurer shall otherwise satisfy all applicable requirements for placement by an excess line broker.

* (b) (1) Within forty-five days after a policy is procured, a licensee shall submit the declarations page or cover note of every policy procured under his or her license to the excess line association established pursuant to section two thousand one hundred thirty of this article for recording and stamping. In the event that no declarations page or cover note is available to the licensee, within forty-five days after the policy is procured, the licensee shall submit a binder to the excess line association in lieu of such declarations page or cover note. In the event that a binder is submitted to the excess line association, the licensee shall submit the declarations page or cover note to the excess line association promptly upon receipt. Every insurance document submitted to the excess line association pursuant to this subsection shall set forth:

(A) the name and address of the insured;

(B) the gross premium charged;

(C) the name of the unauthorized insurer; and

(D) the kind of insurance procured.

(2) Subsequent endorsements which do not affect the premium charged are exempted from stamping.

(3) (A) Except as provided in subparagraph (F) of this paragraph, submission of insurance documents to the excess line association shall be accompanied by a statement subscribed to, and affirmed by, the licensee or sublicensee as true under the penalties of perjury that, after diligent effort, the full amount of insurance required could not be procured, from authorized insurers, each of which is authorized to write insurance of the kind requested and which the licensee has reason to believe might consider writing the type of coverage or class of insurance involved, and further showing that the amount of insurance procured from an unauthorized insurer is only the excess over the amount procurable from an authorized insurer. The licensee, however, shall be excused from affirming that a diligent effort, as defined above, was made to procure the coverage from authorized insurers if the licensee's affidavit is accompanied by the affidavit of another broker involved in the placement affirming as true under the penalties of perjury that, after diligent effort by the affirming broker, the required insurance could not be procured from an authorized insurer which the affirming broker had reason to believe might consider writing the type of coverage or class of insurance involved. The licensee and the affirming broker shall be excused from affirming that a diligent effort was made if the superintendent determines, pursuant to paragraph four of this subsection, that no declinations are required.

(B) A licensee or affirming broker shall be considered to have the reason to believe required by subparagraph (A) of this paragraph if the decision to offer the risk to the authorized insurer was based on any of the following:

(i) Recent acceptance by the authorized insurer of a type of coverage or class of insurance similar to that for which coverage is presently being sought;

(ii) Advertising by the authorized insurer or its agent indicating that the authorized insurer is willing to consider acceptance of this or a similar type of coverage or class of insurance;

(iii) Media communications (i.e., newspaper or magazine articles, trade publications, television and radio programming) indicating that the authorized insurer is writing, or is considering writing, this type

of coverage or class of insurance;

(iv) Communications with other insurance professionals, risk managers, trade associations, the excess line association or the department of financial services which indicates that the authorized insurer might consider writing this type of coverage or class of insurance; or

(v) Any other valid basis for making such decision.

(C) Every licensee, or affirming broker, in connection with the placement of each risk pursuant to this section, shall record on the affidavit required pursuant to subparagraph (A) of this paragraph the name, date of the declination, and national association of insurance commissioners code of each authorized insurer declining a risk and information relied upon that formed the basis of such licensee's or affirming broker's reason to believe that the authorized insurer might consider writing the type of coverage or class of insurance involved. A licensee or affirming broker shall not be required to record on the affidavit the name of the representative declining the risk, the representative's affiliation, or the reason for the declination.

(D) Declinations obtained from authorized insurers which are affiliates of, or, as defined in article fifteen of this chapter, under common control with, each other or the unauthorized insurer shall not meet the requirements of this subsection unless such related insurers operate as distinct and autonomous entities, and for underwriting purposes, compete with each other for the same type of coverage or class of insurance.

(E) The superintendent, in a regulation, may determine whether there are circumstances where it may be appropriate, due to the unavailability from an authorized insurer of the leading type of coverage or the leading class of insurance required by the insured, to waive the requirement in subparagraph (A) of this paragraph that a licensee may procure from an unauthorized insurer only the amount of insurance which is excess over the amount procurable from an authorized insurer, and to instead permit the licensee to procure from an unauthorized insurer the full amount of insurance required by the insured.

(F) A licensee seeking to procure or place insurance in this state for an exempt commercial purchaser shall not be required to satisfy any requirement of this state to make a due diligence search to determine whether the full amount or type of insurance sought by the exempt

commercial purchaser can be obtained from authorized insurers if:

(i) the licensee procuring or placing the excess line insurance has disclosed to the exempt commercial purchaser that the insurance may or may not be available from the authorized market that may provide greater protection with more regulatory oversight; and

(ii) the exempt commercial purchaser has subsequently requested in writing that the licensee procure or place the insurance from an unauthorized insurer.

(4) The number of declinations constituting diligent effort in regard to placement of coverage with authorized insurers for purposes of paragraph three of this subsection shall be three, unless the superintendent after a hearing, on a record, upon findings and conclusions, determines that another number of such declinations is appropriate in regard to particular coverages. In making such determinations, the superintendent shall consider relevant market conditions, including unavailability of particular coverages from authorized insurers, and may conduct market surveys. Any such determination shall be reviewed at least annually by the superintendent.

(5) Before placing business with an unauthorized insurer, each licensee shall ascertain and verify the fact that such insurer is authorized in its domiciliary jurisdiction to write the insurance policy proposed to be procured from it by the licensee. No unauthorized insurer shall be deemed unacceptable for placement of business solely on the ground that it has been so authorized to write such business in its domiciliary jurisdiction for a period of less than three years preceding the placement of such risk by the licensee. In determining whether business may be placed with such unauthorized insurer, the superintendent shall consider such factors as: the interests of the public and policyholders, the length of time such insurer has been authorized in its domiciliary jurisdiction and elsewhere, its financial condition, and unavailability of particular coverages from authorized insurers.

(6) It shall be unlawful for a licensee as defined in section two thousand one hundred one of this article and pursuant to sections two thousand one hundred four and two thousand one hundred five of this article to deliver in this state any declarations page of an insurance policy or cover note evidencing insurance unless such insurance document

is stamped by the excess line association or is exempt from such requirements; provided, however, that a licensee's failure to comply with the requirements of this subsection shall not affect the validity of the coverage.

(7) Compliance by a licensee with the requirements set forth in this section in connection with submitting for recording and stamping declarations pages, cover notes, binders, endorsements, affidavits, notices of excess line placement and other excess line insurance documents may be accomplished by means of electronic or other media transmission, provided the superintendent first approves such methods of submitting for recording and stamping.

* NB Effective until July 1, 2029

* (b) (1) When any policy of insurance is procured under the authority of a license issued pursuant to section two thousand one hundred five of this article, there shall be submitted, both by the licensee or sub-licensee and by the insured, statements subscribed and affirmed by them as true under the penalties of perjury setting forth facts showing that such insured and such licensee were unable after diligent effort to procure, from authorized insurers, each authorized to write coverages of the kind requested, the full amount of insurance required to protect the interest of such insured, and further showing that the amount of insurance procured from an unauthorized insurer or insurers is only the excess over the amount so procurable from authorized insurers; provided, however, that the licensee shall be excused from affirming that a diligent effort was made to procure the coverage from such authorized insurers if the licensee's affidavit is accompanied by the affidavit of another broker involved in the placement affirming as true under the penalties of perjury that, after diligent effort by the affirming broker, the required insurance could not be procured from such authorized insurers.

(2) The number of declinations constituting diligent effort in regard to placement of coverage with authorized insurers for purposes of paragraph one of this subsection shall be three, unless the superintendent after a hearing, on a record, upon findings and conclusions, determines that another number of such declinations is appropriate in regard to particular coverages. In making such determinations, the superintendent shall consider relevant market

conditions, including unavailability of particular coverages from authorized insurers, and may conduct market surveys. Any such determination shall be reviewed at least annually by the superintendent.

(3) Before placing business with an unauthorized insurer, each licensee shall ascertain and verify the fact that such insurer is authorized in its domiciliary jurisdiction to write the insurance policy proposed to be procured from it by the licensee. No unauthorized insurer shall be deemed unacceptable for placement of business solely on the ground that it has been so authorized to write such business in its domiciliary jurisdiction for a period of less than three years preceding the placement of such risk by the licensee. In determining whether business may be placed with an unauthorized insurer, the superintendent shall consider such factors as: the interests of the public and policyholders, the length of time such insurer has been authorized in its domiciliary jurisdiction and elsewhere, its financial condition, and unavailability of particular coverages from authorized insurers.

(4) The statements required pursuant to paragraph one of this subsection shall be filed by such licensee with the superintendent within thirty days after such policies have been procured.

* NB Effective July 1, 2029

* (c) (1) The licensee shall keep a complete and separate record of all policies procured from unauthorized insurers under such license. The licensee shall also maintain files supporting declinations by authorized insurers. An authorized insurer need not maintain underwriting submissions or other records with respect to any declination, unless the superintendent, after a hearing on a record, finds substantial abuses of the provisions of this section and determines that recordkeeping or reporting requirements in regard to authorized insurers are necessary to redress or eliminate such abuses.

(2) Such records shall be open to examination by the excess line association as provided for in section two thousand one hundred thirty of this article and by the superintendent, as provided in section three hundred ten of this chapter, at all reasonable times and shall show:

(A) the exact amount of each kind of insurance permitted under this section which has been procured for each insured;

(B) the gross premiums charged by the insurers for each kind of insurance permitted under this section;

(C) the amount of each kind of premiums of insurance permitted by this section which were returned to each insured;

(D) the name of the insurer or insurers which issued each of said policies;

(E) the effective dates of such policies;

(F) the terms for which they were issued; and

(G) the cities and villages within this state in which the insured risks, respectively, are located.

* NB Effective until July 1, 2029

* (c)(1) The licensee shall keep a complete and separate record of all policies procured from unauthorized insurers under such license. The licensee shall also maintain files supporting declinations by authorized insurers. An authorized insurer need not maintain underwriting submissions or other records with respect to any declination, unless the superintendent, after a hearing on a record, finds substantial abuses of the provisions of this section and determines that recordkeeping or reporting requirements in regard to authorized insurers are necessary to redress or eliminate such abuses. The superintendent shall review recordkeeping requirements applicable to this section and, by October first, nineteen hundred eighty-six, shall take measures in order to simplify forms and other aspects of compliance with such requirements.

(2) Such records shall be open to examination by the superintendent, as provided in section three hundred ten of this chapter, at all reasonable times and shall show:

(A) the exact amount of each kind of insurance permitted under this section which has been procured for each insured;

(B) the gross premiums charged by the insurers for each kind of insurance permitted under this section;

(C) the amount of each kind of premiums of insurance permitted by this section which were returned to each insured;

(D) the name of the insurer or insurers which issued each of said policies;

(E) the effective dates of such policies;

(F) the terms for which they were issued; and

(G) the cities and villages within this state in which the insured risks, respectively, are located.

* NB Effective July 1, 2029

(d) (1) Where this state is the insured's home state, a person, firm, association or corporation licensed pursuant to the provisions of section two thousand one hundred five of this article shall pay to the superintendent a sum equal to three and six-tenths percent of the gross premiums charged the insureds by the insurers for insurance procured by such licensee pursuant to such license, less the amount of such premiums returned to such insureds.

(2) The amount of such payments which represents a sum equal to three percent of fire insurance premiums shall be distributed by the superintendent as prescribed in section nine thousand one hundred five of this chapter, and the balance thereof shall be paid over by the superintendent to the state treasurer.

(3) Such licensee shall be required to make such payments to the superintendent on the fifteenth day of March of each year for the taxes on all policies procured by such licensee, pursuant to such license, during the next preceding calendar year, and on such date such licensee shall also file with the superintendent a return in the form prescribed by the superintendent, showing such information as may be necessary for the proper distribution of such payments.

(e)(1) Except as provided in paragraph two of this subsection, no licensee shall be required to obtain a declination from an association established pursuant to article fifty-four or fifty-five of this chapter, or to apply for insurance through a plan established pursuant to article fifty-three of this chapter, as a condition of procuring insurance pursuant to this section.

(2) (A) Unless the licensee obtains a declination from the appropriate association, or from an insurer pursuant to an application for coverage through a plan, no diligent effort shall be considered to have been made if the insurance is available from the plan or association in connection with the placement of:

(i) a policy of non-commercial motor vehicle liability insurance;

(ii) medical malpractice insurance for a general hospital, as defined in subdivision ten of section two thousand eight hundred one of the public health law, a physician or dentist; or

(iii) insurance which by law must be provided by an authorized insurer.

(B) In connection with the placement of any other kind of insurance, a

declination from the appropriate association, or from an insurer pursuant to an application for coverage through a plan, shall be required unless prior to the placement the insured has been advised of the availability of insurance from the plan or association.

(C) The affirming broker shall provide written notice to the insured that the placement was made with an unauthorized insurer. A copy of this notice shall be attached to the affirming broker's affidavit. The affidavits required by this section to be completed by the affirming broker shall include a statement that the affirming broker advised the insured in writing:

(i) that the unauthorized insurer with which the coverage is being placed is not authorized to do an insurance business in this state and is not subject to supervision by this state;

(ii) that in the event of the insolvency of the unauthorized insurer, losses will not be covered by any New York state insolvency fund;

(iii) that the policy may not be subject to all of the regulations of the superintendent pertaining to policy forms; and

(iv) such other information as the superintendent may, by regulation, require.

(f) (1) An excess line broker licensed pursuant to section two thousand one hundred five of this article may execute an authority to bind coverage and may exercise binding authority on behalf of an insurer not licensed or authorized to do business in this state pursuant to the provisions of this subsection.

(2) As used in this subsection:

(A) an "authority to bind coverage" means the written agreement between an excess line broker and an insurer not licensed or authorized to do business in this state and shall set forth the terms, conditions, and limitations governing the exercise of binding authority by the excess line broker;

(B) a "binder" means written evidence of a temporary insurance contract; and

(C) "binding authority" means the authority to issue and deliver binders, and to issue and deliver insurance policies on behalf of an insurer not licensed or authorized to do business in this state.

(3) (A) Every excess line broker who exercises binding authority shall have filed an authority to bind coverage, the contents of which shall

not be public, with the excess line association established pursuant to section two thousand one hundred thirty of this article.

(B) Such authority shall be valid until (i) terminated by the appointing insurer after termination in accordance with the contract between the broker and the insurer; (ii) the excess line license is suspended or revoked by the superintendent; or (iii) the excess line license expires and is not renewed.

(4) Notwithstanding any other provision of law to the contrary, the execution or filing of an authority to bind coverage and the exercise of binding authority by an authorized excess line broker shall not constitute the doing of insurance business by an insurer not licensed or authorized to do business in this state.

(5) Any coverage so written must be in compliance with this section.

(6) Every binder shall contain a description and location of the subject of insurance, coverage, conditions and term of insurance, the premium, the name and address of the excess line broker, the name and address of the producing broker, the name of the insurer and the name and address of the insured.

(7) Any binding authority agreement made and filed pursuant to this section may authorize an excess line broker to bind coverage for risks located within or outside of the state of New York, notwithstanding any other provision of this chapter.

(8) Any binding authority agreement made and filed pursuant to this section may authorize an excess line broker to issue notice of cancellation of any insurance policy bound pursuant to such agreement (A) for non-payment of premium, (B) for a material increase in the hazard insured, or (C) upon discovery of a material misrepresentation in the application for insurance. The excess line broker shall not be deemed an agent of the insurer solely for issuing such notice of cancellation.

§ 2119. Insurance agents, brokers, consultants, life settlement brokers, and title insurance agents; written contract for compensation; excess charges prohibited.

(a) (1) No person licensed as an insurance agent, broker or consultant may receive any fee, commission or thing of value for examining,

appraising, reviewing or evaluating any insurance policy, bond, annuity or pension or profit-sharing contract, plan or program or for making recommendations or giving advice with regard to any of the above, unless such compensation is based upon a written memorandum signed by the party to be charged and specifying or clearly defining the amount or extent of such compensation.

(2) A copy of every such memorandum or contract shall be retained by the licensee for not less than three years after such services have been fully performed.

(b) (1) No person licensed as an insurance agent, broker or a consultant may receive any compensation, direct or indirect, as a result of the sale of insurance or annuities to, or the use of securities or trusts in connection with pensions for, any person to whom any such licensee has performed any related consulting service for which he has received a fee or contracted to receive a fee within the preceding twelve months unless such compensation is provided for in the memorandum or contract required pursuant to subsection (a) hereof.

(2) This chapter shall not prohibit the offset, in whole or in part, of compensation payable under subsection (a) hereof by compensation otherwise payable to such consultant as agent or broker as a result of such sale of insurance or annuities or the use of securities or trusts in connection with pensions, if any such offset is provided for in the written memorandum or contract required under subsection (a) hereof.

(c) (1) No insurance broker may receive any compensation, other than commissions deductible from premiums on insurance policies or contracts, from any insured or prospective insured for or on account of the sale, solicitation or negotiation of, or other services in connection with, any contract of insurance made or negotiated in this state or for any other services on account of such insurance policies or contracts, including adjustment of claims arising therefrom, unless such compensation is based upon a written memorandum, signed by the party to be charged, and specifying or clearly defining the amount or extent of such compensation.

(2) A copy of every such memorandum shall be retained by the broker for not less than three years after such services have been fully performed.

(3) This subsection shall not affect the right of any such broker to

recover from the insured the amount of any premium or premiums for insurance effectuated by or through such broker.

(4) This subsection shall not affect the requirements of subsection (a) or (b) hereof, subsection (g) of section two thousand one hundred one or section two thousand one hundred eight of this article.

(d) No insurance broker shall, in connection with the sale, solicitation or negotiation, issuance, delivery or transfer in this state of any contract of insurance made or negotiated in this state, directly or indirectly charge, or receive from, the insured or prospective insured therein any greater sum than the rate of premium fixed therefor by the insurer obligated as such therein, unless such broker has a right to compensation for services created in the manner specified in subsection (c) of this section.

(e)(1) No person licensed as a life settlement broker may receive any compensation for examining, appraising, reviewing or evaluating any life settlement contract or for making recommendations or giving advice with regard to such contract; or receive any compensation from any owner or proposed owner for or on account of the solicitation or negotiation of, or other services in connection with, any life settlement contract subject to this chapter or for any other services on account of such contract; unless such compensation is based upon a written memorandum signed by the party to be charged and specifying or clearly defining the amount or extent of such compensation. A copy of every such memorandum shall be retained by the licensee for not less than three years after such services have been fully performed.

(2) No person licensed as a life settlement broker may receive any compensation, direct or indirect, for or on account of the solicitation or negotiation of, or other services in connection with a life settlement contract subject to this chapter from any person for whom any such licensee has performed any related consulting service for which the licensee has received a fee or contracted to receive a fee within the preceding twelve months unless such compensation is provided for in the written memorandum required pursuant to paragraph one of this subsection.

(3) No person licensed as a life settlement broker may receive any compensation, direct or indirect, from a life settlement provider or any other person with respect to any life settlement contract if the life

settlement broker has already received or will receive compensation, direct or indirect from, or on behalf of, the owner with respect to that life settlement contract.

(f) No title insurance agent may receive any compensation or fee, direct or indirect, for or on account of services performed in connection with the issuance of a title insurance policy, unless such compensation is: (1) for ancillary services not encompassed in the rate of premium approved by the superintendent; and (2) based upon a written memorandum signed by the party to be charged, and specifying or clearly defining the amount or extent of such compensation to be charged for each ancillary service as well as the total amount or extent of the compensation to be charged. A copy of every such memorandum shall be retained by the licensee for not less than three years after such services have been fully performed. For purposes of this subsection, legal services performed by a New York state licensed attorney who is also engaged as a title insurance agent shall not be considered ancillary services.

§ 2120. Fiduciary capacity of insurance agents, title insurance agents, insurance brokers and reinsurance intermediaries.

(a) Every insurance agent, title insurance agent, and insurance broker acting as such in this state shall be responsible in a fiduciary capacity for all funds received or collected as insurance agent or insurance broker, and shall not, without the express consent of his, her or its principal, mingle any such funds with his, her or its own funds or with funds held by him, her or it in any other capacity.

(b) Every reinsurance intermediary acting as such in this state shall be responsible, in a fiduciary capacity for all funds received or collected in such capacity, and shall not, without the express consent of his or its principal or principals, mingle any such funds with his or its own funds or with funds held by him or it in any other capacity.

(c) This section shall not require any such insurance agent, title insurance agent, insurance broker or reinsurance intermediary to maintain a separate bank deposit for the funds of each such principal, if and as long as the funds so held for each such principal are reasonably ascertainable from the books of account and records of such

agent, broker or reinsurance intermediary, as the case may be.

(d) A retail insurance producer who violates paragraph (a) of subdivision two of section five hundred seventy-seven-a of the banking law shall be liable for actual damages for the failure to notify, in writing, the premium finance agency of the information required pursuant to such paragraph (a).

§ 2121. Broker authorized to receive premium, when. (a) Any insurer which delivers in this state to any insurance broker or any insured represented by such broker a contract of insurance pursuant to the application or request of such broker, acting for an insured other than himself, shall be deemed to have authorized such broker to receive on its behalf payment of any premium which is due on such contract at the time of its issuance or delivery or payment of any installment of such premium or any additional premium which becomes due or payable thereafter on such contract, provided such payment is received by such broker within ninety days after the due date of such premium or installment thereof or after the date of delivery of a statement by the insurer of such additional premium.

(b) An agent who represents an insured for the purpose of obtaining insurance pursuant to any plan authorized by articles fifty-three, fifty-four and fifty-five of this chapter shall be deemed to be a broker for the purposes of this section.

§ 2122. Advertising by insurance producers.

(a) (1) No insurance producer shall make or issue in this state any advertisement, sign, pamphlet, circular, card or other public announcement purporting to make known the financial condition of any insurer, unless the same shall conform to the requirements of section one thousand three hundred thirteen of this chapter.

(2) No insurance producer or other person, shall, by any advertisement or public announcement in this state, call attention to any unauthorized insurer or insurers.

(b) Every agent of any insurer and every insurance broker shall, in all advertisements, public announcements, signs, pamphlets, circulars

and cards, which refer to an insurer, set forth therein the name in full of the insurer referred to and the name of the city, town or village in which it has its principal office in the United States.

§ 2123. Misrepresentations, misleading statements and incomplete comparisons. (a) (1) No agent or representative of any insurer or health maintenance organization authorized to transact life, accident or health insurance or health maintenance organization business in this state, insurance broker, person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the Affordable Care Act, 42 U.S.C. § 18031, to act as a navigator, including any person employed by a certified navigator, or other person, firm, association or corporation, shall issue or circulate or cause or permit to be issued or circulated, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any policy or contract of life, accident or health insurance, any annuity contract or any health maintenance organization contract, delivered or issued for delivery or to be delivered or issued for delivery, in this state, or shall make any misleading estimate as to the dividends or share of surplus or additional amounts to be received in the future on such policy or contract, or shall make any false or misleading statement as to the dividends or share of surplus or additional amounts previously paid by any such insurer or health maintenance organization on similar policies or contracts, or shall make any misleading representation, or any misrepresentation, as to the financial condition of any such insurer or health maintenance organization, or as to the legal reserve system upon which such insurer or health maintenance organization operates.

(2) No such person, firm, association or corporation shall make to any person or persons any incomplete comparison of any such policies or contracts of any insurer, insurers, or health maintenance organization, for the purpose of inducing, or tending to induce, such person or persons to lapse, forfeit or surrender any insurance policy or health maintenance organization contract.

(3) Any replacement of individual life insurance policies or individual annuity contracts of an insurer by an agent, representative

of the same or different insurer or broker shall conform to standards promulgated by regulation by the superintendent. Such regulation shall:

(A) specify what constitutes the replacement of a life insurance policy or annuity contract and the proper disclosure and notification procedures to replace a policy or contract;

(B) require notification of the proposed replacement to the insurer whose policies or contracts are intended to be replaced;

(C) require the timely exchange of illustrative and cost information required by section three thousand two hundred nine of this chapter and necessary for completion of a comparison of the proposed and replaced coverage; and

(D) provide for a sixty-day period following issuance of the replacement policies or contracts during which the policy or contract owner may return the policies or contracts and reinstate the replaced policies or contracts.

(b) Any comparison of the policies or contracts of any such insurer, insurers or health maintenance organization shall be deemed to be an incomplete comparison if it does not conform to all the requirements for comparisons established by regulation.

(c) In the determination, judicial or otherwise, of the incompleteness or misleading character of any such comparison, it shall not be presumed that the insured knew or knows of any of the provisions, terms or benefits contained in any insurance policy or health maintenance organization contract.

(d) Any agent or representative of an insurer or health maintenance organization, insurance broker, person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, to act as a navigator, including any person employed by a certified navigator, or any other person, firm, association or corporation who, or which, shall violate any of the provisions of this section and shall knowingly receive any compensation or commission for the solicitation, sale or negotiation of any insurance policy, health maintenance organization or annuity contract induced by a violation of this section shall also be liable for a civil penalty in the amount received by such violator as compensation or commission, which penalty may be sued for and recovered for his, her, or its own use and benefit by any person induced to

purchase an insurance policy, health maintenance organization or annuity contract by such violation. In addition, such agent, representative, broker, person, firm, association or corporation violating this section shall be liable for a civil penalty in the amount of any compensation or commission lost by any agent, representative or broker as a result of a violation of this section or the making of such false or misleading statement, which penalty may be sued for and recovered for his, her, or its own use and benefit by such agent, representative or broker.

* (e) Except with respect to a credit unemployment insurance policy, group credit life insurance policy, a group credit health, group credit accident or group credit health and accident policy, or similar group credit insurance covering the person of the insured, state chartered banking institutions, federally chartered banking institutions and any person soliciting the purchase of or selling insurance on the premises thereof, must disclose or cause to be disclosed in writing, where practicable, in clear and concise language, to their customers and prospective customers who are solicited therefor, that any insurance offered or sold:

(1) is not a deposit;

(2) is not insured by the federal deposit insurance corporation or the national credit union share insurance fund, as applicable; and

(3) is not guaranteed by the state chartered banking institution or the federally chartered banking institution.

* NB Repealed September 10, 2029

* (f) For the purposes of this section, the terms "state chartered banking institutions" and "federally chartered banking institutions" shall have the same meanings as set forth in subdivision one of section twelve-a of the banking law.

* NB Repealed September 10, 2029

§ 2124. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil practice law and rules, to review the action of the superintendent in suspending or revoking or refusing to renew any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay shall not be extended for a longer period unless

the court shall determine, after a preliminary hearing of which the superintendent is notified forty-eight hours in advance, that a stay of the superintendent's action pending the final determination or further order of the court will not unduly injure the interests of the people of the state.

§ 2125. Marine insurance; acting as agent, broker or insurer of persons without insurable interest. (a) No person, firm, association or corporation shall knowingly act as insurance agent or act as insurance broker in this state, or shall as insurer knowingly act in this state, in the sale, solicitation or negotiation, issuance or delivery of any binder, cover note, certificate, policy or other evidence of a contract of marine insurance except on the application and in the name of some person or persons having a bona fide interest, direct or indirect, either in the safe arrival of the vessel in relation to which the contract is made or to be made, or in the safety or preservation of the subject matter insured or to be insured, or except on the application and in the name of some person or persons having a bona fide reasonable expectation of acquiring such an interest.

(b) No insurance broker or other person, firm, association or corporation not having such a bona fide interest or bona fide expectation of acquiring such an interest, shall knowingly apply for, effect, accept or transfer in this state any such evidence of a contract of marine insurance without having been previously authorized so to do by, or by the authority of, a person, firm, association or corporation having such a bona fide interest or a bona fide expectation of acquiring such an interest.

§ 2126. Impersonation at examinations prohibited. No person shall impersonate any other person, or permit or aid in any manner any other person to impersonate him, in connection with any examination held in accordance with the provisions of this chapter.

§ 2127. Penalties for violations. (a) The superintendent, in lieu of

revoking or suspending the license of a licensee in accordance with the provisions of this article, may in any one proceeding by order, require the licensee to pay to the people of this state a penalty in a sum not exceeding five hundred dollars for each offense, and a penalty in a sum not exceeding twenty-five hundred dollars in the aggregate for all offenses.

(b) Upon the failure of such a licensee to pay such penalty ordered pursuant to subsection (a) hereof within twenty days after the mailing of such order, postage prepaid, registered, and addressed to the last known place of business of such licensee, unless such order is stayed by an order of a court of competent jurisdiction, the superintendent may revoke the license of such licensee or may suspend the same for such period as he determines.

§ 2128. Commission and fee sharing prohibited. (a) Notwithstanding the provisions of sections two thousand three hundred twenty-four and four thousand two hundred twenty-four of this chapter, no licensee subject to this article shall receive any commissions or fees or shares thereof in connection with insurance coverages placed for or insurance services rendered to the state, its agencies and departments, public benefit corporations, municipalities and other governmental subdivisions in this state, unless such licensee actually placed insurance coverages on behalf of or rendered insurance services to the state, its agencies and departments, public benefit corporations, municipalities and other governmental subdivisions in this state.

(b) The superintendent shall, by regulation, require licensees subject to this article to file disclosure statements with the department of financial services and the most senior official of the governmental unit involved, with respect to any insurance coverages placed for or insurance services rendered to the state, its agencies and departments, public benefit corporations, municipalities and other governmental subdivisions in this state, except that neither a title insurance corporation nor a title insurance agent shall be required to file a disclosure statement if an industrial development agency, state of New York mortgage agency or its successor, or any similar type of entity, is the named insured under the policy and is a mortgagee with respect to

the property insured.

§ 2129. Duty to have an agent or broker at each place of business. (a) Each place of business established by the holder of an agent and/or broker license shall be under the supervision of one or more persons licensed to do the kinds of business transacted in that office. The headquarters location must be supervised by one or more persons licensed to do all the kinds of business for which the licensee is authorized. Any satellite office established by a licensee must be supervised by one or more persons licensed to do the kinds of business to be transacted in that office.

(b) Written notice shall be given to the superintendent containing the location of each satellite office and the licensed person or persons responsible for each satellite office.

*** § 2130. Excess line association.** (a) There is hereby created a non-profit association to be known as the excess line association of New York. All excess line licensees shall be deemed to be members of the association. The association must perform its functions under the plan of operation established and approved under subsection (c) of this section and must exercise its powers through a board of directors established under subsection (b) of this section. The association shall be supervised by the superintendent. The association shall be authorized and have the duty to:

(1) receive and record all excess line insurance documents which excess line brokers are required to file with the association under section two thousand one hundred eighteen of this article. All records which an excess line broker is required to maintain under section two thousand one hundred eighteen of this article shall be open to examination by the excess line association;

(2) notify the superintendent or his designee prior to stamping submitted insurance documents as provided in paragraph three of this subsection if the association believes that the unauthorized insurer does not meet the standards of eligibility imposed by section two thousand one hundred eighteen of this article, together with any rules

and regulations promulgated pursuant to said section;

(3) stamp all excess line insurance documents which excess line brokers are required to file with the association under section two thousand one hundred eighteen of this article, provided that an unauthorized insurer meets the standards of eligibility imposed by section two thousand one hundred eighteen of this article, together with any rules and regulations promulgated pursuant to said section;

(4) prepare reports to be provided to the superintendent on the fifteenth day of every month, which reports shall include premium data from excess line licensee affidavits relating to excess line insurance filed by each licensee and stamped by the association during the preceding calendar month. Such reports shall also include corresponding licensee affidavits in such form as the superintendent may prescribe. The association shall provide each licensee with a copy of the report as it pertains to said licensee's business for the calendar month;

(5) prepare and deliver to each licensee and to the superintendent annually the reports of excess line business, which reports shall include a delineation of the classes and kinds of business procured during the preceding calendar year in such form as the superintendent may prescribe;

(6) deliver to each licensee standard forms for affidavits required under section two thousand one hundred eighteen of this article;

(7) employ and retain such persons as are necessary to carry out the duties of the association;

(8) borrow money as necessary to effect the purposes of the association;

(9) enter contracts as necessary to effect the purposes of the association;

(10) perform such other acts as will facilitate and encourage compliance by its members with the excess line law of this state and rules promulgated thereunder; and

(11) provide such other services to its members as are incidental or related to the purposes of the association; and

(12) utilize the authority granted to unincorporated associations under section twelve of the general associations law.

(b)(1) The association shall function through a board of directors elected by the association members, and officers who shall be elected by

the board of directors.

(2) The board of directors of the association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member's vote to reflect the annual excess line insurance premium written by the member. Members employed by the same or affiliated employers may consolidate their premiums written and delegate an individual officer or partner to represent the member in the exercise of association affairs, including service on the association board of directors. The superintendent shall, within thirty days after the enactment date of this section, appoint an interim board of directors for the sole purpose of conducting an election of directors which election shall be conducted within sixty days after the enactment date of this section.

(3) The board of directors shall elect such officers as may be provided in the plan of operation.

(c)(1) The association shall submit to the superintendent a plan of operation and any amendments thereto to provide operating procedures for the administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the superintendent.

(2) All association members must comply with the plan of operation.

(d) (1) The superintendent shall at least once in three years, make or cause to be made an examination of the association. The reasonable cost of any such examination shall be paid by the association upon presentation to it by the superintendent of a detailed account of such cost. Any examiner authorized by the superintendent shall have the power to administer oaths and to examine under oath any director, officer, member, agent or employee of the association. During the course of such examination, the directors, officers, members, agents and employees of the association shall make available all books, records, accounts, documents and agreements pertaining thereto. The superintendent shall furnish a copy of the examination report to the association. Within thirty days after receipt of the report, the association may request a hearing on the report or any facts or recommendations therein. If the

superintendent finds the association is not in compliance with this section he may issue an order requiring compliance or discontinuance of such violation and the association shall be subject to the penalty provisions of this chapter.

(2) A director may be removed from the association's board of directors by the superintendent for cause, stated in writing, after an opportunity has been given to the director to be heard thereon.

(e) In the absence of gross negligence, fraud, or bad faith, there shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents, or employees for any action taken or omitted by them in the performance of their powers and duties under this section and subsections (b), (c) and (f) of section two thousand one hundred eighteen of this article.

(f) The services performed by the association shall be funded by a stamping fee assessed for each declarations page, cover note or other premium bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time and shall be subject to approval by the superintendent. The stamping fee shall be paid by the excess line licensee. Provided, however, the licensee shall be allowed to receive and collect from the insured the stamping fee if the licensee obtains a written memorandum, signed by the insured, specifying the amount and the insured's agreement to pay the stamping fee.

(g) Nothing in this section shall be construed to modify the obligation of an excess line licensee to comply with the provisions of sections two thousand one hundred five and two thousand one hundred eighteen of this chapter, nor to diminish the power of the superintendent to take any other disciplinary action otherwise authorized by this chapter.

(h) The superintendent may declare an unauthorized insurer ineligible and order the association not to stamp insurance documents issued by such unauthorized insurer.

(i) Compliance by the association with the duties set forth in subsection (a) of this section in connection with filing, receiving, recording and stamping of excess line insurance documents, as well as the requirement to deliver standard forms for affidavits, may be

accomplished by means of electronic or other media transmission, provided that the superintendent first approves such methods of filing, receiving, recording and stamping.

* NB Expires July 1, 2029

§ 2131. Limited license for rental vehicle companies, peer-to-peer car sharing program administrators, wireless communications equipment vendors and self-service storage companies. (a) The superintendent may issue to a rental vehicle company, a peer-to-peer car sharing program administrator, a wireless communications equipment vendor, a self-service storage company or to a franchisee of a rental vehicle company, a wireless communications equipment vendor, or a self-service storage company which has complied with the requirements of this section, a limited license authorizing the licensee, known as a "limited licensee" for the purpose of this article, to act as agent, with reference to the kinds of insurance specified in this section, of any insurer authorized to write such kinds of insurance in this state.

(b) The prerequisites for issuance of a limited license under this section shall be the filing with the superintendent of the following:

(1) an application, signed by an officer of the applicant, for the limited license in such form or forms, and supplements thereto, and containing such information, as the superintendent may prescribe; and

(2) an appointment of a limited licensee by the appointing insurer, in a format approved by the superintendent, no more than fifteen days after the date the agency contract is executed or the first insurance contract is submitted, whichever is later, stating that it has satisfied itself that the named applicant is trustworthy and competent to act as its insurance agent for this limited purpose and that the insurer will appoint such applicant to act as the agent in reference to the doing of such kind or kinds of insurance which are permitted by this section, if the limited license applied for is issued by the superintendent. Such appointment shall be subscribed by an officer or managing agent of such insurer and affirmed as true under the penalties of perjury.

(c) In the event that any provision of this chapter is violated, the superintendent may:

(1) revoke or suspend a limited license issued under this section in

accordance with the provisions of section two thousand one hundred ten of this article; or

(2) after notice and hearing impose such other penalties, including suspending the transaction of insurance at specific locations where violations of this article have occurred, as the superintendent deems necessary or convenient to carry out the purposes of this section.

(d) The rental vehicle company, peer-to-peer car sharing program administrator, wireless communications equipment vendor, or self-service storage company, or franchisee licensed pursuant to subsection (a) of this section may act as agent for an authorized insurer only in connection with the rental of motor vehicles, the sharing of a shared vehicle, the sale or offering for sale of wireless communications equipment, or the rental of storage space, respectively, and only with respect to the following kinds of insurance:

(1) with respect to rental vehicle companies and peer-to-peer car sharing program administrators:

(A) excess liability insurance that provides coverage to the rental car company or franchisee and renters and other authorized drivers of rental vehicles, or that provides coverage to the peer-to-peer car sharing program administrator, shared vehicles owners, or shared vehicle drivers, or a combination thereof, in excess of the standard liability limits provided by the rental vehicle company in its rental agreement or the peer-to-peer car sharing program agreement pursuant to article forty of the general business law, for liability arising from the negligent operation of the rental vehicle or the shared vehicle;

(B) accident and health insurance that provides coverage to renters and other vehicle occupants, or that provides coverage to shared vehicle owners, shared vehicle drivers, or a combination thereof, in excess to the standard first party benefits provided pursuant to article fifty-one of this chapter, for accidental death and/or dismemberment and for medical expenses resulting from an accident that occurs during the rental period or during the peer-to-peer car sharing period;

(C) personal effects insurance that provides coverage to renters and other vehicle occupants or to shared vehicle owners or shared vehicle drivers, or a combination thereof, and other vehicle occupants, for the loss of, or damage to, personal effects that occurs during the rental period or peer-to-peer car sharing period;

(D) any other coverage that the superintendent may approve as meaningful and appropriate in connection with the rental of motor vehicles or the sharing of a shared vehicle; or

(2) with respect to wireless communications equipment vendors, insurance issued to cover the loss, theft, mechanical failure, or malfunction of, or damage to, wireless communications equipment offered as either an individual policy issued to the consumer or as a group policy under which certificates or other evidence of coverage are issued to individual consumers who enroll in the program, provided however, that said insurance shall not extend to wireless services or service contracts governed by article seventy-nine of this chapter; or

(3) with respect to self-service storage companies, the following coverages offered as either an individual policy issued to the consumer or as a group policy:

(A) personal effects insurance that provides coverage to renters of storage spaces at the self-service storage company's facility for the loss of, or damage to, personal property stored at the facility, where the loss or damage occurs at the same facility during the rental period;

(B) any other coverage that the superintendent may approve as meaningful and appropriate in connection with the rental of storage space.

(e) No insurance may be issued pursuant to this section unless:

(1) with regard to the rental of vehicles only, the rental period of the rental agreement does not exceed thirty consecutive days; and

(2) at every location where rental vehicle agreements, wireless communications equipment agreements, or self-service storage agreements are executed, brochures or other written materials are readily available to the prospective consumer, and with regard to a peer-to-peer car sharing program administrator, the administrator provides written materials, that:

(A) summarize, clearly and correctly, the material terms of insurance coverage, including the identity of the insurer and, with regard to wireless communications equipment insurance, the agent licensed under subsection (b) of section two thousand one hundred three of this article;

(B) disclose that these policies may provide a duplication of coverage already provided by a renter's personal automobile insurance policy,

homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(C) state that the purchase by the consumer of the kinds of insurance specified in this section is not required in order to rent a vehicle, to share a shared vehicle, to purchase or lease wireless communications equipment, or to rent storage space;

(D) describe the process for filing a claim in the event the consumer elects to purchase coverage;

(E) the price, deductible, benefits, exclusions and conditions or other limitations of such policies;

(F) disclose that the employee of the rental vehicle company, peer-to-peer car sharing program administrator, wireless communications equipment vendor or self-storage company is not qualified or authorized to evaluate the adequacy of the purchaser's existing coverages, unless otherwise licensed; and

(G) state that the customer may cancel the insurance at any time and any unearned premium will be refunded in accordance with applicable law.

(3) evidence of coverage is provided to every consumer who elects to purchase such coverage.

(f) Rates and forms for insurance under this section shall be subject to article twenty-three of this chapter. Any brochures or other written materials used in connection with insurance under this section shall be filed with the superintendent for review and shall include disclosure of the claims filing process, premium, deductible amounts and limits and shall be prominently displayed in the brochure or other written materials with at least twelve-point type bold headings. Any such brochures or other written materials shall also be subject to section three thousand one hundred two of this chapter, provided, however, that any policy, certificate or other evidence of insurance coverage, whether or not contained in such brochure, shall not be subject to section three thousand one hundred two of this chapter, but shall be written in a clear and coherent manner and whenever practicable shall use words with common and everyday meaning to facilitate readability and to aid the policyholder in understanding the coverage provided.

(g) Any limited license issued under this section shall also authorize any salaried employee or any sales representative authorized by the licensee who, pursuant to subsection (h) of this section, is trained to

act individually on behalf, and under the supervision, of the licensee with respect to the kinds of insurance specified in this section.

(h) Each company or franchisee licensed pursuant to this section shall conduct a training program, which shall be submitted to the superintendent for approval prior to use, and which shall meet the following minimum standards:

(1) each trainee shall receive basic instruction about the kinds of insurance specified in this section offered for purchase by prospective renters of rental vehicles, shared vehicle owners, shared vehicle drivers, purchasers or lessors of wireless communications equipment, or renters of storage space;

(2) each trainee shall be instructed with respect to the disclosures required under subsection (e) of this section and to acknowledge to a prospective renter of a rental vehicle, shared vehicle owner, shared vehicle driver, purchaser or lessor of wireless communications equipment, or renter of storage space that purchase of any such insurance specified in this section is not required in order for the consumer to rent a motor vehicle, share a shared vehicle, purchase or lease wireless communications equipment, or rent storage space;

(3) each trainee shall be instructed to acknowledge to a prospective consumer of the kinds of insurance specified in this section that the consumer may have insurance policies that already provide the coverage being offered by the rental vehicle company, the wireless communications equipment vendor, or self-service storage company pursuant to this section, as applicable; and

(4) with regard to wireless communications equipment insurance and self-service storage company insurance, training materials may be developed and provided by an agent licensed pursuant to subsection (b) of section two thousand one hundred three of this article.

(i) Limited licensees acting pursuant to and under the authority of this section shall comply with all applicable provisions of this article, except that notwithstanding section two thousand one hundred twenty of this article, a limited licensee pursuant to this section shall not be required to treat premiums collected from consumers purchasing such insurance when renting motor vehicles, sharing a shared vehicle, purchasing or leasing wireless communications equipment, or renting storage space as funds received in a fiduciary capacity,

provided that:

(1) the insurer represented by the limited licensee has consented in writing, signed by the insurer's officer, that premiums need not be segregated from funds received by the rental vehicle company, peer-to-peer car sharing program administrator, wireless communications equipment vendor, or self-storage company on account of vehicle rental, sharing of a shared vehicle, wireless communications equipment purchase or lease, or storage space rental; and

(2) the charges for insurance coverage are itemized but not billed to the consumer separately from the charges for rental vehicles, shared vehicles, purchase or lease of wireless communications equipment, or storage space rental.

(j) No limited licensees under this section shall advertise, represent or otherwise hold itself or any of its employees themselves out as licensed insurance agents or brokers.

(k) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

(l) For purposes of this section "wireless communications equipment" shall mean wireless handsets, pagers, personal digital assistants, wireless telephones or wireless telephone batteries and other wireless devices and accessories related to such devices that are used to access wireless communications services and includes wireless services.

(m) For purposes of this section, "peer-to-peer car sharing program administrator", "peer-to-peer car sharing period", "shared vehicle", "shared vehicle driver", and "shared vehicle owner" shall have the meanings set forth in section nine hundred of the general business law.

§ 2132. Continuing education. (a) This section shall apply to resident and non-resident persons licensed pursuant to this article with respect to:

(1) life insurance, annuity contracts, variable annuity contracts and variable life insurance;

(2) sickness, accident and health insurance;

(3) all lines of property and casualty insurance;

(4) life settlements; and

(5) title insurance.

(b) This section shall not apply to:

(1) those persons holding licenses for which an examination is not required by the laws of this state;

(2) any limited licensees or any other licensees as the superintendent may exempt subject to any continuing education requirements deemed appropriate by the superintendent;

(3) for purposes of the continuing education requirements for life settlements, an insurance producer with a life line of authority who is acting as a life settlement broker pursuant to section two thousand one hundred thirty-seven of this article; or

(4) for purposes of a title insurance agent license, an attorney licensed to practice law in this state, provided that such attorney is in good standing with the New York state office of court administration.

(c) Resident and non-resident persons licensed pursuant to this article and not exempt under subsection (b) of this section, and any person previously so licensed whose license was not in effect on the effective date of this section and who has subsequently been relicensed pursuant to the provisions of this article, shall biennially satisfactorily complete such courses or programs of instruction as may be approved by the superintendent, as follows:

(1) Any person holding a license issued pursuant to this article and not exempt under subsection (b) of this section shall, during each full biennial licensing period, satisfactorily complete courses or programs of instruction or attend seminars as may be approved by the superintendent equivalent to fifteen credit hours of instruction.

(2) During the same calendar year biennial licensing period, a licensee may use accumulated continuing education credits to meet the requirements of similar classes of licenses, as follows: (A) subsection (a) of section two thousand one hundred three and section two thousand one hundred seven of this article with respect to life insurance consultants; or (B) subsection (b) of section two thousand one hundred three, section two thousand one hundred four, section two thousand one hundred seven of this article with respect to general insurance

consultants, and section two thousand one hundred eight of this article with respect to public adjusters.

(3) Excess credit hours accumulated during any biennial licensing period shall not carry forward to the next biennial licensing period for that same class of license.

(d) (1) The courses or programs of instruction successfully completed, which shall be deemed to meet the superintendent's standards for continuing education requirements, shall be:

(A) courses, programs of instruction or seminars, approved as to method and content by the superintendent, covering portions of the principal branches of insurance related to the kinds of insurance covered by that license, and given by a degree conferring college or university whose curriculum is registered with the state education department at the time the person takes the course, whether such course be given as part of such curriculum or separately, or by any other institution, agents' association, trade association or insurer, which maintains equivalent standards of instruction and which shall have been approved for such purpose by the superintendent.

(B) continuing education as required by the state in which a non-resident licensee, as defined by section two thousand one hundred one of this article, resides and maintains an insurance office, provided the superintendent deems them equivalent to New York continuing education requirements. If the state in which the non-resident licensee resides and maintains an office has no continuing education requirements, or the superintendent does not deem them equivalent, the licensee must satisfy New York continuing education requirements.

(2) The number of credit hours assigned to each of the courses or programs of instruction set forth in paragraph one of this subsection shall be determined by the superintendent.

(e) Notwithstanding paragraph one of subsection (d) of this section, no course, program of instruction, or seminar developed or sponsored by any insurer, shall be deemed to meet the superintendent's standards of continuing education requirements, unless such insurer is authorized to write that class of insurance in this state.

(f) A person who teaches any approved course of instruction or who lectures at any approved seminar, and who is subject to this section, shall be granted the same number of credit hours as would be granted to

a person taking and successfully completing such course, seminar or program, provided that such credit hours shall be credited only once per approved course during any biennial licensing period.

(g) Every person subject to this section shall furnish, in a form satisfactory to the superintendent, certification attesting to the course or programs of instruction taken and successfully completed by such person pursuant to subsection (d) of this section.

(h) (1) Any person failing to meet the requirements imposed by this section shall not be eligible to renew the license.

(2) Any person whose license was not renewed shall not be eligible to become relicensed during the next biennial licensing period until that person has demonstrated to the satisfaction of the superintendent that continuing education requirements for the last biennial licensing period were met.

(3) Any person whose license was not renewed pursuant to paragraph one of this subsection, who accumulates sufficient credit hours for the prior licensing period to qualify for relicensing in the biennial period following such non-renewal, may not apply those same credit hours toward the continuing education requirements for the current biennial licensing period.

(i) (1) Any entity eligible to provide courses, programs of instruction, or seminars in accordance with subsection (d) of this section, must file for approval by the superintendent on a biennial basis, to conform with its area of instruction, a provider organization application and a course submission application for each course, program and seminar.

(2) The provider organization application shall include the names of all instructors to be used during the contract period, and instructors may be added during the period by notifying the superintendent and paying the appropriate filing fee.

(3) The completed applications shall be returned in a timely manner, as specified by the superintendent, with a non-refundable filing fee of two hundred dollars per organization, fifty dollars per course, program and seminar, and fifty dollars per instructor.

(4) Approval of the application shall be at the discretion of the superintendent.

(j) Each licensee shall pay a biennial fee of ten dollars per license,

for continuing education certificate filing and recording charges, to the superintendent or, at the discretion of the superintendent, directly to an organization under contract to provide continuing education administrative services.

(k)(1) For any biennial licensing period, a firm, association or corporation that is a licensee subject to this section shall be deemed to satisfy the continuing education requirements in this section with respect to that license provided that, as of the date of the biennial renewal date of the licensee's license, every sub-licensee of the licensee either:

(i) satisfies the continuing education requirements in subsection (c) of this section; or

(ii) has an individual license under this article with the same lines of authority for which the individual is a sublicensee of the licensee.

(2) The superintendent may issue such rules and regulations as the superintendent deems necessary to implement the terms of this subsection.

§ 2133. Forged insurance identification cards. Any insurance company, insurance agent, insurance broker or other person who or which, personally or by the action of an employee or agent, possesses, transfers or uses a forged insurance identification card for a motor vehicle, having knowledge, personally or through such employee or agent, of the fact that such insurance identification card, when issued, did not actually represent an owner's policy of liability insurance or a financial security bond issued by an insurance company licensed to do business in this state covering the motor vehicle identified on such card, shall be liable for payment to the people of this state of a civil penalty in a sum not exceeding one thousand dollars for the first such violation and a sum not exceeding five thousand dollars for each subsequent violation. For the purposes of this section the term "forged insurance identification card" means a written insurance identification card which has been falsely made, completed or altered, and the term "falsely made, completed or altered" shall have the same meaning as set forth in section 170.00 of the penal law.

§ 2134. Change of address. (a) A licensee under this article shall inform the superintendent by a means acceptable to the superintendent of a change of address within thirty days of the change.

(b) In addition to the requirements of subsection (a) of this section, a nonresident insurance producer who changes his, her or its home state, or a resident insurance producer who changes his, her or its home state to another state, within thirty days of the date of change, shall provide certification of such change from the new home state. No fee or license application shall be required therefor.

§ 2135. Administration of certain functions. The superintendent may designate the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees to perform ministerial functions, including the collection of fees, related to producer licensing under this article that the superintendent may deem appropriate.

§ 2136. Reciprocity. The superintendent shall waive any requirements for a nonresident license applicant otherwise applicable under this chapter if:

(a) the applicant has a current and valid license in his or her home state and is in good standing in his or her home state;

(b) the applicant has submitted a completed application in the form prescribed by the superintendent or submitted the application for licensure submitted to his or her home state;

(c) the applicant has paid the fees required by this chapter; and

(d) the applicant's home state awards nonresident insurance producer licenses to residents of this state on the same basis as provided in this subsection.

§ 2137. Life settlement brokers; licensing. (a) The superintendent may issue a license to any individual, firm, association or corporation who or that has complied with the requirements of this chapter, authorizing

the licensee to act as a life settlement broker.

(b) Any such license issued to a firm or association shall authorize only the members thereof, named in such license as sub-licensees, to act individually as life settlement brokers thereunder, and any such license issued to a corporation shall authorize only the officers and directors thereof, who are named in such license as sub-licensees, to act individually as life settlement brokers thereunder. Every sub-licensee, acting as a life settlement broker pursuant to such a license shall be authorized so to act only in the name of the licensee.

(c) Every individual applicant for a license under this section and every proposed sub-licensee shall be eighteen years of age or over at the time of the issuance of such license.

(d)(1) Before any original life settlement broker's license is issued, there shall be on file in the office of the superintendent an application by the proposed licensee in such form or forms, and supplements thereto, and containing information the superintendent prescribes. For each business entity, the sub-licensee or sub-licensees named in the application shall be designated responsible for the business entity's compliance with this chapter and regulations promulgated thereunder. The applicant shall fully disclose the identity of all stockholders (except stockholders owning fewer than ten percent of the voting shares of a life settlement broker whose shares are publicly traded), partners, officers, members, directors and persons with a controlling interest and the superintendent may, in the exercise of the superintendent's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any employee, stockholder, partner, officer, member, director or person with a controlling interest thereof who may materially influence the applicant's conduct meets the standards of this article and article seventy-eight of this chapter. Thereafter, the applicant and, if a license has been issued, the licensee, shall provide to the superintendent new or revised information about stockholders (except stockholders owning fewer than ten percent of the voting shares of a life settlement broker whose shares are publicly traded), partners, officers, members, directors and persons with a controlling interest within thirty days of the change. For purposes of this section, "controlling interest" means a person who directly or indirectly, has the power to cause to be directed the management,

control or activities of such licensee.

(2) The superintendent may require any individual named in the application for such license to submit a set of fingerprints, unless such applicant is licensed as an insurance producer with a life line of authority. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check. All such criminal history records sent to the superintendent pursuant to this paragraph shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall not be published or in any way disclosed to persons other than the superintendent, unless otherwise authorized by law. The superintendent shall provide such applicant with a copy of his or her criminal history record, if any, together with a copy of article twenty-three-A of the correction law, and inform such applicant of his or her right to seek correction of any incorrect information contained in such record pursuant to regulations and procedures established by the division of criminal justice services. All determinations to grant or deny clearance for licensure pursuant to this section shall be in accordance with subdivision sixteen of section two hundred ninety-six of the executive law and article twenty-three-A of the correction law. When the superintendent denies an application, written notice of such determination shall be given to the prospective applicant who shall be afforded notice and the right to be heard and offer proof in opposition to such determination.

(e) The superintendent shall, in order to determine the competency of every individual applicant and of every proposed sub-licensee for the life settlement broker license, require such individual to submit to a personal written examination and to pass the same to the satisfaction of the superintendent. The examination shall be held at such times and places as the superintendent shall from time to time determine. Every individual applying to take any written examination shall, at the time of applying therefor, pay to the superintendent or, at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an amount that is the actual documented administrative cost of conducting said qualifying

examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable. The superintendent may accept, in lieu of any such examination, the result of any previous written examination, given by the superintendent, which in the superintendent's judgment, is equivalent to the examination for which it is substituted. No individual shall be deemed qualified to take the examination unless he or she shall have successfully completed a course or courses, approved by the superintendent.

(f)(1) No such written examination or prelicensing education shall be required:

(A) of any insurance producer with a life line of authority licensed in this state for at least one year;

(B) in the discretion of the superintendent, of any individual whose license has been revoked or suspended;

(C) of any applicant who has passed the written examination given by the superintendent for a life settlement broker's license and was licensed as such, or of an applicant who was licensed as a life settlement broker but did not pass such an examination; provided the applicant applies within two years following the date of termination of the applicant's license;

(D) in the discretion of the superintendent, as to all or any part of the written examination or the prerequisite course specified in subsection (e) of this section, of any individual seeking to be named a licensee or sub-licensee, upon whom has been conferred the Chartered Life Underwriter (C.L.U.) or Chartered Life Underwriter Associate designation by The American College; or

(E) any individual seeking to be named a licensee or sub-licensee, who is a nonresident and a life settlement broker or who is licensed as an insurance producer with a life line of authority in the individual's home state for at least one year; provided, however, that the individual's home state grants nonresident licenses to residents of this state on the same basis.

(2) No prelicensing education shall be required of any individual regularly employed by a life settlement provider, life insurance company, life settlement broker, or an insurance producer with a life line of authority, for a period or periods aggregating not less than one

year, during the three years next preceding the date of entrance into the service of the armed forces of the United States or immediately following his or her discharge therefrom, in responsible duties relating to the use of life insurance and annuity contracts in the design and administration of plans for estate conservation and distribution, employee benefits and business continuation, and settlements of life insurance and annuity contracts; provided the application for such license is filed within one year following the date of discharge, and the applicant submits with the application a statement subscribed and affirmed as true under the penalties of perjury by such employer or employers stating facts which show compliance with this requirement.

(g) The superintendent may refuse to issue any life settlement broker's license if, in the superintendent's judgment, the proposed licensee or any sub-licensee: is not trustworthy and competent to act as a life settlement broker; has given cause for license revocation or suspension; or has failed to comply with any prerequisite for the issuance of such license.

(h)(1) Every license issued to a business entity pursuant to subsection (a) of this section shall expire on June thirtieth of odd-numbered years.

(2) Every license issued pursuant to this section to an individual who was born in an odd-numbered year shall expire on the individual's birthday in each odd-numbered year. Every license issued pursuant to this section to an individual who was born in an even-numbered year shall expire on the individual's birthday in each even-numbered year. Every such license may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection.

(3) The license may be issued for all of such two-year terms, or upon application made during any such term, for the balance thereof.

(4) Any license shall be considered in good standing within the license term unless:

(A) revoked or suspended by the superintendent pursuant to this article; or

(B) if at the expiration date of the license term, the licensee fails to file a renewal application, provided the license was in good standing during the term.

(5) Before the renewal of any life settlement broker's license shall be issued, the licensee shall have:

(A) filed a completed renewal application in such form or forms, and supplements thereto, and containing such information as the superintendent may prescribe; and

(B) paid such fees as are prescribed by the superintendent; provided, however, that such fee shall not exceed that which is required for the licensing or renewal for an insurance producer with a life line of authority.

(6) If an application for a renewal license shall have been filed with the superintendent before the expiration of such license, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant and to each proposed sub-licensee. Before refusing to renew any such license, except on the ground of failure to pass a written examination, the superintendent shall notify the applicant of the superintendent's intention to do so and shall give the applicant a hearing.

(7)(A) The superintendent may, in issuing a renewal license, dispense with the requirements of a verified application by any individual licensee or sub-licensee who, by reason of being engaged in any military service for the United States, is unable to make personal application for the renewal license, upon the filing of an application on behalf of such individual, in such form as the superintendent shall prescribe, by a person who, in the person's judgment, has knowledge of the facts and who makes affidavit showing such military service and the inability of the life settlement broker to make personal application.

(B) An individual licensee or sub-licensee who is unable to comply with license renewal procedures due to other extenuating circumstances, such as a long-term medical disability, may request a waiver of such procedures, in such form as the superintendent shall prescribe. The licensee or sub-licensee may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(8) In addition to any examination fee required by subsection (e) of

this section, there shall be paid to the superintendent for each individual license applicant and each proposed sub-licensee a licensing or renewal fee to be determined by the superintendent; provided, however that such fee shall not exceed that which is required for the licensing or renewal for an insurance producer with a life line of authority.

(9) An application for the renewal of a license shall be filed with the superintendent not less than sixty days prior to the date the license expires or the applicant shall be subject to a further fee of ten dollars for late filing.

(10) No license fee shall be required of any person who served as a member of the armed forces of the United States at any time and who (A) shall have been discharged therefrom, under conditions other than dishonorable, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, in a current licensing period, for the duration of such period.

(11) Except where a corporation, association or firm licensed as a life settlement broker is applying to add a sub-licensee, there shall be no fee required for the issuance of an amended license.

(12) The license shall contain the licensee's name, address, personal identification number, the date of issuance, and any other information the superintendent deems necessary. The superintendent may issue the life settlement broker's license in conjunction with any other license, or its renewal, held by the applicant.

(i) If the superintendent deems it necessary, then the superintendent may require any licensed life settlement broker to submit a new application at any time.

(j) The superintendent may issue a replacement for a currently in-force license that has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 2138. Health benefit exchange navigators. A person who has received a grant from and has been certified by the health benefit exchange established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, to act as a navigator, including any person employed by a certified navigator, shall not receive, collect or hold any funds that would constitute fiduciary funds within the meaning of section two thousand one hundred twenty of this article.

§ 2139. Title insurance agents; licensing. (a) The superintendent may issue a license to any person, firm, association or corporation that has complied with the requirements of this chapter, authorizing the licensee to act as a title insurance agent of any authorized title insurance corporation.

(b) Any such license issued to a firm or association shall authorize only the members thereof, named in such license as sub-licensees, to act individually as title insurance agents thereunder, and any such license issued to a corporation shall authorize only the officers and directors thereof, named in such license as sub-licensees, to act individually as title insurance agents thereunder. Every sub-licensee acting as title insurance agent pursuant to such a license shall be authorized so to act only in the name of the licensee. At least one designated sub-licensee must have a financial or other beneficial interest in the licensee.

(c) Every individual applicant for a license under this section and every proposed licensee shall be eighteen years of age or older at the time of the issuance of such license.

(d) Before any original title insurance agent's license is issued, there shall be on file in the office of the superintendent an application by the prospective licensee in such form or forms and supplements thereto, along with a fee in the amount of forty dollars for each year or fraction of a year in which the license shall be valid, and containing information the superintendent prescribes.

(e) The superintendent shall, in order to determine the competency of every individual applicant and of every proposed sub-licensee for the title insurance agent license, require such individual to submit to a personal written examination and to pass the same to the satisfaction of

the superintendent. The examination shall be held at such times and places as the superintendent shall from time to time determine. Every individual applying to take any written examination shall, at the time of applying therefor, pay to the superintendent or, at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an amount that is the actual documented administrative cost of conducting said qualifying examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and shall not be refundable. The superintendent may accept, in lieu of any such examination, the result of any previous written examination, given by the superintendent, which in the superintendent's judgment, is equivalent to the examination for which it is substituted.

(f) Every individual seeking to qualify to obtain a license under subsection (b) of this section shall be required to pass the type or types of examination prescribed by the superintendent. An individual shall not be deemed qualified to take the examination unless the individual has successfully completed a course or courses, approved as to method and content by the superintendent, covering the title insurance business and requiring not less than twenty hours of classroom work or the equivalent in correspondence work or similar instruction. Such course or courses shall have been given by an institution meeting the standards prescribed by subparagraph (A) of paragraph one of subsection (c) of section two thousand one hundred four of this article.

(g) No such written examination or pre-licensing education shall be required of any:

(1) applicant who files an application under this section within one year after the effective date of this subsection and who demonstrates to the satisfaction of the superintendent that such applicant or its prospective sub-licensee has, without interruption, regularly and continuously performed the functions of a title insurance agent for a period of at least five years immediately preceding the filing of such application and is competent and trustworthy to act as a title insurance agent;

(2) applicant who has passed the written examination given by the superintendent for a title insurance agent's license and was licensed as such, or of an applicant who was licensed as a title insurance agent but

did not pass such an examination, provided the applicant applies within two years following the date of termination of the applicant's license; or

(3) applicant seeking to obtain a license as a title insurance agent, when such applicant is a licensed attorney-at-law in this state provided that such attorney is in good standing with the New York state office of court administration.

(h) The superintendent may refuse to issue to an applicant a title insurance agent's license if, in the superintendent's judgment, the proposed licensee or any sub-licensee:

(1) is not trustworthy and competent to act as such agent;

(2) has given cause for the revocation or suspension of such a license; or

(3) has failed to comply with any prerequisite for the issuance of such license.

(i) (1) Every license issued to a business entity pursuant to subsection (a) of this section shall expire on June thirtieth of odd-numbered years.

(2) Every license issued to an individual born in an odd-numbered year shall expire on the individual's birthday in each odd-numbered year. Licenses issued to individuals born in even-numbered years shall expire on the individual's birthday in each even-numbered year.

(3) Every license may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this subsection.

(4) The license may be issued for all of such two year terms, or upon application made during any such term, for the balance thereof.

(5) Any license shall be considered in good standing within the license term unless:

(A) revoked or suspended by the superintendent pursuant to this article; or

(B) if at the expiration date of the license term, the licensee fails to file a renewal application, provided the license was in good standing during the term.

(6) Before the renewal of any title insurance agent's license shall be issued, the licensee shall have:

(A) filed a completed renewal application in such form or forms, and

supplements thereto, and containing such information as the superintendent may prescribe; and

(B) paid such fees as are prescribed in this section.

(7) If an application for a renewal license shall have been filed with the superintendent before the expiration of such license, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant and to each proposed sub-licensee. Before refusing to renew any such license, except on the ground of failure to pass a written examination, the superintendent shall notify the applicant of the superintendent's intention to do so and shall give the applicant a hearing.

(8) The superintendent may, in issuing a renewal license, dispense with the requirements of a verified application by any individual licensee or sub-licensee who, by reason of being engaged in any military service for the United States, is unable to make personal application for such renewal license, upon the filing of an application on behalf of such individual, in such form as the superintendent shall prescribe, by some person or persons who in his or her judgment have knowledge of the facts and who make affidavit showing such military service and the inability of such title insurance agent to make personal application.

(9) An individual licensee or sub-licensee who is unable to comply with license renewal procedures due to other extenuating circumstances, such as a long-term medical disability, may request a waiver of such procedures, in such form as the superintendent shall prescribe. The licensee or sub-licensee may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(10) An application for the renewal of a license shall be filed with the superintendent not less than sixty days prior to the date the license expires or the applicant shall be subject to a further fee of ten dollars for late filing.

(11) No license fee shall be required of any person who served as a member of the armed forces of the United States at any time, and who (A) shall have been discharged therefrom under conditions other than

dishonorable, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, in a current licensing period for the duration of such period.

(12) Except where a corporation, association or firm licensed as a title insurance agent is applying to add a sub-licensee or the date of the expiration of the license is changed, there shall be no fee required for the issuance of an amended license.

(13) The superintendent may issue a replacement license for a currently in-force license that has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

(j) The superintendent may refuse to issue a license or renewal license, as the case may be, to any applicant if the superintendent finds that the applicant has been or will be:

(1) receiving any benefit or advantage in violation of section six thousand four hundred nine of this chapter; or

(2) acting in a manner inconsistent with:

(A) regulations by the superintendent which are promulgated in accordance with the relevant provisions of the federal real estate settlement procedures act of 1974, as amended; or

(B) section twenty-one hundred thirteen of this article.

(k) For the purposes of this chapter, any person or entity performing any activity related to the procurement or issuance of a title insurance policy, as the result of an authorization or request from a licensed title agent or title insurance corporation, shall be presumed to be acting under the authority of such licensed agent or title insurance corporation, for the purpose of performing such activity so authorized or requested.

§ 2140. Restrictions on insurance producers procuring immigration

bonds. (a) No insurance producer shall require the use of an electronic monitoring device as a condition of immigration bail. For the purposes of this section, an "electronic monitoring device" includes any device that tracks or monitors location, any device that tracks or monitors biometric data, or any device that records or transmits video or audio surveillance data.

(b) No insurance producer shall make a referral to or provide contact information for a legal services provider without:

(1) disclosing in writing, in a language understood by the consumer, whether the insurance producer or an entity that is an affiliate of the insurance producer: (A) has a financial or ownership interest in the legal services provider; (B) is receiving any compensation, either directly or indirectly, for making a referral to or providing contact information for the legal services provider; or (C) is compensating, either directly or indirectly, the legal services provider for the legal services rendered; and

(2) stating that: "The payment of premiums to the insurance producer is not for and does not guarantee that you will receive legal representation. Using this legal services provider is not a requirement of bail. If you choose to hire this legal services provider, you have the right to fire the provider at any time and retain your own counsel."

(c) Any agreement, or portion thereof, entered into requiring the waiving of the requirements of this section or otherwise in violation of this section shall be void and unenforceable.

ARTICLE 22

CERTIFICATION OF EMPLOYEES OF INSURERS AND SAVINGS BANKS OFFERING LIFE INSURANCE

Section 2201. Certification.
2202. Prerequisites.
2203. Issuance and duration.
2204. Revocation or suspension.
2205. Prohibitions.
2206. Termination of services.
2207. Transfer.
2208. Misleading statements.

2209. Stay or suspension of superintendent's determination.

§ 2201. Certification. Every officer or employee of a licensed insurer or of a savings bank, other than a duly licensed agent, who in any office of such insurer or of any savings bank, as a part of his duties, negotiates for applications or orders for life insurance or annuity contracts or solicits or procures from the public such applications or orders shall be required to be certified by the superintendent as to his competency and trustworthiness before engaging in such activities.

§ 2202. Prerequisites. (a) Certification shall not be made by the superintendent unless there shall be on file in his office the following documents:

(1) a written application by the person to be certified in such form and containing such information the superintendent prescribes; and

(2) a statement executed by an officer of the insurer or the savings bank which is to be named in such certificate, that the insurer or bank is satisfied that the applicant is trustworthy and competent to negotiate for applications or orders for life insurance or annuity contracts and to solicit and procure from the public such applications or orders.

(b) (1) In order to determine trustworthiness and competency, the applicant shall be required to pass a personal written examination to the satisfaction of the superintendent. Such examination shall be held at times and places set by the superintendent. Every individual taking any such examination shall pay to the superintendent, or at the superintendent's discretion, directly to any organization that is under contract to provide examination services, an examination fee of an amount which is the actual documented administrative cost of conducting said qualifying examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable.

(2) No individual shall be qualified to take the examination unless he possesses the same qualifications regarding insurance course requirements as those required pursuant to subparagraph (A) of paragraph

two of subsection (f) of section two thousand one hundred three of this chapter for agent licensing pursuant to such section.

(3) The superintendent may accept, in lieu of the examination required by paragraph one hereof, the result of any previous written examination given by him which in his judgment is equivalent to the examination for which it is substituted.

(c) The superintendent may refuse to certify any person if, in his judgment, such person is not trustworthy and competent, or has failed to comply with any prerequisite for the issuance of such certificate.

(d) The superintendent may issue a replacement for a currently in force certificate which has been lost or destroyed. Before such replacement certificate shall be issued, there shall be on file in the office of the superintendent a written application for such replacement certificate, affirming under penalty of perjury that the original certificate has been lost or destroyed, together with a fee of fifteen dollars.

§ 2203. Issuance and duration. (a) The superintendent shall issue to the insurer or the savings bank, a certificate with respect to each such applicant who has complied with the requirements of this article.

(b) Any certificate currently in force issued to an officer or employee of a licensed insurer or of a savings bank shall be deemed terminated as of August thirty-first, nineteen hundred ninety-five. On or after July first, nineteen hundred ninety-five, all certificates issued pursuant to this section shall be for a term of two years expiring on June thirtieth of odd numbered years. Such certificates may be issued for all of such two year terms, or, upon application made during such term, for the balance thereof.

(b-1) Any certificate shall be considered in good standing within the certificate term unless:

(1) revoked or suspended by the superintendent pursuant to this article.

(2) all certificates have been terminated by the insurer or savings bank employing the officer or employee, or the insurer employing such officer or employee ceases to be licensed to do an insurance business in this state, or the savings bank employing such officer or employee

ceases to be authorized to conduct the business of life insurance in this state, at which time the certificate shall be terminated.

(3) if at the expiration date of the certificate term, provided the certificate was in good standing during the term, the certified officer or employee fails to file a renewal application.

(b-2) Before the renewal of any certificate shall be issued, the following requirements shall be met:

(1) The certified officer or employee shall have filed a completed renewal application in such form or forms and supplements thereto and containing such information as the superintendent may prescribe.

(2) The certified officer or employee shall have paid such fees as are prescribed in this section.

* (3) The certified officer or employee shall have met the same requirements for continuing education as are required for the renewal of an agent's license pursuant to section two thousand one hundred thirty-two of this chapter for the types of insurance for which the officer or employee is certified.

* NB Applicable only to certificate renewals on and after July 1, 1997.

(b-3) If an application for certificate renewal shall have been filed with the superintendent before July first of the year of expiration, the certificate sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal certificate applied for or until five days after the superintendent shall have refused to issue such renewal certificate and shall have given notice of such refusal to the applicant. Before refusing to renew any such certificate, except on the ground of failure to pass a written examination, the superintendent shall notify the applicant of his intention to do so and shall give such applicant the opportunity to request a hearing.

(b-4) In addition to any examination fee required by paragraph one of subsection (b) of section two thousand two hundred two of this article, there shall be paid to the superintendent for each certificate applicant the sum of twenty dollars for each year or fraction of a year in which a certificate shall be valid. If, however, the certificate applicant should withdraw the application or the superintendent should deny the application before the certificate applied for is issued, the

superintendent may refund the fee paid by the applicant for the certificate applied for with the exception of any examination fees required pursuant to paragraph one of subsection (b) of section two thousand two hundred two of this article.

(b-5) An application for the renewal of a certificate filed with the superintendent after May first of the year in which the certificate expires shall be subject to a further fee for late filing of five dollars.

(c) The superintendent may require any certified officer or employee of any insurer or savings bank to submit a new application at any time.

§ 2204. Revocation or suspension. (a) The superintendent may revoke, or may suspend for such period as he may determine, any certificate if he determines that the person named in the certificate has:

(1) violated any provision of, or any obligation imposed by this chapter or has violated any law in the course of any activities for which such certificate is required;

(2) made a material misstatement in the application for such certificate;

(3) been guilty of fraudulent or dishonest practices; or

(4) demonstrated his incompetency or untrustworthiness.

(b) Before revoking or suspending any such certificate, the superintendent shall give to the person and the employer of the person named in such certificate notice of hearing as specified in this chapter.

§ 2205. Prohibitions. (a) It shall be unlawful for any officer or employee of a licensed insurer or of a savings bank, other than a duly licensed agent, as a part of his duties, to negotiate for applications or orders for life insurance or annuity contracts or to solicit or procure from the public such applications or orders in any office of any insurer or of any savings bank, without being certified pursuant to this article.

(b) It shall be unlawful for any insurer or any savings bank to employ any uncertified person, as a part of his duties, to negotiate for

applications or orders for life insurance or annuity contracts or to solicit or procure from the public such applications or orders in any office of the insurer or bank.

§ 2206. Termination of services. (a) Every insurer or savings bank shall, upon the termination of the services of any officer or employee certified under this article, forthwith file with the superintendent a statement, in such form as the superintendent prescribes, of the cause and facts relative to such termination. The certificate issued or reasonable proof of loss acceptable to the superintendent shall accompany such statement.

(b) Every statement made pursuant to this section shall be a privileged communication.

§ 2207. Transfer. The superintendent is authorized to transfer the certification of any person issued pursuant to this article from one insurer or savings bank to another insurer or savings bank, without examination.

§ 2208. Misleading statements. Every person who has been certified pursuant to the provisions of this article shall be subject to sections two thousand one hundred twenty-two, two thousand one hundred twenty-three and two thousand one hundred twenty-seven of this chapter.

§ 2209. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil practice law and rules, to review any action by the superintendent in issuing or in refusing to issue, or in suspending or revoking, or in refusing to suspend or revoke, any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay shall not be extended for a longer period unless the court shall determine, after a preliminary hearing of which the superintendent is notified forty-eight hours in advance, that a stay of the

superintendent's action pending the final determination or further order of the court will not unduly injure the interests of the people of the state.

ARTICLE 23

PROPERTY/CASUALTY INSURANCE RATES

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§ 2301. Purpose. The purpose of this article is to promote the public welfare by regulating insurance rates to the end that they not be excessive, inadequate or unfairly discriminatory, to promote price competition and competitive behavior among insurers, to provide rates that are responsive to competitive market conditions, to improve the availability and reliability of insurance and to authorize and regulate cooperative action among insurers within the scope of this article.

§ 2302. Applicability. (a) This article shall apply to all kinds of insurance written on risks or operations in this state by an insurer authorized to do business in this state except:

(1) reinsurance (other than joint reinsurance to the extent stated in section two thousand three hundred seventeen of this article);

(2) accident and health insurance;

(3) annuities, life insurance, including provisions for non-cancellable disability benefits in conjunction therewith;

(4) marine insurance (other than inland marine insurance and insurance upon automobiles, airplanes, seaplanes, dirigibles or other aircraft);

(5) marine protection and indemnity insurance;

(6) insurance issued by an assessment cooperative fire insurance company; and

(7) service contract reimbursement insurance.

(b) The superintendent may from time to time make investigations with respect to classes of risks of the kinds of insurance exempted in paragraph one hereof and may call upon all authorized insurers and rate service organizations making rates for such risks to furnish information relative thereto.

§ 2303. Standards for rates. Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers. In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer and any insurer controlling or controlled by such insurer or under common control by or with such insurer on all its investments of any kind and wherever located. The superintendent shall further determine whether any component of such rates represent an effort on the part of the insurer to recover losses incurred in another state due to any referendum, law or regulation which requires a general reduction in rates for the kinds of insurance described in section two thousand three hundred two of this article. Such a finding shall be deemed unfairly discriminatory for the purposes of this article.

§ 2304. Rate making and supporting information. (a) In the making of rates, consideration shall be given to past and prospective loss experience, including the conflagration and catastrophe hazards, if any, both within and without this state, to all factors reasonably attributable to the class of risks, to a reasonable profit, to past and prospective expenses both country-wide and those specially applicable to

this state, and in the case of participating insurers to policyholders' dividends, savings or unabsorbed premium deposits allowed or returned to policyholders, members or subscribers.

(b) The information furnished in support of a filing may include:

(1) the experience or judgment of the insurer or rate service organization making the rate;

(2) its interpretation of any statistical data it relies upon;

(3) the experience of other insurers or rate service organizations; or

(4) any other relevant factors.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(d) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to one or more kinds of insurance, or subdivisions of kinds of insurance, or classes of risks, or any part or combination of the foregoing, for which separate expense provisions are applicable.

(e)(1) Premiums for workers' compensation insurance for employments classified under sections two hundred twenty, two hundred forty and two hundred forty-one of the labor law, provided such employments are classified under each of said sections, shall be established on the basis of payroll and a formula which provides appropriate credits, provided such credits shall not apply to payroll in excess of the payroll limitation amount set forth in subdivision two of section eighty-nine of the workers' compensation law and this subsection. With the exception of employments engaged in the construction of one or two family residential housing, premiums shall be calculated in accordance with the following limitations:

(A) For policies with rating anniversary dates after September thirtieth, nineteen hundred ninety-nine and before October first, two thousand, an employer's payroll for premium computation purposes in the

affected construction classifications shall be the actual weekly payroll per employee for the number of weeks employed subject to a maximum of nine hundred dollars per week per employee plus one-half of the difference between the employer's total payroll and the limited payroll.

(B) For policies with rating anniversary dates after September thirtieth, two thousand and before October first, two thousand one, an employer's payroll for premium computation purposes in the affected construction classifications shall be the actual weekly payroll per employee for the number of weeks employed subject to a maximum of nine hundred dollars per week per employee.

(C) For policies with rating anniversary dates after September thirtieth, two thousand one and before October first, two thousand two, an employer's payroll for premium computation purposes in the affected construction classifications shall be the actual weekly payroll per employee for the number of weeks employed subject to a maximum of eight hundred dollars per week per employee.

(D) For policies with rating anniversary dates after September thirtieth, two thousand two, an employer's payroll for premium computation purposes in the affected construction classifications shall be the actual weekly payroll per employee for the number of weeks employed subject to a maximum of the greater of seven hundred fifty dollars per week or the weekly payroll amount upon which the maximum weekly benefit is based, per employee.

(2) The loss costs applicable to employments classified under sections two hundred twenty, two hundred forty and two hundred forty-one of the labor law, provided such employments are classified under each of said sections, shall be adjusted to reflect the payroll limitations required by this section as they separately affect such rates for work actually performed within each of the following geographic territories:

(A) Territory 1 comprising the counties of the Bronx, Kings, New York, Queens, and Richmond;

(B) Territory 2 comprising the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester; and

(C) Territory 3 comprising all other counties within the state.

(f) The rate adjustments required by subsection (e) of this section shall be filed by the New York compensation insurance rating board in accordance with the provisions of section two thousand three hundred

forty-seven of this article, and shall not become effective until approved by the superintendent.

(g) "Loss costs," for the purpose of workers' compensation insurance in this article, means that portion of a rate intended to represent the anticipated costs of claim payments and loss adjustment expenses associated with such claim payments, and may include one or more trend factors. Loss costs do not include provisions for expenses (other than loss adjustment expenses) such as acquisition costs, overhead and taxes, or profit. For all other purposes, the superintendent, except as otherwise provided in this chapter, may promulgate regulations defining loss costs.

(h) A loss cost filing shall be deemed to be a rate filing under this article.

(i) Nothing in this section shall prohibit the application of payroll limitation provisions at the discretion of the superintendent, provided such programs were in effect prior to the effective date of this subsection.

(j)(1) On or before July first, two thousand sixteen, the department shall make rules establishing requirements for health care facilities to obtain a reduced worker's compensation rate for safe patient handling programs implemented pursuant to title one-A of article twenty-nine-A of the public health law.

(2) The department shall complete an evaluation of the results of the reduced rate, including changes in claim frequency and costs, and shall report to the appropriate committees of the legislature on or before December first, two thousand eighteen and again on or before December first, two thousand twenty.

§ 2305. Rates or rating plans; no prior approval; prior approval.

* (a) Except as otherwise provided in subsection (b) hereof or section two thousand three hundred eight of this article, prior approval of rates, rating plans, rating rules and rate manuals by the superintendent shall not be required.

* NB Expires July 1, 2026

(b) rate filings for:

(1) workers' compensation insurance;

(2) motor vehicle insurance, or surety bonds, required by section three hundred seventy of the vehicle and traffic law, except as provided in section two thousand three hundred twenty-eight of this article, article forty-four-B of the vehicle and traffic law, or article forty of the general business law;

(3) joint underwriting;

(4) motor vehicle assigned risk insurance;

(5) insurance issued by the New York Property Insurance Underwriting Association;

(6) risk sharing plans authorized by section two thousand three hundred eighteen of this article;

(7) title insurance;

(8) medical malpractice liability insurance;

(9) insurance issued by the Medical Malpractice Insurance Association;

(10) mortgage guaranty insurance;

(11) credit property insurance, as defined in section two thousand three hundred forty of this article;

(12) gap insurance; and

(13) private passenger automobile insurance, except as provided in section two thousand three hundred fifty of this article,

shall be filed with the superintendent and shall not become effective unless either the filing has been approved or thirty days, which the superintendent may with cause extend an additional thirty days and with further cause extend an additional fifteen days, have elapsed and the filing has not been disapproved as failing to meet the requirements of this article, including the standard that rates be not otherwise unreasonable. After a rate filing becomes effective, the filing and supporting information shall be open to public inspection. If a filing is disapproved, then notice of such disapproval order shall be given, specifying in what respects such filing fails to meet the requirements of this article. Upon his or her request, the superintendent shall be provided with support and assistance from the workers' compensation board and other state agencies and departments with appropriate jurisdiction. The loss cost multiplier for each insurer providing coverage for workers' compensation, as defined by regulation promulgated by the superintendent, shall be promptly displayed on the department's website and updated in the event of any change.

(c) Rates filed with the superintendent shall be accompanied by the information upon which the insurer supports the rate as set forth in subsection (b) of section two thousand three hundred four of this article.

(d) When a filing subject to subsection (b) hereof or to section two thousand three hundred forty-four of this article is not accompanied by the information upon which the insurer supports the filing and the superintendent does not have sufficient information to determine whether the filing meets the requirements of this article, the insurer shall be required to furnish such information and in such event the thirty, thirty or fifteen day period of subsection (b) hereof or subsection (d) of section two thousand three hundred forty-four shall commence as of the date such information is furnished.

(e) The superintendent: (1) by regulation may, in lieu of the waiting period set forth in subsection (b) of this section, require workers' compensation insurance rate filings to be specifically approved before they become effective; and (2) shall hold a public hearing if a rate service organization makes a loss cost filing for workers' compensation that is an increase of five percent or more over the approved loss costs from the prior year. Until June second, two thousand twenty-eight, a rate service organization for workers' compensation shall make a loss cost filing every year on or before June first, or such earlier date as is set by the superintendent.

(f) Subsection (a) of this section shall be of no force or effect during the period August third, two thousand one through the day before the effective date of the property/casualty insurance availability act, and after June thirtieth, two thousand twenty-nine. During the period August third, two thousand one through the day before the effective date of the property/casualty insurance availability act, and again commencing on July first, two thousand twenty-nine, all rates previously subject to subsection (a) of this section, other than rates that are not required to be filed pursuant to subsection (b) of section two thousand three hundred ten of this article or that have been suspended from the filing requirement pursuant to section two thousand three hundred eleven of this article, shall become subject to subsections (b), (c) and (d) of this section. All other provisions of this article applicable to kinds of insurance or insurance activities the rates for which are subject to

prior approval under subsection (b) of this section shall apply to kinds of insurance the rates for which were previously subject to subsection (a) of this section or the rates for which are not required to be filed pursuant to subsection (b) of section two thousand three hundred ten of this article or the rates for which have been suspended from the filing requirement pursuant to section two thousand three hundred eleven of this article.

(g) (1) If all rates should become subject to the prior approval provisions of subsections (b), (c) and (d) hereof as set forth in subsection (f) hereof, rates for inland marine risks which by general custom of the business are not written according to manual rates or rating plans are not required to be filed unless the superintendent directs they be filed.

(2) Specific inland marine rates on risks specially rated by a rate service organization shall be filed and such rates and any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order, rule or regulation of a public body, not covered by a previous filing, shall become effective when filed and shall be deemed to meet the requirements of this article until such time as the superintendent reviews the filing and disapproves it.

§ 2306. Delegation of rate filing obligation. An insurer or group of insurers may discharge the rate filing obligation required by subsections (b) and (c) of section two thousand three hundred five of this article by giving notice to the superintendent that it uses rates and rate information prepared by a designated rate service organization, with such information and modifications thereof as is necessary fully to inform the superintendent. The rate and rate information of such insurer or group of insurers shall be those filed from time to time by the rate service organization, including any amendments thereto as filed, subject, however, in the case of an insurer to the modifications filed by such insurer.

§ 2307. Rating classifications or territories; policy forms. (a) No insurer or rate service organization shall use a rating classification

or territory unless it has been filed with the superintendent and either he has approved it, or ninety days have elapsed and he has not disapproved it as unfairly discriminatory or violative of public policy.

(b) Except as otherwise provided herein, no policy form shall be delivered or issued for delivery unless it has been filed with the superintendent and either he has approved it, or thirty days have elapsed and he has not disapproved it as misleading or violative of public policy. After notice and hearing to the insurer or rate service organization which submitted a policy form for approval, the superintendent may withdraw approval of such form on finding that the use of such form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of the withdrawal of approval shall be prescribed by the superintendent but shall be not less than ninety days after notice of withdrawal. With regard to residual value insurance, policy forms and any amendments thereto shall be filed with the superintendent within thirty days of their use by the insurer. For purposes of this subsection, "residual value insurance" shall have the same meaning as set forth in paragraph twenty-two of subsection (a) of section one thousand one hundred thirteen of this chapter, provided however, for the purposes of this subsection such insurance shall only be utilized for commercial purposes, and shall not include personal lines of insurance as defined in paragraph two of subsection (a) of section three thousand four hundred twenty-five of this chapter or any commercial auto insurance, and, provided further that applicants for such insurance shall sign a statement that the applicant has an appropriate level of knowledge and understanding of the use of residual value insurance.

* (c) With respect to kinds of insurance or insurance activities the rates for which, pursuant to subsection (a) of section two thousand three hundred five of this article, are not subject to prior approval, any requirement in subsections (a) and (b) of this section of filing with or prior approval by the superintendent may be waived by regulation adopted by the superintendent after a public hearing.

* NB Expires July 1, 2026

(d) All policy forms and rating classifications and territories filed with the superintendent shall be available for public inspection at the department.

(e) Policy forms for inland marine risks where the rates for such risks by general custom of the business are not written according to manual rates or rating plans shall not be filed pursuant to subsection (b) of this section, unless the superintendent directs that they be filed.

*** § 2308. Imposition of prior approval.** (a) If the superintendent determines, after a hearing, at which representatives of consumers and other interested parties may participate, and on the basis of findings of fact and conclusions, that, with respect to any territory or to any kind, subdivision or class of insurance, competition is either insufficient to assure that rates will not be excessive, or so conducted as to be destructive of competition or detrimental to the solvency of insurers, he shall order that the rates for such insurance or territory shall be subject to prior approval under subsection (b) of section two thousand three hundred five of this article and to all other provisions of this article applicable to rates subject to such subsection. Such order shall have a specified duration of not more than one year but may be renewed by the superintendent upon appropriate findings of fact, conclusions and order. Within thirty days after the close of the hearing the superintendent shall make his determination in a report which shall be made public.

(b) The superintendent, by regulation adopted after a hearing, shall, where appropriate, establish objective standards, including industry-wide profitability standards and market concentration standards, for determining when a hearing pursuant to subsection (a) hereof shall be called.

(c) This section shall be applicable to kinds of insurance or insurance activities the rates for which, pursuant to subsection (a) of section two thousand three hundred five of this article, are not subject to prior approval.

* NB Expires July 1, 2026

§ 2309. Excess rate. Notwithstanding any other provisions of this article, upon the written application of the insured, stating the

insured's reasons therefor, filed with and approved by the superintendent, a rate in excess of the rate provided by a filing otherwise applicable may be used on any specific risk.

§ 2310. Informational filings. * (a) Every insurer and rate service organization shall furnish to the superintendent, on or before the date of their use, all changes in the rating rules and schedules of rates which are not subject to prior approval pursuant to subsection (b) of section two thousand three hundred five of this article and the statistical, rating and other information in support of changes in such rating classifications and territories. Such rules, schedules and information shall be available for public inspection at the department.

* NB Expires July 1, 2026

(b) The rates for inland marine risks which by general custom of the business are not written according to manual rates or rating plans shall not be filed pursuant to subsection (a) hereof, unless the superintendent directs that they be filed.

(c) Specific inland marine rates on risks specially rated, made by a rate service organization, shall be filed pursuant to subsection (a) hereof.

§ 2311. Suspension of filing requirement. (a) Under such rules and regulations as he shall adopt, the superintendent may, by order, suspend or modify the requirements of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used.

(b) Such orders, rules and regulations shall be made known to insurers and rate service organizations affected thereby.

§ 2312. Immigration bond premium. (a) The premium for giving an immigration bond or depositing money or property as immigration bail in any court having immigration jurisdiction or in any immigration action or proceeding shall not exceed ten per centum of the amount of such bond or deposit in actions where such bonds or deposits do not exceed the sum

of three thousand dollars. Where such bonds or deposits exceed the sum of three thousand dollars, the premium shall not exceed ten per centum of the first three thousand dollars and eight per centum of the excess amount over three thousand dollars up to ten thousand dollars and six per centum of the excess amount over ten thousand dollars.

(b) No person, firm, corporation, or other entity, including an insurance producer, shall:

(1) charge, collect, or receive, directly or indirectly, any fee or compensation in connection with an immigration bail deposit or immigration bond, other than the premium based on rates subject to the maximum specified in subsection (a) of this section and filed with the superintendent by the insurer pursuant to this article, notwithstanding subsection (c) of section two thousand one hundred nineteen of this chapter; or

(2) accept any fee or compensation for obtaining a license or for obtaining an insurance producer or immigration bond or for an immigration bail deposit.

(c) Any person, firm, corporation, or other entity that violates this section shall be guilty of a misdemeanor. An indemnitor may maintain a cause of action in a court of competent jurisdiction against any person, firm, corporation, or other entity to recover any fee or compensation in excess of the amount authorized pursuant to this section. The person, firm, corporation, or other entity shall, in any action brought by an indemnitor to recover any such overcharge, be liable for treble damages.

(d) Any agreement, or portion thereof, entered into requiring the waiving of the requirements of this section or otherwise in violation of this section shall be void and unenforceable.

§ 2313. Rate service organization; defined. (a) In this article, "rate service organization" means a person or any other entity which makes or files rates as permitted by this article, or which assists insurers in rate making or filing by collecting, compiling and furnishing loss or expense statistics, or by recommending rates or rate information, or which inspects risks, tests appliances, formulates rules or establishes standards, as such activities relate to rate making or to administration of rates. It shall include a person or entity which prepares and files

policy forms and endorsements on behalf of insurers. It shall not include a joint underwriting association under section two thousand three hundred seventeen of this article, or any employee of an insurer, or in the case of insurers under common control or management an employee of any such insurer or their manager, nor shall it include actuaries, certified public accountants, attorneys or other professionals who in their respective vocations may advise insurers on rate questions.

(b) Except as provided in subsection (j) hereof, no insurer shall utilize the services of a rate service organization unless the organization has obtained a license as provided by this section.

(c) No rate service organization shall refuse to supply any services which it is permitted to render in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

(d) A rate service organization applying for a license as required by subsection (b) hereof shall include with its application:

(1) a copy of its constitution, charter, articles of organization, agreement, association or corporation, and a copy of its by-laws, plan of operation and any other rules or regulations governing the conduct of its business;

(2) a list of its members and its subscribers;

(3) the name and address of one or more residents of this state upon whom notices, process affecting it or orders of the superintendent may be served;

(4) where appropriate a statement indicating one or more kinds of insurance, or classes of risks, or any part or combination of the foregoing, for which it seeks to obtain a license;

(5) a statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

(6) any other relevant information and documents that the superintendent may require.

(e) The officers, members of the governing board or committee, and other persons in control of a corporation or of an unincorporated association, for the time being, and each partner of a partnership, shall be held individually responsible for knowingly violating any provisions of this article applicable to such corporation, association

or partnership as a rate service organization.

(f) Every organization which has applied for a license pursuant to subsection (d) hereof shall thereafter promptly notify the superintendent of every material change in the facts or in the documents as filed.

(g) If the superintendent finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of law are met, he shall issue a license specifying the authorized activity of the applicant.

(h) Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked.

(i) Any amendment to a document filed pursuant to paragraph one of subsection (d) hereof shall be filed at least thirty days before it becomes effective. Failure to comply shall be a ground for revocation of the license granted pursuant to subsection (h) hereof.

(j) A rate service organization which does not make or file rates, as permitted by this article, is not required to obtain a license under this section but no insurer shall utilize the services of such a rate service organization unless the organization has filed with the superintendent the information and documents prescribed in subsection (d) hereof and shall thereafter promptly notify the superintendent of every material change in the information or documents. The superintendent may order any insurer or rate service organization found to be in violation of this subsection to discontinue such violation.

(k) If, after a hearing, the superintendent finds that the furnishing of such information or assistance by a rate service organization subject to subsection (j) hereof involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this article, he may issue a written order specifying in what respects the act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this article, and requiring the discontinuance of the act or practice.

(l) No rate service organization shall directly or indirectly require the payment of any licensing, registration or membership fee by any broker, as such, who is licensed under this chapter; nor shall any rate

service organization or any other association or bureau refuse to do business with, or prohibit or prevent the payment of commissions to, any person licensed as an insurance broker under this chapter.

(m) No rate service organization shall adopt any rule, the effect of which would be to prohibit or regulate the payment of dividends to policyholders.

(n) A rate service organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all members and subscribers without discrimination.

(o) Cooperation among rate service organizations or among rate service organizations and insurers in rate making or in other matters within the scope of this article is hereby authorized, provided the filing resulting from such cooperation is subject to all the provisions of this article which are applicable to filings generally. The superintendent may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with this article, he may issue an order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with this article, and requiring the discontinuance of such activity or practice.

(p) A rate service organization which pursuant to subsection (j) hereof is not required to obtain a license is expressly prohibited from using or permitting the use of the phrase "supervised by the department of financial services of the state of New York" or any comparable phrase, or one which is likely to create the impression that such organization is supervised or subject to supervision by it.

(q) Any rate service organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, or the cancellation thereof, and may make reasonable rules governing their submission. Such rules shall contain a provision that in the event an insurer does not within sixty days furnish satisfactory evidence to the rate service organization of the correction of any error or omission previously called to its attention by the rate service organization, it shall be the duty of the rate service organization to notify the superintendent. All information so submitted for examination shall be confidential.

(r) A rate service organization licensed pursuant to this section

which files rates, rating plans or other statistical information pursuant to paragraph one of subsection (b) of section two thousand three hundred five of this article or otherwise relating to or in support of coverages written by its members or subscribers pursuant to paragraph fifteen of subsection (a) of section one thousand one hundred thirteen of this chapter shall be subject to audit by the superintendent by December thirty-first, nineteen hundred ninety-seven and not less than once every three years thereafter. Such audit shall examine the finances and operations of such rating organization and shall further make recommendations for actions to be taken by such rating organization in furtherance of the findings of such audit. The superintendent shall complete an audit report no later than sixty days after the conclusion of the audit period and shall submit such audit report to the governor and the legislature.

(s) Notwithstanding any other provision of this article, no rate service organization may file rates for workers' compensation insurance after February first, two thousand eight, but a rate service organization may file loss costs or other statistical information, including rating plans, until June second, two thousand eighteen. Notwithstanding subsection (j) of this section, any such rate service organization shall nonetheless be required to be licensed pursuant to this section.

* (t) (1) The governing body of a workers' compensation rate service organization shall be comprised of nine voting members. Four members shall represent insurers authorized to write workers' compensation insurance in this state, and shall be selected in such manner as is determined by the members of the rate service organization. One member of the governing body shall be a representative of the state insurance fund. Each of the remaining four members of the governing body shall serve for a term of two years and until his or her successor shall have been appointed and approved, provided that the appointing entity appoints a successor member within one hundred twenty days of the expiration of the term of office, and shall not be employed by, or serve as an officer or director of, an insurer authorized to write workers' compensation insurance in this state, or any parent, subsidiary, or affiliate thereof. One such member of the governing body shall be appointed by the superintendent. The other three such members shall be

appointed subject to the approval of the superintendent by the following: (A) the workers' compensation board; (B) the Business Council of New York State, Inc.; and (C) the American Federation of Labor - Congress of Industrial Organizations of New York State. Any vacancy on the governing body shall be filled in the same manner as the initial appointment. The governing body shall select a chief executive officer who shall serve at the pleasure of the governing body and whose terms and conditions of employment shall be approved by the governing body. No restriction in this subsection shall apply if compliance is prevented by the failure of any appointing authority to make an appointment, or of the superintendent to approve such appointment.

(2) The governing body of a workers' compensation rate service organization shall have charge of the general activities of the organization, including control and supervision over its finances and authority to establish budgets, approve assessments and impose fines on members of the rate service organization.

(3) A workers' compensation rate service organization shall have an underwriting committee and a medical and claims committee, and such other committees as the governing body deems appropriate. The underwriting committee shall have the same allocation of voting members as the workers' compensation rate service organization governing body, and it shall be the responsibility of the underwriting committee to address matters with respect to policy forms and endorsements, loss costs, rating and statistical plans, payroll audits and other employer related issues. It shall be the responsibility of the medical and claims committee to study the administration of claims under the workers' compensation law, and medical, surgical and hospital care of injured workers.

(4) A workers' compensation rate service organization shall have an actuarial committee. It shall be the responsibility of the actuarial committee to review methodology and data collection processes used to develop loss costs. The American Federation of Labor - Congress of Industrial Organizations of New York State and the Business Council of New York State, Inc. shall together appoint one independent casualty actuary who is a fellow or associate of the casualty actuarial society to serve as a member of the actuarial committee. The appointment of such actuary, and his or her compensation and terms and conditions of

retention, shall be subject to the approval of the superintendent as reasonable and customary for such professional. The actuary shall be paid by the workers' compensation rate service organization. Such actuary shall have the same access to the workers' compensation rate service organization data and documents as the other members of that committee. The governing body of a workers' compensation rate service organization shall select a chief actuary of the actuarial committee, who shall serve at the pleasure of the governing body and whose terms and conditions of employment shall be approved by the governing body. The public actuary shall issue a report on or before June first, two thousand eighteen and each of the next ten years, indicating the overall savings in the workers' compensation system as a result of the two thousand seventeen reforms.

(5) A workers' compensation rate service organization shall assess insurers that write workers' compensation coverage in New York state for expenses it incurs in its operation. Nothing in this paragraph shall prevent a workers' compensation rate service organization from also obtaining funds from any other source.

(6) A workers' compensation rate service organization shall retain all data used to calculate rates, class relativities, and experience modifications, as well as all data underlying any loss cost or other filing made with the department, and any other data the superintendent may direct, for such period of time as the superintendent shall direct.

* NB Repealed June 2, 2028

§ 2314. Charging of rates. No authorized insurer shall, and no licensed insurance agent, no title insurance agent, no employee or other representative of an authorized insurer, and no licensed insurance broker shall knowingly, charge or demand a rate or receive a premium that departs from the rates, rating plans, classifications, schedules, rules and standards in effect on behalf of the insurer, or shall issue or make any policy or contract involving a violation thereof.

§ 2315. Recording and reporting of experience; statistical plans. (a) Every authorized insurer shall annually file with the rate service

organization of which it is a member or subscriber, or with such other agency as the superintendent may approve, a statistical report showing a classification schedule of its premiums and losses on all kinds or types of insurance business subject to this article, and such other information as the superintendent may deem necessary or expedient for the administration of the provisions of this article. The superintendent from time to time may prescribe the form of the report including statistical data conforming to established classifications. The statistical reports shall be consolidated in accordance with regulations prescribed by the superintendent. Such consolidations shall be made available, subject to reasonable rules promulgated by the superintendent, to insurers and rate service organizations. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it, except that the superintendent may require each insurer writing private passenger automobile coverages to file annually with the superintendent (or a statistical agent designated by the superintendent for such purpose), in the form prescribed by the superintendent, a statistical report showing a schedule of its premiums, losses, and exposures classified by United States postal zip code. No statistical report shall be issued or otherwise made available to any rate service organization (except in the capacity of designated statistical agent), insurers, or persons other than appropriate governmental entities, except on a consolidated manner, or in such aggregate form as to protect an individual insurer's schedule of premiums, losses and exposures for any specific zip code.

(b) Statistical plans and rules shall be promulgated for the recording and reporting of expense experience on a country-wide basis. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of country-wide expense experience.

(c) In order to further uniform administration of rate regulatory laws, the superintendent and every insurer and rate service organization may exchange information and experience data with insurance supervisory officials, insurers, and rate service organizations in other states and may consult with them with respect to rate making and the application of

rating systems. Reasonable rules and plans may be promulgated by the superintendent for the interchange of data necessary for the application of rating plans. In the promulgation of statistical plans and rules the superintendent shall give consideration to the rating systems on file with him and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans in other states.

(d) No plan, rule or regulation, or amendment thereto, shall be promulgated by the superintendent pursuant to subsection (a), (b) or (c) hereof except upon notice, and after hearing, to every rate service organization affected thereby. No such plan, rule or regulation, or amendment thereto, shall become effective less than sixty days after promulgation.

(e) The willful withholding of information from, or giving of false or misleading information to, the compensation insurance rating board or any other rate service organization or any insurer or the superintendent or any statistical agency designated by the superintendent, which will in any way affect the rate or premium chargeable to any assured or group of assureds shall constitute a violation of this chapter and also be subjected to the penalty provided for in subsection (e) of section two thousand three hundred twenty-one of this article.

*** § 2316. Prohibition of anti-competitive behavior.** (a) (1) No insurer or rate service organization shall monopolize or attempt to monopolize, or combine or conspire with any other person or persons to monopolize, in any territory, the business of insurance or any kind, subdivision or class thereof.

(2) No insurer or rate service organization shall agree with any other insurer or rate service organization to charge or adhere to any rate, although insurers and rate service organizations may continue to exchange statistical information.

(3) No insurer or rate service organization shall make any agreement with any other insurer, rate service organization or other person to restrain trade.

(4) No insurer or rate service organization shall make any agreement with any other insurer, rate service organization or other person the

effect of which may be substantially to lessen competition in any territory or in any kind, subdivision or class of insurance.

(5) No insurer may acquire or retain any capital stock or assets of, or have any common management with, any other insurer or insurers, if the effect of such acquisition, retention or common management may be substantially to lessen competition in any territory or in any kind, subdivision or class of insurance.

(6) No insurer or rate service organization shall make any agreement with any other insurer or rate service organization to refuse to deal with any person in connection with the sale of insurance.

(7) No rate service organization or member or subscriber thereof shall interfere with the right of any insurer to make its rates independently of such rate service organization or to charge rates different from the rates made by such rate service organization.

(8) No member of or subscriber to a rate service organization shall refuse to do business with, or prohibit or prevent the payment of commissions to, any licensed agent or broker on the ground that such agent or broker does business with an insurer which makes its rates, or any portion thereof, independently of such rate service organization.

(9) Nothing contained in this article shall be construed as requiring any insurer to become a member of or a subscriber to any rate service organization, or as preventing any insurer, while a member of or subscriber to a rate service organization, from making its own rates for any kind, subdivision or class of insurance, for which it does not elect to authorize the rate service organization to act on its behalf.

(10) Any insurer which is a member of or subscriber to a rate service organization may make its own rates for any kind, subdivision or class of insurance. No rate service organization shall have authority to act on behalf of any insurer which is a member of or subscriber to such rate service organization except as authorized in writing by such member or subscriber, which authority may be supplemented, modified or revoked, in whole or in part, at any time by such member or subscriber at its option.

(11) No rate service organization shall have or adopt any rule or exact any agreement, or formulate or engage in any program, the effect of which would be to require any member, subscriber or other insurer to utilize some or all of its ratings services, or to adhere to its rates,

rating plans, rating systems, underwriting rules, or policy forms, or to prevent any insurer from acting independently.

(b) (1) Any rate made in violation of subsection (a) hereof shall be disapproved by the superintendent pursuant to the applicable procedures prescribed in subsection (b) of section two thousand three hundred twenty of this article, and each violator shall be subject to the penalties of subsection (c) of such section.

(2) The superintendent, through the attorney general, and any person injured in his business or property by reason of anything forbidden in subsection (a) hereof, may maintain an action to enjoin any violation of such subsection.

(3) Any person injured in his business or property by reason of anything forbidden in subsection (a) hereof may maintain an action and shall recover threefold the damages sustained by him.

(c) Nothing in this section shall be construed as applying to or prohibiting cooperative action authorized and regulated under this article. Nor shall this section apply to kinds of insurance or insurance activities the rates for which are subject to prior approval pursuant to subsection (b) of section two thousand three hundred five of this article, except that this article shall not be construed as requiring an insurer to become a member of or subscriber to a rate service organization.

* NB Expires July 1, 2026

§ 2317. Joint underwriting or joint reinsurance. (a) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance shall be subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other applicable provisions of this article and, with respect to joint reinsurance, to subsection (e) of section two thousand three hundred twenty-one and section two thousand three hundred twenty-two of this article.

(b) If, after hearing, the superintendent finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this article, he may issue a written order specifying in what respects such

activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this article, and requiring the discontinuance of such activity or practice.

(c) Every such group, association, or other organization of insurers shall be subject to examination by the superintendent as often as he may deem it expedient.

§ 2318. Risk sharing plans. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications subject to the approval of the superintendent; but this section shall not apply to workers' compensation insurance.

§ 2319. Information to be furnished insureds; aggrieved person. (a) Every insurer and rate service organization shall within a reasonable time after receiving written request therefor, and upon payment of a reasonable charge, furnish to any insured affected by a rate made by it, or to the authorized representative of the insured, all pertinent information as to the rate.

(b) Except as provided in subsection (c) of this section, every insurer or rate service organization shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by an authorized representative, on written request to review the manner in which such rating system has been applied in connection with the insurance afforded or offered. If the insurer or rate service organization fails to grant or reject the request within thirty days, applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the insurer or rate service organization on the request may within thirty days after written notice of such action appeal to the superintendent, who, after a hearing held upon not less than ten days written notice to the appellant and to the insurer or rate service organization, may affirm, modify or reverse such action.

(c) (1) Subject to the regulations of the superintendent, every workers' compensation rate service organization shall establish and implement procedures for the review of its determination to make a rating classification, relating to insurance authorized pursuant to paragraph fifteen of subsection (a) of section one thousand one hundred thirteen of this chapter, which has been filed with and approved by the superintendent. Such procedures for review shall (A) ensure that such organization shall, within a reasonable period of time after receiving written request therefor, furnish any insured affected by a rating classification made by the organization, or to the authorized representative of the insured, any information pertaining to the insured's file and any information, upon request, pertaining to the application of the classification, and (B) require an insured aggrieved by such determination to submit a written request for review of the rating classification. The failure of such rate service organization to respond in writing to a written request submitted pursuant to this subsection within sixty days, shall authorize the applicant for review to proceed as though the classification challenged was disapproved by the rate service organization. If the workers' compensation rate service organization cannot, within such sixty day period, make such determination or advise the insured that an inspection, audit or study is required, the organization shall submit a written request to the superintendent, within the sixty day period, requesting a reasonable extension of the time period in which to make such determination.

(2) Any insured adversely affected by a review, completed pursuant to paragraph one of this subsection, may, within thirty days of receiving written notice of the results of the review, appeal such review in writing to the superintendent. Such appeal shall specify the grounds to be relied upon by the appellant. The superintendent shall make a determination and notify the insured within sixty days of receipt of the request for an appeal as to whether he or she finds that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing. If the superintendent determines that such criteria have been met by the insured's application, then the superintendent shall hold a hearing on such matter within sixty days of receipt of the request for an appeal, but upon no less than ten days written notice to

the parties of the hearing. The superintendent may affirm, modify or reverse the review of the rate service organization.

(3) Any determination by the superintendent, pursuant to paragraph two of this subsection, shall be reviewable pursuant to article seventy-eight of the civil practice law and rules.

*** § 2320. Enforcement and penalties; where prior approval is not required.** (a) The superintendent may as often as he deems it expedient examine any insurer or rate service organization to ascertain whether its rating and underwriting practices are in accordance with law. Rate service organizations which make or file rates, whether or not advisory, shall be examined at least once in every five years pursuant to the provisions of this chapter applicable to the examination of insurers. Filed reports on examinations shall be available for public inspection at the department.

(b) (1) If the superintendent determines after a hearing that any rate used by an insurer does not comply with the applicable provisions of this article, he shall order that the rate be disapproved, and the order may include provision for premium adjustment. The order may also require that, for such period of time as the superintendent may determine, subsequent rate filings of the insurer subject to subsection (a) of section two thousand three hundred five of this article shall not become effective unless the filings are made in accordance with the provisions of subsection (b) of such section.

(2) The superintendent may, upon fifteen days prior written notice:

(A) order the suspension, prospectively, of a rate used by an insurer and reimpose the last previous rate in effect; or

(B) order the suspension, prospectively, of a rate used by an insurer and determine an adjusted rate that complies with the standards set forth in this article.

In any such event, the insurer may within that same fifteen day period make a written request for a hearing, in which event the superintendent may establish an interim rate by reimposing the last previous rate in effect or determining an adjusted rate pursuant to subparagraphs (A) and (B), respectively, of this paragraph. This interim rate shall remain effective pending the close of the hearing, which shall be held within

fifteen days of the insurer's request. Within fifteen days after the close of the hearing, the superintendent shall determine the rate that complies with the standards set forth in this article based upon the hearing record, and the rate so determined shall apply prospectively for a period not to exceed one year.

(3) At any such hearing, the insurer shall have the burden of justifying the rate in question. All such determinations of the superintendent shall be on the basis of findings of fact and conclusions. Nothing in this subsection shall preclude the superintendent from determining that the last previous rate in effect or the rate filed by the insurer or rate service organization complies with the standards set forth in this article. Nothing in this subsection shall preclude the insurer or a rate service organization from making or modifying any rate filing at any time.

(c) If the superintendent, after notice and hearing, finds that any insurer, rate service organization or other person has violated the applicable provisions of this article, he shall order the payment of a penalty. The issuance, procurement or negotiation of a single policy of insurance shall be deemed a separate offense. A penalty not to exceed one thousand dollars may be imposed for each such offense. A further penalty not to exceed two thousand five hundred dollars may be imposed for each offense in which the superintendent finds that there was a knowing violation, provided that a minumum penalty of at least twenty-five thousand dollars shall be imposed regardless of the number of such knowing offenses.

(d) This section shall be applicable to kinds of insurance or insurance activities the rates for which are not subject to prior approval and which are subject to this article.

* NB Expires July 1, 2026

§ 2321. Enforcement and penalties; where prior approval is required. (a) Rate service organizations shall be subject to examination by the superintendent, as often as he may deem it expedient, pursuant to the provisions of this chapter applicable to the examination of insurers. Rate service organizations which make rates, whether or not advisory, shall be examined at least once in every five years.

(b) (1) If the superintendent finds that any rate filing theretofore filed does not comply with the provisions of this article or that such filing provides rates or rules which are inadequate, excessive, unfairly discriminatory, destructive of competition, detrimental to the solvency of the insurer, or otherwise unreasonable, the superintendent may order the filing withdrawn and the rate suspended prospectively upon fifteen days prior written notice to the rate service organization or to the insurer which filed them, provided, however, such rate service organization or insurer may request a hearing, in which case no withdrawal or suspension shall become effective pending the close of the hearing, which shall be held within fifteen days of the request. Within fifteen days after the close of the hearing, the superintendent shall determine an adjusted rate based upon the hearing record deemed to be in compliance with the standards set forth in this article, and the rate so determined shall apply prospectively for a period not to exceed one year.

(2) At any such hearing, the insurer or rate service organization shall have the burden of justifying the rate in question. All such determinations of the superintendent shall be on the basis of findings of fact and conclusions. Nothing in this subsection shall preclude the superintendent from determining that the last previous rate in effect or the rate filed by the insurer or rate service organization complies with the standards set forth in this article. Nothing in this subsection shall preclude the insurer or a rate service organization from making or modifying any rate filing at any time.

(c) Whenever the superintendent finds, after notice and a hearing, that unfair discrimination exists in the making or in the application of rates made or used by any rate service organization or by any authorized insurer, he may order that the rate service organization or the insurer remove the discrimination; but the same shall not be removed by increasing the rate on any risk affected by the order unless the rate is approved by the superintendent as reasonable. Before making such order, the superintendent shall give notice to the rate service organization, if any, which made such rate, and to all insurers and other persons which he may deem directly affected thereby. Every rate service organization receiving any such notice shall promptly notify all its members or subscribers who would be affected by the order, and notice to

such rate service organization shall be deemed notice to its members or subscribers.

(d) Proceedings pursuant to subsections (b) and (c) hereof may be instituted upon the initiative of the superintendent or upon written application to the superintendent by any aggrieved person or organization, other than a rate service organization, for a hearing, if the superintendent finds that the application is made in good faith and that the grounds otherwise justify holding such a hearing.

(e) Any person, association, corporation or rate service organization wilfully violating the applicable provisions of this article shall, in addition to any other penalty provided by law, be liable to the people of this state for a penalty in an amount not less than twenty-five dollars nor more than one thousand dollars for each offense. If the superintendent finds after notice and hearing, that any authorized insurer, licensed agent or licensed insurance broker has wilfully violated any of the provisions of this article, he may, in lieu of any other penalty provided by law, order the insurer, agent or broker, as the case may be, to pay to the people of this state a penalty in the sum of one hundred dollars, for each offense, and the failure of any such person to pay the penalty within thirty days after the making of the order, unless the order is suspended by a court of competent jurisdiction, shall constitute a violation of the provisions of this chapter. Within the meaning of this subsection, the issuance, procurement or negotiation of each policy of insurance, by an insurer, agent or broker, as the case may be, in willful violation of the provisions of this article shall be deemed a separate offense.

(f) This section shall be applicable to kinds of insurance or insurance activities the rates for which are subject to prior approval and which are subject to this article.

§ 2322. Final determination; procedure on orders without hearing. (a) After a final determination against an insurer, the amount of any overcharge received by such insurer during the pendency of the proceedings, with interest thereon, shall upon demand be refunded by the insurer to the persons entitled thereto.

(b) Any insurer or rate service organization to which the

superintendent has directed an order made without a hearing may, within thirty days after notice to it of the order, make written request to the superintendent for a hearing. Pending a hearing and a decision affirming, reversing or modifying his previous action, the superintendent may suspend or postpone the effective date of his previous action.

*** § 2323. Profitability and rates of return; where prior approval is not required.** (a) The superintendent shall by regulation establish a method for determining profitability, from whatever source profits are derived, and rates of return on net worth, assets and earned premiums, with respect to each kind of insurance subject to this article, based on reasonable and uniform assumptions, including assumptions as to:

(1) amounts of net worth attributable to such kinds of insurance;

(2) assets available for investment generated by such kinds of insurance;

(3) federal income taxes; and

(4) average earnings on insurers' investments.

(b) The regulation shall require insurers annually to report to the superintendent, who will make these reports available to the public, concerning such profitability and rates of return.

(c) This section shall be applicable to kinds of insurance or insurance activities the rates for which, pursuant to subsection (a) of section two thousand three hundred five of this article, are not subject to prior approval.

* NB Expires July 1, 2026

§ 2324. Rebating and discrimination. (a) No authorized insurer, no licensed insurance agent, no licensed insurance broker, and no employee or other representative of any such insurer, agent or broker shall make, procure or negotiate any contract of insurance other than as plainly expressed in the policy or other written contract issued or to be issued as evidence thereof, or shall directly or indirectly, by giving or sharing a commission or in any manner whatsoever, pay or allow or offer to pay or allow to the insured or to any employee of the insured, either

as an inducement to the making of insurance or after insurance has been effected, any rebate from the premium which is specified in the policy, or any special favor or advantage in the dividends or other benefit to accrue thereon, or shall give or offer to give any valuable consideration or inducement of any kind, directly or indirectly, which is not specified in such policy or contract, other than any valuable consideration, including but not limited to merchandise or periodical subscriptions, not exceeding twenty-five dollars in value, or shall give, sell or purchase, or offer to give, sell or purchase, as an inducement to the making of such insurance or in connection therewith, any stock, bond or other securities or any dividends or profits accrued thereon, nor shall the insured, his agent or representative knowingly receive directly or indirectly, any such rebate or special favor or advantage, provided, however, a licensed insurance agent or a licensed insurance broker may retain the usual commission or underwriting fee on insurance placed on his own property or risks, if the aggregate of such commissions or underwriting fees will not exceed five percent of the total net commissions or underwriting fees received by such licensed insurance agent or insurance broker during the calendar year.

(b) Within the meaning of subsection (a) hereof, the sharing of a commission with the insured shall be deemed to include any case in which a licensed insurance agent or a licensed insurance broker which is a subsidiary corporation of, or a corporation affiliated with, any corporation insured, received commissions for the negotiation or procurement of any policy or contract of insurance for the insured.

(c) This section shall not prohibit any insurer from equitably distributing to its policyholders dividends payable from surplus on earned premiums, nor prohibit the return at any time during the term or at the termination of the contract of insurance of dividends, savings or the unused or unabsorbed portion of premiums and premium deposits to policyholders of a mutual insurer or to subscribers of a reciprocal insurer, nor prohibit any insurer or insurance agent from paying commissions to a licensed insurance broker for negotiating a policy or contract of insurance, nor prohibit any licensed insurance broker from sharing or dividing a commission earned or received by him with any other licensed insurance broker or brokers who shall have aided him in respect to the insurance for the negotiation of which the commission has

been earned or paid.

(d) This section shall not prohibit the making of temporary contracts of insurance, either by temporary binders or other memoranda, if the premium applicable to the insurance shall be due and shall be paid for the time during which the insurance is in force by virtue of the temporary contract.

(e) This section shall not apply to any policy or contract of reinsurance nor to any contract or policy of life insurance, accident insurance or health insurance which is subject to the provisions of section four thousand two hundred twenty-four of this chapter, nor to any contract or policy of marine insurance, other than contracts or policies of automobile insurance, or of marine protection and indemnity insurance, nor to any insurance contract, or rate of insurance in connection with any insurance contract either against loss or damage to, or legal liability in connection with, any property located wholly outside of this state or any activity carried on outside of this state or any motor vehicle or aircraft principally garaged and used outside of this state.

(f) Any person or corporation violating the provisions of this section shall, in addition to all other penalties provided by law, pay to the people of this state as a penalty the sum of five hundred dollars for each such violation.

§ 2325. Accounts and statistics. The superintendent shall have power, in his discretion, to prescribe by regulation, uniform classifications of accounts to be observed, and statistics to be reported by insurers and other organizations which are subject to the provisions of this article. He may also in his discretion prescribe, by regulation, forms of reporting such data by insurers and such other organizations. Such classifications of accounts and statistics to be reported and forms of reporting shall be reasonable and may vary with the kind or type of insurer or organization. No such regulation or amendment thereto shall be promulgated by the superintendent except upon notice and after hearing to all insurers and organizations affected thereby. Any regulation or amendment thereto shall be promulgated by the superintendent at least six months before the beginning of the calendar

year in which the same shall take effect.

*** § 2326. Evaluation of competitive rating provisions.** The superintendent shall continuously monitor the operation of the provisions of this article which are applicable to the kinds of insurance or insurance activities the rates for which, pursuant to subsection (a) of section two thousand three hundred five of this article, are not subject to prior approval.

* NB Expires July 1, 2026

§ 2327. Verification of driving history. No insurer who utilizes an applicant's New York state driving history as a rating or underwriting factor for private passenger motor vehicle insurance in this state shall bind a policy of insurance, or process a percentage of the annual premium due for a policy, without first making a good faith effort to verify said applicant's New York state driving history, as well as the New York state driving history of all named drivers that are used to rate the policy and are listed by the applicant on the private passenger motor vehicle insurance application, through the use of a third-party database. An insurer also shall verify, through a third-party database, the New York state driving history of a named driver used to rate the policy when added during the policy period, unless the New York state driving history is unavailable at the time of the initial inquiry due to a temporary website outage, service interruption or other circumstances beyond the control of the insurer, producer or third-party representative.

§ 2328. For hire motor vehicle insurance rates; flexible rating; prior approval. (a) An insurer shall submit to the superintendent, for the superintendent's prior approval, its rates, rating plans, rating rules, and rate manuals applicable to motor vehicle insurance, including no-fault coverages under article fifty-one of this chapter, by August first, two thousand twenty-five and at least every two years thereafter, unless the superintendent requests the rates, rating plans, rating

rules, or rating manuals more frequently. For rates submitted on or before August first, two thousand twenty-five, the superintendent may approve the phasing in of rates that meet the standards set forth in section two thousand three hundred three of this article if the superintendent determines that it would be in the best interests of the people of this state.

(b) Except as provided in subsection (c) of this section, no changes in rates, rating plans, rating rules and rate manuals applicable to motor vehicle insurance, including no-fault coverages under article fifty-one of this chapter, shall be made effective until approved by the superintendent, notwithstanding any inconsistent provisions of this article.

(c) Starting December first, two thousand twenty-five, overall average (for all coverages combined) rate level increases above an insurer's rates in effect that are up to a percentage specified in a regulation promulgated by the superintendent but not to exceed five percent during any twelve-month period, may take effect without the superintendent's prior approval after submitting an informational filing pursuant to section two thousand three hundred ten of this article. An insurer shall not implement more than two rate increases pursuant to this section, the total of which shall not exceed the limitation specified in a regulation, during any twelve-month period. An insurer also shall not implement a rate increase within the limitation specified in a regulation until the onset of the new policy period and unless the insurer, at least thirty but not more than sixty days in advance of the end of the policy period, mails or delivers to the named insured, at the address shown in the policy, a written notice of its intention to change the rate. The specific reason or reasons for the rate change shall be stated in or shall accompany the notice. An insurer shall not implement a rate change under this subsection when the insurer: (1) has submitted a rate filing under subsection (a) of this section and the superintendent has not yet approved it; or (2) is in the process of phasing in its rates pursuant to the superintendent's approval under subsection (a) of this section.

(d) The superintendent shall monitor the degree and continued existence of competition and the effectiveness of flexible rating in this state on an on-going basis. In doing so, the superintendent shall

utilize the following standards or factors:

(1) the standards contained in section two thousand three hundred eight of this article;

(2) existing relevant information, analytical systems and other sources, or rely on some combination thereof;

(3) the number of insurers or group of affiliated insurers actively engaged in providing coverage, taking into account the specialization traditionally required for insurance in the particular rating territory;

(4) measures of market concentration and changes of market concentration over time, which may include the use of Herfindahl-Hirschman Index (HHI) and the United States Department of Justice merge guidelines for an unconcentrated market ease of entry, and the existence of financial or economical barriers that could prevent new firms from entering the market;

(5) the extent to which any insurer or group of affiliated insurers controls all or a dominant portion of the market has actively sought to prevent competition;

(6) whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options;

(7) the availability of insurance coverage to consumers;

(8) the opportunities available to consumers in the market to acquire pricing and other consumer information; and

(9) any other factors relevant to inquiry.

Such activities may be conducted internally within the department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner, provided that the department shall report to the speaker of the assembly, temporary president of the senate, and governor on the effectiveness of flexible rating on the for hire motor vehicle market by December first, two thousand twenty-seven and every two years thereafter.

(e) This section shall apply only to policies covering losses or liabilities arising out of ownership of a motor vehicle used principally for the transportation of persons for hire, including a bus or a school bus as defined in sections one hundred four and one hundred forty-two of the vehicle and traffic law, provided, however, that subsections (a) and (c) of this section shall not apply to a bus or a school bus as defined

in sections one hundred four and one hundred forty-two of the vehicle and traffic law.

§ 2329. Motor vehicle insurance rates; excess profits. (a) Each insurer issuing policies that are subject to article fifty-one of this chapter, including policies of motor vehicle personal injury liability insurance or policies of motor vehicle property damage liability insurance or insurance for loss or damage to a motor vehicle, shall establish a fair, practicable, and nondiscriminatory plan for crediting to those purchasing such policies their share of the insurer's excess profit, if any, on such policies. An excess profit shall be an underwriting gain for the three most recent calendar years combined which is greater than the anticipated underwriting profit plus five percent of earned premiums for those calendar years. Each plan shall apply to policy periods for the periods January first, nineteen hundred seventy-four through August second, two thousand one, and the effective date of the property/casualty insurance availability act through June thirtieth, two thousand twenty-nine. The superintendent may, through duly promulgated regulations, waive any requirement for credit that the superintendent determines to be de minimis or impracticable, adopt forms of returns that shall be made to the superintendent in order to establish the amount of any credit due, establish periods and times for the determination and distribution of credits, and shall provide that insurers receive appropriate credit against any credits required by any such plan for policyholder dividends and for return premiums that may be due under rate credit or retrospective rating plans based on experience.

(b) If an insurer subject to this section distributes a credit pursuant to this section due to the reforms enacted in the state fiscal year two thousand twenty-six--two thousand twenty-seven budget, the insurer shall provide notice to policyholders of this credit and indicate that the credit was due to the reforms enacted in the state fiscal year two thousand twenty-six--two thousand twenty-seven budget. This notification shall be made at the time the credit is distributed.

(c) As used herein with respect to any three-year period, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer in effect during such

period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies. Underwriting gain or loss for each calendar year shall be computed as follows: the sum of the incurred losses and loss adjustment expenses as of March thirty-first of the following year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, will be subtracted from the calendar year earned premium to determine the underwriting gain or loss.

(d) On or before March thirty-first of each year, an insurer subject to this section shall submit a report to the superintendent, in a format specified by the superintendent, demonstrating whether the insurer realized an excess profit for the three most recent calendar years combined. Such report shall include all relevant information required to calculate underwriting gain and loss and determine whether an excess profit threshold has been realized. If an insurer realized an excess profit, then the insurer shall notify the superintendent when the insurer has completed making any credits required by this section. If an insurer has realized an excess profit, the superintendent shall provide notice to the speaker of the assembly, the temporary president of the senate, the chair of the assembly insurance committee, the chair of the senate insurance committee, and the governor.

(e)(1) Each insurer subject to this section shall, by July first, two thousand twenty-seven, and annually thereafter, submit a report to the superintendent that:

(A) identifies and quantifies, in a manner prescribed by the superintendent, the estimated impact on losses, expenses, and premiums resulting from statutory or regulatory reforms enacted in or the result of the state fiscal year two thousand twenty-six--two thousand twenty-seven budget; and

(B) reflects such estimated impact in the insurer's proposed rates, rating plans, and rating rules.

(2) In reviewing any rate filing submitted after enactment of the state fiscal year two thousand twenty-six--two thousand twenty-seven budget, the superintendent shall consider the estimated impact of the

reforms described in paragraph one of this subsection and shall not approve any rate that, after such consideration, fails to meet the standards set forth in section twenty-three hundred three of this article.

(3) On or before December thirty-first, two thousand twenty-nine, the superintendent shall submit a report to the governor, the temporary president of the senate, the speaker of the assembly, the chair of the assembly insurance committee, and the chair of the senate insurance committee that:

(A) summarizes the estimated aggregate impact of the reforms described in paragraph one of this subsection on insurer losses, expenses, and premiums; and

(B) evaluates the extent to which such savings have been reflected in approved rates and realized by policyholders.

(4) The superintendent may promulgate regulations or guidance necessary to implement the provisions of this subsection.

§ 2330. No fault motor vehicle insurance rates; reflection of reduced exposure to loss. Where the principal operator of a motor vehicle or such operator's spouse is eligible for medicare benefits for items of basic economic loss specified in paragraph one of subsection (a) of section five thousand one hundred two of this chapter, or where the insurer's obligation to pay first party benefits for loss of earnings from work is reduced by virtue of the provisions of such subsection, the premium attributable to coverage under the automobile insurance policy for such items shall be appropriately modified to reflect the insurer's reduced exposure to loss.

§ 2331. Motor vehicle comprehensive insurance rates; age, sex or marital status. No filing of a rate, rating plan, rating rule or rate manual applicable to insurance for loss of or damage to a motor vehicle other than by collision or upset, shall be approved by the superintendent if the filing is based, in whole or in part, on the age, sex or marital status of an owner or operator of an insured motor vehicle unless such filing is supported by and reflective of actuarially

sound statistical data.

§ 2332. Non-commercial private passenger automobile insurance rates; experienced and inexperienced principal operators. With respect to non-commercial private passenger automobiles, no filing of a rate, rating plan, rating rule or rate manual applicable to motor vehicle collision insurance, the insurance provided for in section five thousand one hundred three of this chapter, bodily injury liability insurance or property damage liability insurance shall be approved by the superintendent unless, in accordance with a regulation issued after a public hearing, the filing reflects an appropriate rate differential between an experienced and inexperienced principal operator.

§ 2333. Non-commercial private passenger automobile insurance rates; apportionment of expenses. With respect to non-commercial private passenger automobiles, no filing of a rate, rating plan, rating rule or rate manual applicable to insurance for loss of or damage to a motor vehicle, the insurance provided for in section five thousand one hundred three of this chapter, bodily injury liability insurance or property damage liability insurance shall be approved by the superintendent, if the filing allocates all of an insurer's administrative expenses as a percentage of premium. Every insurer shall reasonably apportion such expenses among its policyholders. For the purpose of this section, administrative expenses includes general expenses and acquisition expenses other than commissions.

§ 2334. Non-commercial private passenger automobile insurance rates; merit rating plans. (a) The superintendent shall, after public hearing, promulgate a regulation, which may be amended from time to time, applicable to non-commercial private passenger automobile insurance merit rating plans which reflect an individual driver's experience with respect to accidents, claims or traffic violations. The regulation shall continue to encourage competition among insurers, but shall discourage merit rating plan provisions which may tend to create confusion or

misunderstanding among insureds. The regulation shall establish standards and limitations intended to insure that merit rating plans are reasonable, understandable and objective and are not unfairly discriminatory, inequitable, violative of public policy or otherwise contrary to the best interests of the people of this state.

(b) Insurers shall review their merit rating plans which were approved by the superintendent prior to the promulgation of the regulation required by this section and shall, before November first, nineteen hundred eighty-two, file with the superintendent statements that their merit rating plans conform with the regulation, or file appropriate amendments to their plans which will bring them into compliance with the standards of the regulation. Such amendments shall become effective upon approval by the superintendent.

*** § 2335. Motor vehicle liability insurance rates; prohibition of surcharges for certain accidents and traffic infractions.** No insurer authorized to transact or transacting business in this state, or controlling or controlled by or under common control by or with an insurer authorized to transact or transacting business in this state, which sells a policy providing motor vehicle liability insurance coverage in this state shall increase the policy premium in connection with the insurance permitted or required by this chapter solely because the insured or any other person who customarily operates an automobile covered by the policy:

(a) has had an accident that does not result in aggregate damage to property in excess of two thousand dollars, provided that any policy surcharge shall be permissible for any accident which results in bodily injury or if the insured has more than one accident in the merit rating experience period. Nothing in this subsection shall change the dollar amount of the accident reporting threshold required under paragraph one of subdivision (a) of section six hundred five of the vehicle and traffic law.

(b) has been found guilty of a traffic infraction under any of the provisions of the vehicle and traffic law provided, however, that this provision shall not apply to a conviction for a violation which occurred during the thirty-six month period ending on the last day of the fourth

month preceding the month of the effective date of the policy if such conviction consisted of:

(1) operating a motor vehicle at a speed of more than fifteen miles per hour in excess of the legal limit;

(2) operating a motor vehicle in excess of the speed limit, or in a reckless manner, where injury or death results therefrom;

(3) operating a motor vehicle in excess of the speed limit, or reckless driving, or any combination thereof, on three or more occasions;

(4) operating a motor vehicle while intoxicated or impaired by the consumption of alcohol;

(5) operating a motor vehicle while impaired by the use of a drug, within the meaning of section one thousand one hundred ninety-two of the vehicle and traffic law;

(6) homicide or assault arising out of the use or operation of a motor vehicle, or criminal negligence in the use or operation of a motor vehicle resulting in the injury or death of another person, or use or operation of a motor vehicle directly or indirectly in the commission of a felony;

(7) operating a motor vehicle while seeking to avoid apprehension or arrest by a law enforcement officer;

(8) filing or attempting to file a false or fraudulent automobile insurance claim, or knowingly aiding or abetting in the filing or attempted filing of any such claim;

(9) leaving the scene of an incident without reporting;

(10) filing a false document with the department of motor vehicles, or using a license or registration obtained by filing a false document with the department of motor vehicles;

(11) operating a motor vehicle in a race or speed test;

(12) knowingly permitting or authorizing an unlicensed driver to operate a motor vehicle insured under the policy;

(13) operating a motor vehicle insured under the policy without a valid license or registration in effect, except when the person convicted had possessed a valid license or registration which had expired and was subsequently renewed, or during a period of revocation or suspension thereof, or in violation of the limitations applicable to a license issued pursuant to article twenty-one or article twenty-one-a

of the vehicle and traffic law; or

(14) two or more moving violations of any other provision of the vehicle and traffic law;

(c) has had a temporary suspension of a driver's license pending a hearing, prosecution or investigation or an indefinite suspension of a driver's license which is issued because of the failure of the person suspended to perform an act, which suspension will be terminated by the performance of the act by the person suspended, or has had more than one such temporary or indefinite suspension arising out of the same incident issued against him or her, provided that the foregoing provisions of this section shall not apply if such suspension or suspensions has or have not been terminated on or before the effective date of the policy; or

(d) with respect to a non-commercial private passenger automobile insurance policy, has had an accident while operating a commercial vehicle in the course of employment and in the discharge of the employee's duties at the time of the accident, unless the accident is determined to have been caused by the intentional action or gross negligence of the insured.

* NB Expires July 1, 2026

§ 2335-a. Prohibition of rate increases for persons involved in emergency use of vehicles. No insurer authorized to transact or transacting business in this state, or controlling or controlled by or under common control by or with an insurer authorized to transact or transacting business in this state, which sells a policy providing motor vehicle liability insurance coverage in this state shall increase the policy premium in connection with the insurance permitted or required by this chapter solely because the insured or any other person who customarily operates an automobile covered by the policy has had an accident while operating a motor vehicle in response to an emergency, where the insured was either responding to a call to duty as a paid or volunteer member of any police or fire department or first aid squad; or was performing any other function on behalf of the state, any political subdivision thereof, a public authority, public benefit corporation, or any other governmental agency or instrumentality in a public emergency.

§ 2336. Motor vehicle liability, comprehensive and collision insurance rates; premium reductions in certain cases. * (a) (1) Any schedule of rates or rating plan for motor vehicle liability and collision insurance submitted to the superintendent shall provide for an actuarially appropriate reduction in premium charges for any insured for a three year period after successfully completing a motor vehicle accident prevention course, known as the national safety council's defensive driving course, or any driver improvement course approved by the department of motor vehicles as being equivalent to the national safety council's defensive driving course, provided that, except as provided in article twelve-C of the vehicle and traffic law, there shall be no reduction in premiums for a self-instruction defensive driving course or a course that does not provide for actual classroom instruction for a minimum number of hours as determined by the department of motor vehicles. Such reduction in premium charges shall be subsequently modified to the extent appropriate, based upon analysis of loss experience statistics and other relevant factors. All such accident prevention courses shall be monitored by the department of motor vehicles and shall include components of instruction in "Road Rage" awareness and in "Work Zone Safety" awareness as defined by the commissioner of motor vehicles. The provisions of this section shall not apply to attendance at a program pursuant to article twenty-one of the vehicle and traffic law as a result of any traffic infraction.

(2) Any insured who successfully completes a course pursuant to this subsection and receives a premium reduction on the insured's insurance policy covering the for-hire vehicle, shall not, during the period set forth in subsection (e) of section two thousand three hundred fifty-three of this article, also be eligible for an additional premium reduction on the insured's commercial risk insurance policy covering the for-hire motor vehicle for successful completion of the for-hire safety motor vehicle course authorized under section two thousand three hundred fifty-three of this article.

* NB Effective until April 1, 2028

* (a) (1) Any schedule of rates or rating plan for motor vehicle liability and collision insurance submitted to the superintendent shall

provide for an actuarially appropriate reduction in premium charges for any insured for a three year period after successfully completing a motor vehicle accident prevention course, known as the national safety council's defensive driving course, or any driver improvement course approved by the department of motor vehicles as being equivalent to the national safety council's defensive driving course, provided that in either event there shall be no reduction in premiums for a self-instruction defensive driving course or a course that does not provide for actual classroom instruction for a minimum number of hours as determined by the department of motor vehicles. Such reduction in premium charges shall be subsequently modified to the extent appropriate, based upon analysis of loss experience statistics and other relevant factors. All such accident prevention courses shall be monitored by the department of motor vehicles and shall include components of instruction in "Road Rage" awareness and in "Work Zone Safety" awareness as defined by the commissioner of motor vehicles. The provisions of this section shall not apply to attendance at a program pursuant to article twenty-one of the vehicle and traffic law as a result of any traffic infraction.

(2) Any insured who successfully completes a course pursuant to this subsection and receives a premium reduction on the insured's insurance policy covering the for-hire vehicle, shall not, during the period set forth in subsection (e) of section two thousand three hundred fifty-three of this article, also be eligible for an additional premium reduction on the insured's commercial risk insurance policy covering the for-hire motor vehicle for successful completion of the for-hire safety motor vehicle course authorized under section two thousand three hundred fifty-three of this article.

* NB Effective April 1, 2028

* (b) Any schedule or rating plan for non-commercial private passenger automobile insurance shall provide for an appropriate reduction in premium charges for personal injury protection and medical payment coverages with respect to any insured vehicle equipped with a passive occupant restraint system for front-seat passengers. Such discount shall apply to passive occupant restraint systems that meet applicable federal or appropriate equivalent standards. With respect to vehicles other than non-commercial private passenger automobiles, any schedule rating plan

shall include an appropriate premium credit which reflects the existence of such a passive occupant restraint system.

* NB Expires July 1, 2026

(c) Any schedule or rating plan for non-commercial private passenger automobile insurance shall also provide for an appropriate reduction in premium charges for bodily injury liability, property damage liability, personal injury protection, medical payment and collision coverages with respect to automobiles equipped with factory installed anti-lock brakes, or such other safety devices which the superintendent determines, after a public hearing, may be expected to reduce losses for such coverages. In determining the appropriate reductions, consideration shall be given to other safety discounts that already apply to the coverages affected.

(d) Premium charge reductions made pursuant to the provisions of subsection (a) of this section shall be effective upon issuance of a certificate of completion to the insured and such premium charge reduction shall be calculated from such completion date unless such completion certificate is presented within forty-five days prior to the renewal of the policy, in which case the insurer may elect to commence the discount upon the first day of the new policy period for the full term of statutory discount; provided, however, that if the certificate of completion is not presented to the insurer within ninety days after completion of the course the insurer may, at its discretion, apply the premium discount from the date such certificate was presented rather than the date of completion. A discount applied during a policy period shall be prorated over the term of the policy.

(e) Any schedule or rating plan for non-commercial private passenger automobile insurance shall provide for an appropriate reduction in premium charges for comprehensive coverage with respect to any insured vehicle equipped with an operational anti-theft and recovery device consisting of an electronic homing device used in conjunction with a participating police agency and using a radio frequency network allocated by the Federal Communications Commission; provided, however, that in no event shall the non-use of this device or any other anti-theft device constitute grounds for an increase in policy premiums or cancellations or non-renewal of a non-commercial private passenger automobile insurance policy.

(f) (1) Any schedule or rating plan for non-commercial private

passenger automobile insurance shall provide for an appropriate reduction in premium charges for comprehensive coverage with respect to any insured vehicle equipped with window glass etched with the vehicle identification number or any other unique identifying symbol. The term "window glass" shall include not less than the windshield, door glass, rear window, T-top and the moon/sun roof of the insured vehicle.

(2) In order to qualify for a comprehensive premium discount pursuant to paragraph one of this subsection, the window glass etching performed on vehicles on or after the effective date of this paragraph shall meet the following standards:

(i) Etching shall be a vehicle identification number comprising seventeen digits as mandated for all vehicles sold in the United States pursuant to the United States Motor Vehicle Theft Act of 1984 or, if approved by the superintendent, with a unique identifying symbol. The windshield and rear window shall be etched within one inch from the bottom and the windshield shall be etched in close proximity to the vehicle identification number.

(ii) Etched indicia (numbers and letters of the seventeen digit vehicle identification number), when utilizing the vehicle identification number of the subject vehicle, shall be verified by input through a computer program with a checking algorithm prior to being etched onto any vehicle. In the event that a unique identifying symbol is utilized, the vendor utilizing such symbol shall provide a toll-free number to all vehicle owners, to be applied on vehicle window surface by decal.

(iii) Etched indicia shall not be greater than one-third inch in height nor less than one-eighth inch in height.

(iv) Auto glass etching shall be done by a laser, chemical process or mechanical process. Products used to etch vehicles in compliance with this section, whether comprising chemical or other methods of etching window glass, shall be products within the marketplace which are lawfully sold and delivered to consumers within New York state.

(v) Window etchings shall result in etched indicia within the surface of vehicle window glass which are permanent and cannot be removed without destroying the vehicle window. However, etching sufficient to achieve permanent markings shall not exceed a depth in the surface of the window which would affect the window's structural integrity.

(vi) A message line may be included below the etched vehicle identification number which directs callers to a registry listing etched vehicle identification numbers and unique identifying symbols for assistance in reporting and identifying stolen vehicles.

(vii) Nothing in this paragraph shall relieve an insurer from continuing to provide discounts pursuant to paragraph one of this subsection for etching installed on window glass prior to the effective date of this paragraph, notwithstanding any departure of such etchings from the standards provided for pursuant to this paragraph.

(g) Any schedule or rating plan for non-commercial private passenger automobile insurance shall also provide for an actuarially appropriate reduction in premium charges for bodily injury liability, property damage liability, personal injury protection, medical payments and collision coverage with respect to automobiles equipped with factory installed daytime running lamps (DRL).

(h) Any schedule or rating plan applicable to commercial risk insurance for motor vehicles weighing in excess of ten thousand pounds shall provide for an actuarially appropriate reduction in premium charges for bodily injury liability, property damage liability, personal injury protection, medical payments and collision coverage with respect to such motor vehicles equipped with factory installed auxiliary running lamps. Such lamps shall be designed to reduce accidents by increasing vehicle visibility during the day and night. The superintendent shall, after consulting with the departments of motor vehicles and transportation, promulgate rules and regulations establishing the qualifications and standards for the approval, utilization and installation of such lamps.

§ 2336-a. Snowmobile liability insurance rates; premium reductions in certain cases. Any schedule of rates or rating plan for snowmobile liability insurance submitted to the superintendent may provide for an actuarially appropriate reduction in premium charges for any insured who has successfully completed a snowmobile safety course which has been approved by the commissioner of parks, recreation and historic preservation.

§ 2336-b. Boat liability insurance rates; premium reductions in certain cases. (a) Any schedule of rates or rating plan for boat liability insurance submitted to the superintendent shall provide for an appropriate reduction in premium charges, as described in section seventy-eight-a of the navigation law, for any insured who has successfully completed a boating safety course or an advanced boating safety course which meets the requirements of part five of article four of the navigation law and has been approved by the commissioner of parks, recreation and historic preservation. The provisions of this section shall not apply to attendance at a course pursuant to sections forty-five or forty-nine of the navigation law as a result of any boating infraction.

(b) For the purposes of this section:

(1) the term "boat" shall mean any residential or pleasure vessel that is not a crew racing shell as defined in section two of the navigation law.

(2) the term "boating safety course" or "advanced boating safety course" shall mean a course of instruction or advanced course of instruction that has been approved by the commissioner of parks, recreation and historic preservation pursuant to section seventy-nine of the navigation law.

(3) the term "boating safety certificate" shall mean a document which cannot be altered and which is provided to a person who successfully completes a boating safety course or advanced boating safety course pursuant to section seventy-eight of the navigation law.

(c) An insurer, upon approval of the superintendent, may upon submission of a completion certificate by an insured, provide an actuarially appropriate reduction of the premium for such insured's yacht or boating liability insurance.

(d) The superintendent may establish, by rule or otherwise, standards or guidelines to be used to accomplish the provisions of this section.

§ 2337. Private passenger automobile physical damage insurance; statistics on use of anti-theft devices and the maximum discount for all anti-theft devices. (a) In accordance with procedures prescribed by the

superintendent pursuant to the provisions of subsection (a) of section two thousand three hundred fifteen of this article, each insurer which offers physical damage insurance subject to the provisions of section three thousand four hundred eleven of this chapter shall maintain statistics of the fire, theft and comprehensive insurance experience of its insureds whose automobiles are and are not equipped with anti-theft devices. Such statistics shall include the name, type and manufacturer of such devices. The superintendent shall direct that insurers appropriately modify the premium attributable to fire, theft and comprehensive coverages for automobiles equipped with such devices, to reflect reduced exposure to loss.

(b) The maximum discount on theft and comprehensive motor vehicle insurance coverage for all anti-theft devices provided for in this article shall be an appropriate discount based solely on sound actuarial practices and limited only by sound actuarial determinations.

§ 2338. Appeal from rate service organization action. (a) This section shall apply only to kinds of insurance the rates for which are subject to prior approval pursuant to subsection (b) of section two thousand three hundred five of this article.

(b) Any member of or subscriber to a rate service organization may appeal to the superintendent from the action or decision of the rate service organization in approving or rejecting any proposed change in or addition to its filings. The superintendent, within thirty days after the filing of such appeal, shall hold a hearing upon not less than ten days' written notice to the appellant and to the rate service organization. After the hearing the superintendent shall issue an order approving the action or decision of the rate service organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rate service organization in rejecting a proposed addition to its filings, he may, in the event he finds that such action or decision was unreasonable, issue an order directing the rate service organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order.

(c) If the appeal is based upon the failure of the rate service organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in subsection (d) of section two thousand three hundred four of this article, from the system of expense provisions included in a filing made by the rate service organization, the superintendent shall, if he grants the appeal, order the rate service organization to make the requested filing for use by the appellant. In deciding the appeal the superintendent shall apply the standards set forth in section two thousand three hundred three of this article.

§ 2339. Charging or receiving of rates; deviations. (a) This section shall apply only to kinds of insurance the rates for which are subject to prior approval pursuant to subsection (b) of section two thousand three hundred five of this article.

(b) No member of or subscriber to a rate service organization, and no insurer which makes and files its own rates, shall charge or receive any rate which deviates from the rates, rating plans, classifications, schedules, rules and standards made and filed by such rate service organization, or by such insurer, as the case may be, which are applicable to any kind or type of business done by such member or subscriber, or by such insurer, except as provided in this article.

(c) Any insurer which is a member of or subscriber to a rate service organization may make written application to the superintendent for permission to deviate from the rates, schedules, rating plans or rules filed on its behalf by the rate service organization. The application shall specify the basis for the modification and a copy shall also be sent simultaneously to such rate service organization. In considering the application to deviate the superintendent shall give consideration to the available statistics and the principles for rate making as provided in section two thousand three hundred four of this article. If the superintendent finds the deviation to be justified, he shall approve it to be effective for a period to be fixed by him, but in no event for a period of less than one year, unless sooner terminated by the applicant with the permission of the superintendent or unless sooner

withdrawn or appropriately adjusted by an order of the superintendent made in accordance with the provisions of this article generally applicable to rate filings. If the superintendent finds that the deviation applied for does not meet the requirements of this article, he shall send to the applicant written notice of his disapproval, specifying in what respects he finds it fails to meet the requirements of this article. The superintendent shall inform the rate service organization of his action upon the deviation application.

(d) (1) Notwithstanding any other provision of law, except as provided in paragraph three of this subsection, the state insurance fund shall not charge an insured any rate, or receive from an insured any rate in excess of the total of (i) the applicable loss cost approved by the superintendent, (ii) the applicable expense component of the state insurance fund and (iii) a fair and reasonable differential charge which takes into consideration the nature and hazards of the insured's business or operations, the insured's prior loss experience, the insured's prior and presently existing safety practices, the insured's prior premium payment history, the number of persons the insured employs in such business or operations and the specific type of work they perform, the insured's prior and current compliance with obligations imposed upon the insured by the workers' compensation law and other laws which require premium or other payments by the insured on the basis of earnings and other remuneration earned by persons engaged in the furtherance of the insured's enterprise or enterprises, the promptness and completeness of such reports as the insured has filed on accidents and claims, and such other factors as may be relevant to the appraisal of the insured or proposed insured as a risk in whole.

(2) A differential charge applied by the state insurance fund to a workers' compensation and employer's liability insurance policy may be challenged by the insured by an appeal to the superintendent after an exhaustion by the insured of all internal review procedures of the state insurance fund as established by rules adopted by the commissioners of the state insurance fund and filed with the secretary of state; provided that a writing setting forth the grounds upon which such appeal is based is served and filed with the superintendent and with the secretary to the board of commissioners of the state insurance fund within thirty days after a final determination by the state insurance fund. Appeals to

the superintendent shall be determined upon papers and documents that were before the state insurance fund in connection with the internal review procedures, the writing setting forth the grounds of the insured's appeal and any answer to such appeal served by the state insurance fund upon the insured and filed with the superintendent within thirty days after the service of the insured's notice.

(3) The provisions of this section shall not apply to a policy sold by the state insurance fund under article six-G of the executive law. The rate which the state insurance fund may charge under such article shall be governed only by such regulations or guidelines as the superintendent may issue.

§ 2340. Credit property insurance. (a) The superintendent may promulgate regulations covering the business of credit property insurance.

(b) "Credit property insurance" means insurance against loss of or damage to personal property covering a creditor's security interest in such property when insurance is written as a part of a credit transaction.

*** § 2341. Prohibition against the use of employment, education, homeownership, and zip code for private passenger motor vehicle insurance rates.** (a) An insurer shall not use the following factors as the sole basis for initial tier placement, tier movement, or the establishment of rates for motor vehicle insurance subject to section three thousand four hundred twenty-five of this chapter:

(1) occupational status or type of occupation;

(2) education level attained;

(3) homeownership; and

(4) the zip code in which the motor vehicle is principally garaged, provided, however, that an insurer may use a group of contiguous zip codes in accordance with section two thousand three hundred seven of this article.

(b) Nothing in this section shall be construed to prohibit:

(1) consideration of occupational status or type of occupation to

determine whether a motor vehicle is used for a business or commuting purpose; or

(2) consideration of occupation to the extent strictly necessary to offer policies pursuant to a mass merchandising plan; or

(3) any actuarially justified discounts approved by the superintendent.

* NB Effective November 23, 2026

§ 2342. Expiration of certain provisions. The provisions of subsection (c) of section two thousand three hundred seven, section two thousand three hundred eight, subsection (a) of section two thousand three hundred ten, sections two thousand three hundred sixteen, two thousand three hundred twenty, two thousand three hundred twenty-three, two thousand three hundred twenty-six, and two thousand three hundred thirty-five, and subsection (b) of section two thousand three hundred thirty-six of this article shall cease to be of any force or effect during the period August third, two thousand one through the day before the effective date of the property/casualty insurance availability act, and after June thirtieth, two thousand twenty-nine.

§ 2343. Medical malpractice insurance rates; special additional provisions regarding such rates. (a) Whereas the provisions of a chapter of the laws of nineteen hundred eighty-five regarding medical and dental malpractice will have both a prospective and retrospective effect upon the loss experience of physicians, dentists and hospitals professional liability insurers, including the medical malpractice insurance association, the superintendent is directed forthwith to review rates previously in effect for the period commencing July first, nineteen hundred eighty-four and ending June thirtieth, nineteen hundred eighty-five, and, where appropriate, require modification of such rates for such period.

(b) Any such modified rate shall remain in effect as a provisional rate for the period commencing July first, nineteen hundred eighty-five and ending on November thirtieth, nineteen hundred eighty-five. The superintendent, subsequent to December first, nineteen hundred

eighty-five, shall approve final rates for the period commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-six. No insurer shall have the duty to file for final rates for the period commencing July first, nineteen hundred eighty-five prior to December first, nineteen hundred eighty-five.

(c) Notwithstanding any other provision of this chapter, no application for an order of rehabilitation or liquidation of a domestic insurer whose primary liability arises from the business of medical malpractice insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter, shall be made on the grounds specified in subsection (a) or (c) of section seven thousand four hundred two of this chapter at any time prior to December thirty-first, two thousand twenty-eight.

(d) The superintendent shall promulgate a regulation, which may be amended from time to time, establishing a physicians professional liability insurance merit rating plan applicable to medical malpractice insurance coverage whether written as an individual policy or through a voluntary attending physician ("channeling") program previously permitted by the superintendent which reflects an individual physician's or surgeon's experience with respect to incidents or occurrences of alleged medical malpractice. The regulation shall establish standards and limitations intended to insure that merit rating plans are reasonable and are not unfairly discriminatory, inequitable, violative of public policy or otherwise contrary to the best interests of the people of this state. Such regulation shall include:

(1) reasonable standards to be applied in arriving at premium rates, surcharges and discounts based on an evaluation of the hazards of the insured, geographical area, specialties of practice, past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, and the limited nature, if any, of the practice of the insured;

(2) rules for recognizing experience of individual risks;

(3) any other factors deemed relevant in a system of merit rating for the purpose of establishing equitable merit rates.

The superintendent shall also consider, in establishing such

regulation, whether premium rates unfairly burden physicians who are initiating their practice, those who are transitioning to retirement or those who practice part-time or hold academic positions.

Insurers shall review merit rating plans which were approved by the superintendent prior to the promulgation of the regulation required by this subsection and shall, before January first, nineteen hundred eighty-six, file with the superintendent statements that their merit rating plans conform with the regulation, or file an appropriate plan or amendments to their existing plans which will bring them into compliance with the standards of the regulation. Any such amendments shall become effective upon approval by the superintendent.

(e) The superintendent may approve an appropriate premium reduction for an insured physician who successfully completes a risk management course, which must be approved by the superintendent subject to such standards as the superintendent may prescribe by regulation. In prescribing such regulation the superintendent may consult with the commissioner of health.

*** § 2344. Flexible rate limitations in problem markets.** (a) As used in this section:

(1) "Market" means a line, subline or classification (other than a classification delineated by geographic location) of property/casualty insurance risks whose coverages are not subject to subsection (b) of section two thousand three hundred five, section two thousand three hundred twenty-eight, section three thousand four hundred twenty-five, or three thousand four hundred forty-six of this chapter.

(2) "Rate" means charge per unit of exposure (whether such rate is manually generated or based upon judgment) for a particular market.

(b) The superintendent shall by regulation establish annual limitations upon rate level increases or decreases which may take effect without prior approval with respect to a market. The regulation shall be designed to restore and promote stability in such markets. Upon a determination made that, as to a particular market, competition is either sufficient to assure that rates will not be excessive or that such market is conducted in a manner not resulting in inadequate rates,

not destructive of competition or detrimental to the solvency of insurers, the superintendent shall exempt such market from the limitations set forth in such regulation. The superintendent, upon a determination that annual limitations are necessary to restore and promote stability in such a market, shall thereafter withdraw or modify such exemption. The superintendent shall whenever he deems it appropriate hold a hearing, on a record and at which representatives of consumers and other interested parties may participate, for the purpose of determining, on the basis of findings of fact and conclusions, whether an exemption (or withdrawal or modification thereof) of any market is appropriate. The initial hearing for such purpose shall be held within sixty days of the effective date of this section, and the superintendent shall act expeditiously in determining whether to exempt any market.

(c) Limitations established or modified pursuant to subsection (b) of this section may vary by market and, in establishing or modifying such limitations, the superintendent may consider such factors as: the extent and nature of competition; size and significance of the coverage; level and range of rates and rate changes among insurers; investment and underwriting experience of insurers; reinsurance availability; extent of consumer complaints to the department of financial services; extent of denials and restrictions of coverage; volume of cancellations and nonrenewals; or changing conditions in the economic, judicial and social environment.

(d) (1) Notwithstanding any other provisions of this article, in any market governed by such regulation and not exempted by the superintendent pursuant to this section, filings that produce rate level changes within the limitations specified in such regulation shall become effective without prior approval pursuant to subsection (a) of section two thousand three hundred five of this article; filings which produce rate level changes beyond such limitations shall not become effective until approved by the superintendent pursuant to subsection (b) of section two thousand three hundred five of this article, except that filings shall be deemed approved unless disapproved by the superintendent within thirty days, which the superintendent may with cause extend an additional thirty days and with further cause extend an additional fifteen days.

(2) No insurer shall cause an expiring policy to be renewed with another insurer under common control, as defined by paragraph sixteen of subsection (a) of section one hundred seven of this chapter in order to avoid the limitations established by this section. An insurer may renew an expiring policy with another insurer under common control based upon underwriting criteria or other valid business reasons.

(e) The superintendent shall by regulation establish reasonable standards for rating plans (including experience rating plans, schedule rating plans, individual risk premium modification plans and expense reduction plans) designed to modify rates in the development of premiums for individual risks insured in a property/casualty market. Such standards shall permit recognition of expected differences in loss or expense characteristics, and shall be designed so that such plans are reasonable and equitable in their application, and are not unfairly discriminatory, violative of public policy or otherwise contrary to the best interests of the people of this state. Such standards shall not prevent the development of new or innovative rating methods which otherwise comply with this article. Such rating plans shall be filed or refiled by insurers in compliance with the regulation. The superintendent shall review such plans, and may without a hearing disapprove a plan that does not comply with the regulation. The regulation shall establish maximum debits and credits that may result from the application of a rating plan, shall encourage loss control, safety programs and other methods of risk management, and shall require insurers to maintain documentation of the basis for the debits or credits applied under any plan. Once it has been filed and approved, use of the rating plan shall become mandatory and such plan shall be applied uniformly for eligible risks in a manner that is not unfairly discriminatory.

(f) The superintendent shall review all rates filed between June first, nineteen hundred eighty-six, and the effective date of the regulation promulgated pursuant to subsection (b) of this section, and shall, on a selective basis, review rates established prior to June first, nineteen hundred eighty-six, including rates not manually rated, to determine whether they comply with the applicable standards prescribed by this article for purposes of the annual limitations established or modified pursuant to subsection (b) of this section. In

establishing priorities for such selective review, the superintendent shall give consideration to markets which have been subject to the largest rate changes in the twelve month period prior to June first, nineteen hundred eighty-six and to markets affecting the greatest number of risks; the superintendent shall to the extent material also give consideration to the criteria set forth in subsection (c) of this section. In addition, the superintendent shall to the fullest extent possible review markets not manually rated, for the purpose of determining whether a manual rate is appropriate and shall, upon a determination of appropriateness, require that a manual rate be developed for such market. If the superintendent determines that the reviewed rate pursuant to the mandatory or selective review specified by this subsection does not comply with the applicable standards prescribed by this article, the insurer shall be afforded an opportunity to be heard and shall file in accordance with such determination prospective rates applicable to new and renewal policies. Except as to the procedures set forth in this subsection, nothing contained in this subsection shall be construed to alter, limit, modify, enlarge or abrogate any right of any insurer or any power or authority of the superintendent under any other provision of this chapter.

(g) (1) Within ninety days after the effective date of this section every insurer licensed to write property/casualty coverages in regard to a market not exempted pursuant to subsection (b) of this section and affected by the statutory provisions specified in this paragraph shall file with the superintendent rates, for each such market written by the insurer, appropriately modified to reflect the likely reductive cost effects reasonably attributable to any newly enacted statutory provisions of the civil practice law and rules, court of claims act and not-for-profit corporation law. Such filings shall contain a specific explanation of the reductive cost effects (which shall also be expressed in amounts or percentages) ascribed to such statutory provisions, in a form prescribed by the superintendent. In regard to a market not subject to this section or exempted pursuant to this section, subsequent filings shall reflect likely reductive cost effects reasonably attributable to such statutory provisions appropriate to such market.

(2) The superintendent shall determine whether the rates filed pursuant to paragraph one of this subsection reasonably reflect the

likely reductive cost effects attributable to the statutory provisions specified in paragraph one of this subsection.

(3) In the event that the superintendent determines that the likely reductive cost effects are not properly reflected in such rates, the basis for such determination shall be stated and, within thirty days after receipt of such determination, the affected insurer may request a hearing. All policies written or renewed on or after the effective date of the statutory provisions specified in paragraph one of this subsection shall be subject to appropriate premium adjustments in the event the superintendent's determination is sustained, and the insurer shall maintain its records in regard to each such policy for a period of no less than six years in order to verify that appropriate adjustments have been made.

(4) For purposes of the annual limitations established pursuant to subsection (b) of this section, the rates determined by the superintendent to reasonably reflect the likely reductive cost effects of the provisions specified in paragraph one of this subsection shall be treated as if they had been in effect for the twelve month period prior to the date of such determination.

(h) This section shall cease to be of any force or effect during the period August third, two thousand one through the day before the effective date of the property/casualty insurance availability act, and after June thirtieth, two thousand twenty-nine, except that rates shall reflect the likely reductive cost effects reasonably attributable to the statutory provisions specified in paragraph one of subsection (g) of this section.

* NB Expires July 1, 2029

§ 2345. Disclosure of premium reductions and surcharges.

(a) Every authorized insurer shall specify the nature of each premium reduction or surcharge applied on a non-commercial motor vehicle insurance policy.

(b) The insurer shall also specify the total dollar amount attributable to all surcharges and the dollar amount attributable to each reduction.

(c) The disclosures shall be made on either the premium bill, the

declarations page or a notice accompanying the premium bill or the declarations page, when the surcharge or reduction is initially made and thereafter at each policy renewal.

§ 2346. Reduction in rates of fire insurance, homeowners insurance or property/casualty premiums for residential property. 1. The superintendent may provide for a reduction in the rates of fire insurance premiums or the fire insurance component of homeowners insurance premiums applicable to residential real property equipped with smoke detecting alarm devices, approved sprinkler systems or fire extinguishers, should a statistically valid study of insurer experience indicate an actuarially significant decrease in losses in the aforementioned circumstances. The reductions provided for shall be proportionally related to the actuarially calculable decrease in losses in the aforementioned circumstances.

2. The superintendent may provide for a reduction in the rates of homeowners insurance premiums applicable to residential real property equipped with dead-bolt locks, should a statistically valid study of insurer experience indicate an actuarially significant decrease in losses attributable to the use of such a device. The superintendent shall by regulation establish standards for dead-bolt locks for which a reduction may be approved. The reductions provided for shall be proportionally related to the actuarially calculable decrease in losses attributable to the use of such a device.

3. The superintendent shall provide for an actuarially appropriate reduction in the rates of homeowner's insurance premiums applicable to residential real property fitted or retrofitted with hurricane/storm shutters. The superintendent shall by regulation establish standards for hurricane/storm shutters, including the safe and secure installation thereof.

4. The superintendent shall provide for an actuarially appropriate reduction in the rates of homeowner's insurance premiums applicable to residential real property fitted or retrofitted with hurricane resistant

laminated glass windows or doors. The superintendent shall by regulation establish standards for hurricane resistant laminated glass windows and doors, including the safe and secure installation thereof.

5. (a) Definitions. For the purposes of this subsection, the following terms shall have the following meanings:

(1) "Completion certificate" means a document which cannot be altered and which is provided to a person who successfully completes a homeowner natural disaster preparedness, home safety and loss prevention course.

(2) "Natural disaster" means the occurrence or imminent threat of widespread catastrophic or severe damage, injury, or loss of life or property resulting from any natural cause including, but not limited to, fire, flood, earthquake, hurricane, tornado, high water, landslide, mudslide, wind, storm, wave action, ice storm, epidemic, air contamination, blight, drought, infestation, explosion, water contamination, bridge failure, or bridge collapse.

(3) "Homeowner natural disaster preparedness, home safety and loss prevention course" means a natural disaster preparedness, home safety and loss prevention course that has been submitted to the superintendent for their information and review by an applicant. Such course may provide useful information to participants on items including, but not limited to: courses of action that can be taken before, during and after the occurrence of a natural disaster, strategies to reduce risk exposure to insured residential property owners and renters, and information about the installation of equipment, devices or other capital improvements to real property which can help to eliminate or mitigate damage to real or personal property, personal injury or the loss of life caused by a natural disaster or other insurable event or occurrence of a fire, theft, burglary, personal injury or property damage.

(4) "Applicant" means an insurer, or any other person, agency or organization which submits a proposed homeowner natural disaster preparedness, home safety and loss prevention course to the superintendent for their information and review, and who or which is prepared and able to offer such course to insureds upon the approval thereof.

(b) The superintendent may provide for an actuarially appropriate reduction for a period of three years in rates of homeowner's insurance

and property/casualty insurance premiums applicable to residential real property for each triennial completion of a homeowner natural disaster preparedness, home safety and loss prevention course by the insured occupant of such residential real property. In addition, the superintendent may also provide for actuarially appropriate reductions in such rates for the installation of equipment, devices or other capital improvements to real property which can help to eliminate or mitigate natural disaster damage, improve home safety or prevent other losses.

(c) An insurer, upon approval of the superintendent, may upon submission of a completion certificate by an insured, provide an actuarially appropriate reduction, for a period of three years, of the premium for such insured's homeowner's insurance or property/casualty insurance on the residential real property which is the insured's place of residence.

(d) The superintendent may establish, by rule or otherwise, standards or guidelines to be used by the superintendent when reviewing the proposed homeowner natural disaster preparedness, home safety and loss prevention courses.

§ 2346-a. Reduction in rates of certain commercial risk insurance premiums for real property. The superintendent shall provide for an actuarially appropriate reduction in the rates of premiums for certain commercial risk insurance, as defined in subparagraph (A) of paragraph forty-seven of subsection (a) of section one hundred seven of this chapter, to a purchaser of such insurance and shall also provide such reduction to a public entity as defined in paragraph fifty-one of subsection (a) of section one hundred seven of this chapter for the loss of or damage to real property fitted or retrofitted with hurricane resistant laminated glass windows or doors. The superintendent shall by regulation establish standards for hurricane resistant laminated glass windows and doors, including the safe and secure installation thereof.

§ 2347. Workers' compensation rate changes. (a) Any rate change affecting the general rate level for the kind of insurance authorized by

paragraph fifteen of subsection (a) of section one thousand one hundred thirteen of this chapter and pursuant to the provisions of section two thousand three hundred two of this article shall be approved by the department no later than the fifteenth day of July for the year in which the rate change is to take effect, provided that (1) the filing is submitted on or after the fifteenth day of April and before the fifteenth day of July of that same year, and (2) any such rate change shall not take effect until on or after October first of that same year.

(b) In all cases other than those described in subsection (a) of this section, rate filings shall be approved by the department not less than seventy-five days before the effective date of such rates filed.

(c) Every insurer shall notify any insured affected by a rate change subject to this section affecting the general rate level made by it of that change at least thirty days prior to the date of any billing for such rate change made by the insurer. Such notice shall include an estimate of the increase as well as an explanation of the nature of the increase, and cost factors associated with said increase.

(d) Premiums based upon a rate change subject to this section affecting the general rate level shall be payable by an insured on an installment basis of not less than two payments per policy period, should the insured so choose, for any policy with a premium in excess of one thousand dollars.

(e) The department shall make available to the public a list of rate changes subject to this section affecting the general rate level by industry classification within fifteen days from the date the department approves any rate changes.

§ 2348. Anti-theft and fraud savings. In the review and approval of rate filings submitted pursuant to section two thousand three hundred twenty-eight or section two thousand three hundred fifty of this article, the superintendent shall take steps appropriate to ensure that the rates of each insurer reflect that insurer's savings resulting from reduced theft and fraud due to the impact of anti-theft and anti-fraud programs supported by the New York motor vehicle theft and insurance fraud prevention fund.

§ 2349. Multi-tier program. (a) An insurer may make available a multi-tier program, with more than one rate level in the same company, for private passenger motor vehicle insurance in the voluntary market, provided that:

(1) the program and the insurer's business plan encourage depopulation of the assigned risk plan established by article fifty-three of this chapter;

(2) the program is based upon mutually exclusive underwriting rules per tier, to the extent feasible;

(3) credits and surcharges pursuant to an approved rating plan can be applied on a per tier basis; and

(4) the program conforms to regulations promulgated by the superintendent.

(b) For an insurer with an approved multi-tiering program, the provisions of subsection (f) of section three thousand four hundred twenty-five of this chapter shall apply in all respects, except that the two percent limitation set forth therein shall:

(1) not apply to any risk moved from a tier to a lower-rated tier; and

(2) be deemed to be three percent for risks moved from a tier to a higher-rated tier.

*** § 2350. Flexible rating for nonbusiness automobile insurance policies.** (a) Except as provided in subsection (b) of this section, overall average (for all coverages combined) rate level increases or decreases of five percent above or below the insurer's rates in effect may take effect without prior approval with respect to rates for policies covering losses or liabilities arising out of the ownership of a motor vehicle predominantly used for nonbusiness purposes, including classification plans predominantly consisting of vehicles used for nonbusiness purposes, when a natural person is the named insured under a policy of automobile insurance.

(b) Notwithstanding any other provisions of this article, for any policies governed by this section, filings that produce rate level changes within the limitation specified in subsection (a) of this section shall become effective without prior approval pursuant to

subsection (a) of section two thousand three hundred five of this article, provided however (1) that no more than two rate increases the total of which shall not exceed the limitation specified in subsection (a) of this section may be implemented during any twelve month period; and (2) no rate increase within the limitation specified in subsection (a) of this section may be implemented until the onset of the new policy period and unless the insurer, at least thirty but not more than sixty days in advance of the end of the policy period, mails or delivers to the named insured, at the address shown in the policy, a written notice of its intention to change the rate. The specific reason or reasons for the rate change shall be stated in or shall accompany the notice.

(c) The superintendent shall promulgate rules and regulations implementing the provisions of this section.

(d) The superintendent shall monitor the degree and continued existence of competition and the effectiveness of flexible rating in this state on an on-going basis. In doing so, the superintendent shall utilize the following standards or factors:

(1) the standards contained in section two thousand three hundred eight of this article;

(2) existing relevant information, analytical systems and other sources, or rely on some combination thereof;

(3) the number of insurers or group of affiliated insurers actively engaged in providing coverage, taking into account the specialization traditionally required for insurance in the particular rating territory;

(4) measures of market concentration and changes of market concentration over time, which may include the use of Herfindahl-Hirschman Index (HHI) and the United States Department of Justice merge guidelines for an unconcentrated market ease of entry, and the existence of financial or economical barriers that could prevent new firms from entering the market;

(5) the extent to which any insurer or group of affiliated insurers controls all or a dominant portion of the market has actively sought to prevent competition;

(6) whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options;

(7) the availability of insurance coverage to consumers;

(8) the opportunities available to consumers in the market to acquire

pricing and other consumer information; and

(9) any other factions relevant to inquiry.

Such activities may be conducted internally within the department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner.

* NB Effective until November 27, 2026

* § 2350. Flexible rating for nonbusiness automobile insurance policies. (a) Except as provided in subsection (b) of this section, overall average (for all coverages combined) rate level decreases of five percent below the insurer's rates in effect may take effect without prior approval with respect to rates for policies covering losses or liabilities arising out of the ownership of a motor vehicle predominantly used for nonbusiness purposes, including classification plans predominantly consisting of vehicles used for nonbusiness purposes, when a natural person is the named insured under a policy of automobile insurance.

(b) Notwithstanding any other provisions of this article, for any policies governed by this section, filings that produce rate level changes within the limitation specified in subsection (a) of this section shall become effective without prior approval pursuant to subsection (a) of section two thousand three hundred five of this article.

(c) The superintendent shall promulgate rules and regulations implementing the provisions of this section.

(d) The superintendent shall monitor the degree and continued existence of competition and the effectiveness of flexible rating in this state on an on-going basis. In doing so, the superintendent shall utilize the following standards or factors:

(1) the standards contained in section two thousand three hundred eight of this article;

(2) existing relevant information, analytical systems and other sources, or rely on some combination thereof;

(3) the number of insurers or group of affiliated insurers actively engaged in providing coverage, taking into account the specialization traditionally required for insurance in the particular rating territory;

(4) measures of market concentration and changes of market

concentration over time, which may include the use of Herfindahl-Hirschman Index (HHI) and the United States Department of Justice merge guidelines for an unconcentrated market ease of entry, and the existence of financial or economical barriers that could prevent new firms from entering the market;

(5) the extent to which any insurer or group of affiliated insurers controls all or a dominant portion of the market has actively sought to prevent competition;

(6) whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options;

(7) the availability of insurance coverage to consumers;

(8) the opportunities available to consumers in the market to acquire pricing and other consumer information; and

(9) any other factions relevant to inquiry.

Such activities may be conducted internally within the department, in cooperation with other state insurance departments, through outside contractors and/or in any other appropriate manner.

* NB Effective November 27, 2026

* NB Repealed May 27, 2030

§ 2351. Homeowners' insurance policies. (a) For the purposes of this section, "homeowners insurance" means a contract of insurance insuring against the contingencies described in subparagraphs (A), (B) and (C), or (B) and (C) of paragraph two of subsection (a) of section three thousand four hundred twenty-five of this chapter and which is a "covered policy" of personal lines insurance as defined in such paragraph; provided, however, that the coverages provided under such subparagraphs (B) and (C) shall not apply where the natural person does not have an insurable interest in the real property, or a portion thereof, or the residential unit in which such person resides.

(b) Multi-tier programs. An insurer may make available a multi-tier program with more than one rate level in the same company for homeowners' insurance in the voluntary market provided that:

(1) the program and the insurer's business plan encourage availability of homeowners' insurance in the voluntary market for insureds in high

risk areas, including coastal areas;

(2) the program is based upon mutually exclusive and objective eligibility rules per tier, to the extent feasible; and

(3) credits can be applied on a per tier basis pursuant to an approved rating plan.

(c) Prior to the approval of the provision authorized in subsection (b) of this section, the superintendent may promulgate rules and regulations governing the application of such provision.

§ 2352. Multiple rating programs. (a) Subject to the superintendent's prior approval, an insurer may establish more than one rating program within the same company for policies of insurance that are subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this chapter; provided that:

(1) each rating program shall apply only to policies newly written on or after the effective date of the rating program but prior to the effective date of any subsequently approved rating program; provided however if an insurer terminates a rating program, then the insurer shall renew the policies that were subject to the terminated rating program in a subsequently approved rating program.

(2) the provisions of subsection (f) of section three thousand four hundred twenty-five and subsection (b) of section two thousand three hundred forty-nine of this chapter shall be applied to each rating program to which they are applicable separately.

(b) The superintendent may promulgate rules and regulations to implement the provisions of this section.

§ 2353. For-hire motor vehicle safety program; reduction in rates of certain commercial risk insurance premiums for motor vehicles. (a) For the purposes of this section, an association shall mean an association where all the eligible members of the association have the same profession, trade, or occupation, and the association has been organized and maintained in good faith for purposes principally other than that of obtaining insurance, and has been in active existence for at least two years.

(b) An association representing motor vehicles engaged in the business of carrying or transporting passengers for-hire, having a seating capacity of not less than eight passengers, shall be authorized to create and implement a comprehensive educational program designed to advance for-hire motor vehicle safety, which provides for the training of all operators in the safe operation of for-hire motor vehicles, education about safety equipment that can enhance the safe operation of vehicles, and training related to passenger safety. Such program shall include, but not be limited to, instruction which addresses the following subject areas:

(1) the concept of collision prevention, including a discussion of the factors involved in traffic situations;

(2) alcohol and drug use as a contributing factor in motor vehicle collisions;

(3) accident prevention techniques;

(4) the use of occupant restraints;

(5) the risk factors involved in driver attitude and behavior such as speeding, reckless and aggressive driving, and improper lane use;

(6) traffic laws in New York state;

(7) physical and mental condition of drivers;

(8) conditions and strategies of driving;

(9) safe driving techniques in hazardous weather conditions including rain, wind, snow, ice, sleet and fog;

(10) equipment that can enhance the safe operation of vehicles; and

(11) passenger safety including but not limited to recommending the use of seat belts to passengers, warning passengers to exercise care when boarding and exiting a vehicle and notifying passengers of emergency exits if applicable.

(c) The association described in subsection (b) of this section shall provide a certificate to members of such association who successfully complete a course of instruction on for-hire vehicle safety as authorized pursuant to this section.

(d) The superintendent shall provide for an actuarially appropriate reduction for a period of three years in the rates of premiums for commercial risk insurance applicable to motor vehicles engaged in the business of carrying or transporting passengers for-hire, having a seating capacity of not less than eight passengers, for each triennial

completion of a course of instruction on for-hire motor vehicle safety as authorized pursuant to this section. The commissioner of motor vehicles shall evaluate and approve any for-hire vehicle safety program created pursuant to this section within sixty days of the effective date of this section.

(e) An authorized insurer shall, upon submission of a certificate by an insured evidencing that such insured has completed a course of instruction on for-hire motor vehicle safety as authorized pursuant to this section, provide an actuarially appropriate reduction, for a period of three years, of the premium for such insured's commercial risk insurance applicable to motor vehicles engaged in the business of carrying or transporting passengers for-hire, having a seating capacity of not less than eight passengers.

(f) Any insured who successfully completes a course of instruction on for-hire motor vehicle safety pursuant to this section and receives a premium reduction on the insured's commercial risk insurance policy covering the for-hire vehicle shall not, during the period set forth in subsection (e) of this section, also be eligible for an additional premium reduction on the insured's commercial risk insurance policy covering the for-hire vehicle for successful completion of the motor vehicle accident prevention course, known as the national safety council's defensive driving course, or any driver improvement course approved by the department of motor vehicles as being equivalent to the national safety council's defensive driving course, authorized under section two thousand three hundred thirty-six of this article.

(g) The superintendent may promulgate any rules and regulations necessary to implement the provisions of this section.

§ 2356. Premium change explanations. (a) An insurer shall include a notice accompanying the premium bill that includes the amount of the premium increase from the prior policy period and a written explanation for the premium increase, including the primary rating factors causing the increase, for a covered policy as defined in paragraph one and in subparagraph (A) of paragraph two of subsection (a) of section three thousand four hundred twenty-five of this chapter, where the total policy premium increase is in excess of ten percent, exclusive of any

premium increase due to insured value added.

(b) (1) Except when an insurer provides an explanation pursuant to subsection (a) of this section, an insurer shall include a prominent notice accompanying the premium bill, for a policy covering a motor vehicle or a policy covering loss of or damage to real property used predominantly for residential purposes, that states the following: "Policyholders receiving an increase to their premiums at renewal may request a written explanation, including the primary rating factors causing the increase, by contacting their insurers in writing." An insurer shall include its contact information with the prominent notice.

(2) Upon a policyholder's written request at policy renewal, an insurer shall provide a written explanation for the increased premiums, including the primary rating factors causing the increase, for a policy covering a motor vehicle or a policy covering loss of or damage to real property used predominantly for residential purposes. An insurer shall provide the written explanation to the policyholder, including the primary rating factors causing the increase, within twenty days from receipt of the policyholder's written request.

(c) For the purpose of this section, primary rating factors shall include factors that resulted in a premium rate increase, such as:

(1) individual claims history;

(2) changes made to the policy, including the policyholder adding or replacing a vehicle, family members being added to the policy, or a change in address;

(3) anticipated losses in the rating territory that would require a need for an increased premium; and

(4) increased costs associated with claims, including the increased cost of vehicle repairs, claims processing, or medical costs.

(d) If an insurer offering a private passenger automobile insurance policy reduces premium rates due to the reforms of the state fiscal year two thousand twenty-six -- two thousand twenty-seven budget, such insurer shall provide notice to the policyholder of this rate reduction and indicate that the reduction was due to the reforms of the state fiscal year two thousand twenty-six -- two thousand twenty-seven budget.

ARTICLE 24

UNFAIR METHODS OF COMPETITION AND UNFAIR AND DECEPTIVE ACTS AND PRACTICES

Section 2401. Purpose.
2402. Definitions.
2403. Unfair methods of competition or unfair and deceptive acts or practices prohibited.
2404. Power of superintendent.
2405. Hearings and reports on defined violations and determined violations.
2406. Procedure after report; defined violation.
2407. Procedure after report; determined violation.
2408. Judicial review by intervenor.
2409. Effect on other powers and laws.

§ 2401. Purpose. The purpose of this article is to regulate trade practices in the business of insurance, including the business of life settlements, in accordance with the intent of congress as expressed in Public Law 15, 79th Congress, by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

§ 2402. Definitions. In this article: (a) "Person" means any individual and any legal entity subject to any provision of this chapter, engaged in the business of insurance in this state, including any reciprocal exchange or Lloyds insurer, or in the business of life settlements.

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two

thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, two thousand nine hundred two, two thousand nine hundred five, three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, seven thousand eight hundred ten, seven thousand eight hundred eleven, seven thousand eight hundred thirteen, seven thousand eight hundred fourteen and seven thousand eight hundred fifteen of this chapter; or section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one hundred five of the penal law.

(c) "Determined violation" means any unfair method of competition or any unfair or deceptive act or practice, which is not a defined violation but is determined by the superintendent pursuant to section two thousand four hundred five of this article to be such method, act or practice.

§ 2403. Unfair methods of competition or unfair and deceptive acts or practices prohibited. No person shall engage in this state in any trade practice constituting a defined violation or a determined violation as defined herein.

§ 2404. Power of superintendent. The superintendent is empowered to examine and investigate into the affairs of any person in order to determine whether the person has violated or is violating section two thousand four hundred three of this article. In the event any person does not provide a good faith response to a request for information from the superintendent, within a time period specified by the superintendent

of not less than fifteen business days, as part of an examination or investigation initiated by the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance or health maintenance organization coverage, the superintendent is authorized, after notice and hearing, to levy a civil penalty against such person in an amount not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response, but in no event shall such penalty exceed ten thousand dollars. In the event the superintendent levies five separate civil penalties against any one person within five years for failure to comply with this section, the superintendent is authorized, after notice and hearing, to levy an additional civil penalty against such person in an amount not to exceed fifty thousand dollars. The superintendent is also authorized to levy additional civil penalties not to exceed fifty thousand dollars, after notice and hearing, against such person for every five subsequent violations of this section within a five year period. Any person licensed pursuant to article twenty-one of this chapter may surrender such license in lieu of payment of any civil penalty imposed by the superintendent pursuant to this section.

§ 2405. Hearings and reports on defined violations and determined violations. (a) Whenever the superintendent has reason to believe that a person has committed or is committing a defined violation or has been engaged in or is engaging in any method of competition, or any act or practice, could become a determined violation and that a proceeding thereon would be in the interest of the public, the superintendent shall serve upon the person in the manner provided by section three hundred four of the financial services law, a statement of the charges and notice of a hearing to be held at a time not less than ten days after the date of service of the notice and at the place fixed in the notice.

(b) The person shall have an opportunity at the hearing to be heard personally or by counsel, and, in the case of a defined violation, to show cause why an order should not be made by the superintendent requiring the person to cease and desist from the charged defined violation. Upon good cause shown, the superintendent shall permit anyone to intervene, appear and be heard at the hearing personally or by

counsel.

(c) After the hearing, the superintendent shall make a written report containing the superintendent's findings, and shall serve a copy of the report upon the person and any intervenor.

§ 2406. Procedure after report; defined violation. (a) If the hearing was on a charge of a defined violation the superintendent shall make an order on his report and serve a copy of the findings and order upon the person charged with the violation and any intervenor. If the superintendent finds that the person complained of has engaged in a defined violation, the order shall require the person to cease and desist from engaging in such defined violation. Furthermore, if the superintendent finds, after notice and hearing, that the person complained of has engaged in an act prohibited by section three thousand two hundred twenty-four-a of this chapter, the superintendent is authorized to levy a civil penalty against such person in an amount up to five hundred dollars per day for each day beyond the date that a bill or claim was to be processed in accordance with section three thousand two hundred twenty-four-a of this chapter, but in no event shall such penalty exceed five thousand dollars.

(b) Until a proceeding for judicial review has been commenced, or the time to commence the proceeding has expired, the superintendent may, upon notice and in the manner he deems proper, modify or set aside all or part of any order issued by him under this section.

(c) If a proceeding for judicial review has not been commenced within the time allowed, the superintendent may, after notice and opportunity for hearing, modify or set aside, all or part, of any order issued by him under this section, whenever in his opinion changed conditions of fact or law or the public interest require.

(d) A cease and desist order issued under this section is final upon the expiration of the time allowed for commencing a proceeding for judicial review if no proceeding has been commenced within such time, or upon the final decision of the court affirming the order or dismissing the proceeding.

(e) Any person who violates a cease and desist order issued by the superintendent under this section after it has become final, and while

it is in effect, shall be liable to the people of this state for a penalty in an amount not to exceed five thousand dollars for each violation. In determining the amount of the penalty the question of whether the violation was wilful shall be taken into consideration. Nothing herein shall limit a court in enforcing its own orders.

§ 2407. Procedure after report; determined violation. (a) If the report charges a determined violation and if the method of competition, act or practice constituting such determined violation has not been discontinued, the superintendent may, through the attorney general, at any time after the service of the report cause an action to be instituted to enjoin the person from engaging in such determined violation.

(b) The court may on motion and affidavits grant a preliminary injunction and interlocutory injunction upon such terms as may be just.

(c) A certified transcript of the proceedings before the superintendent including all evidence taken and the report and findings shall be received in evidence in the action.

§ 2408. Judicial review by intervenor. If the report of the superintendent made pursuant to subsection (c) of section two thousand four hundred five of this article or the order of the superintendent made pursuant to subsection (a) of section two thousand four hundred six of this article does not charge a violation of this article, then any intervenor in the proceedings may, after the service of such report or order upon the intervenor and within the time allowed by law, commence a proceeding for judicial review.

§ 2409. Effect on other powers and laws. (a) The powers vested in the superintendent by this article shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices defined in section two thousand four hundred two of this article as defined violations or determined violations.

(b) No order of the superintendent under this article or order of a court to enforce the same shall in any way relieve any person affected by the order from any liability under any other law.

ARTICLE 25

PROHIBITIONS AGAINST CONTROLLED BUSINESS

Section 2502. Designation of particular insurer, agent or broker in property financing transactions and other unfair practices.
2503. Designation of particular insurer, agent, broker or fund for insurance provided to discharge statutory requirement.
2504. Designation of particular insurer, agent or broker for insurance in certain public construction contracts.
2505. Designation of particular insurer, agent or broker for construction contracts generally.

*** § 2502. Designation of particular insurer, agent or broker in property financing transactions and other unfair practices.** (a)(1) No person, firm, or corporation engaged in the business of financing the purchase of real or personal property, lending money on the security thereof, or servicing a mortgage thereon, and none of its trustees, directors, officers, agents or other employees, shall require, as a condition precedent to financing any such purchase or making any such loan or renewing or extending any such loan or mortgage or performing any other act in connection therewith, that the person, firm or corporation for whom the transaction is undertaken negotiate any policy of insurance or renewal thereof covering such property through a particular insurance company, agent or broker.

(2) State chartered banking institutions and federally chartered banking institutions shall not extend credit, lease or sell property of any kind, or furnish any services, or fix or vary the consideration for any of the foregoing, on the condition or requirement that the customer obtain insurance from such institution, its affiliate or subsidiary, or a particular insurer, agent or broker, provided, however, that this

prohibition shall not prevent such institution from engaging in any activity described in this subdivision that would not violate section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. This prohibition shall not prevent a state chartered banking institution or federally chartered banking institution from informing a customer that insurance is required in order to obtain a loan or credit, that loan or credit approval is contingent upon the customer's procurement of acceptable insurance, or that insurance is available from such institution; provided, however, that the state chartered banking institution or the federally chartered banking institution shall also inform the customer in writing that his or her choice of insurance provider shall not affect the institution's credit decision or credit terms in any way. Such disclosure shall be given prior to or at the time that any such institution or person selling insurance on the premises thereof solicits the purchase of any insurance from a customer who has applied for a loan or extension of credit.

(b) This section shall not prevent the exercise of any right to approve or disapprove of the insurance company selected to underwrite the insurance, except that in exercising such right, whether pursuant to this section or any other law, such person, firm, or corporation and its trustees, directors, officers, agents and employees shall not:

(1) discriminate against an insurance company which issues a policy of insurance that is non-assessable as to any designated mortgagee or any secured creditor designated as a loss payee because of the insurer's type of organization, or

(2) refuse to accept an insurance policy because it was not negotiated through a particular insurance company, agent or broker.

(c) No such person, firm or corporation shall, in connection with compliance with a covenant to insure, require that the person, firm or corporation for whom the purchase of the property is financed or to whom a mortgage loan is made or who owns the property shall pay a fee or other charge as a condition to accepting, during the unexpired term of a policy then held, another policy of insurance in substitution therefor. No state chartered banking institution or federally chartered banking institution shall require a debtor, insurer, or insurance agent or broker to pay a separate charge in connection with the handling of

insurance that is required in connection with a loan or other extension of credit or the provision of another traditional banking product solely because the insurance is being provided by an insurance agent or broker which is not the state chartered banking institution or federally chartered banking institution or any subsidiary or affiliate thereof.

(d) Except with respect to a flood insurance policy or a credit unemployment insurance policy, group credit life insurance policy, a group credit health, group credit accident or group credit health and accident policy, or similar group credit insurance covering the person of the insured, when a customer obtains insurance and credit from a state chartered banking institution or federally chartered banking institution, then the credit and insurance transactions shall be completed through separate documents. The expense of insurance premiums may not be included in the primary credit transaction without the express written consent of the customer.

(e) Any state chartered banking institution or federally chartered banking institution and any subsidiary or affiliate thereof which is licensed to sell insurance in this state shall maintain separate and distinct books and records relating to its insurance transactions, including all files relating to and reflecting consumer complaints, and such insurance books and records shall be made available to the superintendent for inspection upon reasonable notice.

(f) For the purposes of this section, the terms "state chartered banking institution" and "federally chartered banking institution" shall have the same meanings as set forth in subdivision one of section twelve-a of the banking law.

* NB Effective until September 10, 2029

* § 2502. Designation of particular insurer, agent or broker in property financing transactions. (a) No person, firm or corporation engaged in the business of financing the purchase of real or personal property, lending money on the security thereof, or servicing a mortgage thereon, and none of its trustees, directors, officers, agents or other employees, shall require, as a condition precedent to financing any such purchase or making any such loan or renewing or extending any such loan or mortgage or performing any other act in connection therewith, that the person, firm or corporation for whom the transaction is undertaken negotiate any policy of insurance or renewal thereof covering such

property through a particular insurance company, agent or broker.

(b) This section shall not prevent the exercise of any right to approve or disapprove of the insurance company selected to underwrite the insurance, except that in exercising such right, whether pursuant to this section or any other law, such person, firm, or corporation and its trustees, directors, officers, agents and employees shall not:

(1) discriminate against an insurance company which issues a policy of insurance that is non-assessable as to any designated mortgagee or any secured creditor designated as a loss payee because of the insurer's type of organization, or

(2) refuse to accept an insurance policy because it was not negotiated through a particular insurance company, agent or broker.

(c) No such person, firm or corporation shall, in connection with compliance with a covenant to insure, require that the person, firm or corporation for whom the purchase of the property is financed or to whom a mortgage loan is made or who owns the property shall pay a fee or other charge as a condition to accepting, during the unexpired term of a policy then held, another policy of insurance in substitution therefor.

* NB Effective September 10, 2029

§ 2503. Designation of particular insurer, agent, broker or fund for insurance provided to discharge statutory requirement. No person, firm or corporation who or which shall be the primary beneficiary of insurance provided in discharge of any statutory requirement of this state, and no representative of any primary beneficiary of such insurance, shall require anyone obligated to comply with such statutory requirement, to obtain such insurance from a particular insurance company, insurance fund of this state, agent, or broker.

§ 2504. Designation of particular insurer, agent or broker for insurance in certain public construction contracts. (a) (1) No officer or employee of this state, or of any public corporation as defined in section sixty-six of the general construction law, or of any public authority, and no person acting or purporting to act on behalf of such officer, employee, public corporation or public authority, shall, with

respect to any public building or construction contract which is about to be, or which has been, competitively bid, require the bidder to make application to any particular insurance company, agent or broker for or to obtain or procure therefrom, any surety bond or contract of insurance specified in connection with such contract, or specified by any law, general, special or local.

(2) In paragraph one hereof, "public corporation" and "public authority" shall not include:

(A) a public corporation or public authority created pursuant to agreement or compact with another state,

(B) the city of New York, a public corporation or public authority, in connection with the construction of electrical generating and transmission facilities or construction, extensions and additions of light rail or heavy rail rapid transit and commuter railroads,

(C) the city of New York, the city school district of the city of New York, the New York city industrial development agency, the New York city health and hospitals corporation, or the New York city housing authority, in connection with a contract the principal purpose of which is construction that (i) has an estimated cost of no less than five million dollars or (ii) is subject to an owner-controlled insurance program for projects, provided that any contract undertaken pursuant to this subparagraph that has an estimated cost of five million dollars or more may only be undertaken pursuant to a project labor agreement as such term is defined in section two hundred twenty-two of the labor law,

(D) the state department of transportation in connection with a contract or contracts, the principal purpose of which is construction or reconstruction of state route 33, also known as the Kensington Expressway, and the Humboldt Parkway, in the city of Buffalo, that (i) has an estimated cost of no less than five million dollars, or (ii) that is subject to an owner-controlled insurance program for projects, provided that any contract undertaken pursuant to this subparagraph may only be undertaken pursuant to a project labor agreement as such term is defined in section two hundred twenty-two of the labor law,

(E) the state university of New York at Buffalo, in coordination with the state university construction fund as created pursuant to article eight-A of the education law, the principal purpose of which is construction at the state university of New York at Buffalo and shall

include without limitation the empire AI research institute authorized pursuant to section three hundred sixty-one of the economic development law, in connection with a contract or contracts that (i) has an estimated cost of no less than five million dollars, or (ii) that is subject to an owner-controlled insurance program for projects, provided that any contract undertaken pursuant to this subparagraph may only be undertaken pursuant to a project labor agreement as such term is defined in section two hundred twenty-two of the labor law, or

(F) the Niagara Frontier transportation authority as established pursuant to article five of the public authorities law in connection with a contract or contracts, the principal purpose of which is construction to extend or expand the railroad in the Niagara Frontier transportation district, that (i) has an estimated cost of no less than five million dollars, or (ii) that is subject to an owner-controlled insurance program for projects, provided that any contract undertaken pursuant to this subparagraph may only be undertaken pursuant to a project labor agreement as such term is defined in section two hundred twenty-two of the labor law.

(b) No such officer or employee, and no person, firm or corporation acting or purporting to act on behalf of such officer or employee, shall negotiate, make application for, obtain or procure any of such surety bonds or contracts of insurance (except contracts of insurance for builders risk or owners protective liability) which can be obtained or procured by the bidder, contractor or subcontractor.

(c) This section shall not, however, prevent the exercise by such officer or employee on behalf of the state or such public corporation or public authority of its right to approve the form, sufficiency, or manner of execution, of surety bonds or contracts of insurance furnished by the insurance company selected by the bidder to underwrite such bonds or contracts. Any provisions in any invitation for bids, or in any of the contract documents, in conflict herewith are contrary to the public policy of this state.

§ 2505. Designation of particular insurer, agent or broker for construction contracts generally. (a) In any building or construction contract bid, negotiated or executed except as described in section two

thousand five hundred four of this article, no contractor or subcontractor shall be required to pay premiums or related charges for policies of insurance or surety bonds specified in connection with such contract on policies or surety bonds acquired by an owner or other contractor. No contractor or subcontractor shall be required to make application to any particular insurance company, agent or broker for, or to obtain or procure therefrom, any policy of insurance or surety bond specified in connection with such contract, or specified by any law, general, special or local.

(b) This section shall not, however, prevent an owner or other contractor from providing all insurance policies or surety bonds required by such contract without reimbursement from the contractor or subcontractor. Nor shall it preclude such owner or contractor from requiring that the contractor or subcontractor provide a credit in his bid which reflects the amount the bidding contractor or subcontractor would otherwise add if he provided his own insurance as required in the bid specifications. This section shall not deny an owner or contractor the right to approve the form, sufficiency, or manner of execution, of any insurance policies or surety bonds furnished by the insurance company selected by the bidder.

ARTICLE 26

UNFAIR CLAIM SETTLEMENT PRACTICES; OTHER MISCONDUCT; DISCRIMINATION

Section 2601. Unfair claim settlement practices; penalties.
2602. Rebates on life insurance; witnesses' immunity.
2603. Issue or circulation of false literature.
2604. False statements as to insurers.
2605. Penalty for violating workers' compensation law.
2606. Discrimination because of race, color, creed, national origin, or disability.
2607. Discrimination because of sex or marital status.
2608. Discrimination because of treatment for a mental disability.
2608-a. Discrimination in enrollment against certain children.
2609. Discrimination in the issuance of performance or surety bonds.

2610. Collision or comprehensive coverage on motor vehicles; claims; repairs.
2610-a. Rental vehicle reimbursement coverage.
2611. HIV written informed consent.
2612. Discrimination based on being a victim of domestic violence.
2613. Eligibility for life and disability insurance for persons with a history of any type of cancer.
2614. Discrimination because of past lawful travel.
2615. Genetic testing written informed consent.
2616. Discrimination because of status as a living organ or tissue donor.
2617. Unfair discrimination for the use of prescriptions to block the effects of opioids.
2618. Standards for prompt investigation and settlement of claims.

§ 2601. Unfair claim settlement practices; penalties. (a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:

(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;

(5) compelling policyholders to institute suits to recover amounts due

under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) failing to promptly disclose coverage pursuant to subsection (d) or subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter;

(7) submitting reasonably rendered claims to the independent dispute resolution process established under article six of the financial services law; or

(8) artificially deflating or otherwise lowering cost data used for adjusted claims, or using cost data that is not appropriate for the region of the state where the loss occurred; this shall include but is not limited to claims adjusted by a person issued a temporary permit pursuant to subsection (n) of section two thousand one hundred eight of this chapter.

(b) Evidence as to numbers and types of complaints to the department against an insurer and as to the department's complaint experience with other insurers writing similar lines of insurance shall be admissible in evidence in any administrative or judicial proceeding under this section or article twenty-four or seventy-four of this chapter, but no insurer shall be deemed in violation of this section solely by reason of the numbers and types of such complaints.

(c) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance with subsection (a) hereof may be treated as a separate violation of this section for purposes of ordering a monetary penalty pursuant to subsection (b) of section one hundred nine of this chapter. A violation of this section shall not be a misdemeanor.

§ 2602. Rebates on life insurance; witnesses' immunity. (a) No person shall knowingly receive any rebate or allowance or deduction from any premium, or any valuable thing, special favor or advantage whatever not specified in the policy, as an inducement to take any policy of life insurance.

(b) In any criminal proceeding before any court or grand jury for a violation of this section, the court or grand jury may confer immunity in accordance with the provisions of section 50.20 or 190.40 of the

criminal procedure law.

§ 2603. Issue or circulation of false literature. No insurance corporation, or any officer, director or agent thereof, shall issue or circulate, or cause or permit to be issued or circulated, in this state any illustration, circular or statement indicating the corporation can transact in this state any business of a character except that which it is authorized to transact under its certificate of authority issued by the superintendent.

§ 2604. False statements as to insurers. No person shall either (i) wilfully make, circulate or transmit to another any statement written, printed or by word of mouth, which is untrue in fact and is directly or by inference derogatory to the financial condition, or affects the solvency or financial standing, of any insurer doing business in this state, or (ii) knowingly counsel, aid, procure or induce another to start, transmit or circulate any such statement.

§ 2605. Penalty for violating workers' compensation law. The superintendent may impose a penalty not to exceed twenty-five hundred dollars upon any insurer required to be licensed under the provisions of this chapter, if, after notice to and a hearing of such insurer, he finds it has unreasonably failed to comply with the workers' compensation law.

§ 2606. Discrimination because of race, color, creed, national origin, or disability. (a) Except as provided in section one thousand one hundred eight of this chapter, no individual or entity subject to the supervision of the superintendent shall because of race, color, creed, national origin, or disability:

(1) Make any distinction or discrimination between persons as to the premiums or rates charged for insurance policies or in any other manner whatever.

(2) Demand or require a greater premium from any persons than it requires at that time from others in similar cases.

(3) Make or require any rebate, discrimination or discount upon the amount to be paid or the service to be rendered on any policy.

(4) Insert in the policy any condition, or make any stipulation, whereby the insured binds themselves, or their heirs, executors, administrators or assigns, to accept any sum or service less than the full value or amount of such policy in case of a claim thereon except such conditions and stipulations as are imposed upon others in similar cases; and any such stipulation or condition so made or inserted shall be void.

(b) Except as provided in section one thousand one hundred eight of this chapter, no individual or entity subject to the superintendent's supervision shall solely because of the applicant's race, color, creed, national origin, or disability:

(1) Reject any application for a policy of insurance issued and/or sold by it.

(2) Refuse to issue, renew or sell such policy after appropriate application therefor.

(3) Fix any lower rate or discriminate in the fees or commissions of agents or brokers for writing or renewing such a policy.

(c) For the purposes of this section "disability" shall have the same meaning as ascribed thereto in subdivision twenty-one of section two hundred ninety-two of the executive law.

(d) The prohibition of subsection (a) of this section shall not preclude an insurer from including a pre-existing condition provision as permitted pursuant to regulations of the superintendent or from establishing selection criteria on the basis of disability where the insurer can prove that its decision was based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience. In such case the selection criteria permitted must be based on such principles. The insurer shall notify the insured of its specific reason or reasons for such decision.

(e) If it can be proven that the provisions of subsection (d) of this section are inadequate to address such actual or anticipated loss experience, the prohibition of subsection (b) of this section shall not preclude an insurer from establishing selection criteria on the basis of

disability. In such case the selection criteria permitted must be based on such principles. The insurer shall notify the insured of its specific reason or reasons for such decision.

(f) Nothing in this section shall permit an insurer to include a pre-existing condition provision or establish selection criteria for individual and small group health insurance policies which are inconsistent with sections three thousand two hundred thirty-one, three thousand two hundred thirty-two, four thousand three hundred seventeen and four thousand three hundred eighteen of this chapter.

§ 2607. Discrimination because of sex or marital status. (a) No individual or entity shall refuse to issue any policy of insurance, or cancel or decline to renew the policy because of the sex or marital status of the applicant or policyholder or engage in sexual stereotyping.

(b) For the purposes of this section, "sex" shall include sexual orientation, gender identity or expression, and transgender status.

§ 2608. Discrimination because of treatment for a mental disability. (a) No individual or entity shall refuse to issue or renew, or shall cancel any policy of insurance because of any past treatment for a mental disability of the insured.

(b) The prohibition of subsection (a) hereof shall not preclude an insurer from refusing to issue or renew or from cancelling a policy based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience. The insurer shall notify the insured or his physician of its specific reason or reasons for refusal to issue or renew or for cancelling such policy.

(c) In this section, mental disability has the meaning defined in subdivision three of section 1.03 of the mental hygiene law.

§ 2608-a. Discrimination in enrollment against certain children. (a) No employer, health insurer, group health plan, health maintenance organization, or other entity offering medical benefits whether by

insurance or otherwise, including an employee retirement income security act or service benefit plan, shall deny enrollment of a child under the health coverage of the child's parent on the ground that:

(i) the child was born out of wedlock,

(ii) the child is not claimed as a dependent on the parent's federal income tax return, or

(iii) the child does not reside with the parent or in the insurer's service area.

(b) Any inconsistent provisions of this title or other law notwithstanding, any insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent, shall:

(i) provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(ii) permit the custodial parent, or a health care provider with the custodial parent's approval, to submit claims for covered services without the approval of the non-custodial parent; and

(iii) make payment on claims directly to such custodial parent, the provider, or the social services district furnishing medical assistance to a child.

§ 2609. Discrimination in the issuance of performance or surety bonds. No person, firm or corporation engaged in the business of issuing performance or surety bonds shall refuse to issue such a bond to any person, firm or corporation, solely because of the race, creed, color, sex, national origin, age or marital status of the applicant.

§ 2610. Collision or comprehensive coverage on motor vehicles; claims; repairs. (a) Whenever a motor vehicle collision or comprehensive loss shall have been suffered by an insured, no insurer providing collision or comprehensive coverage therefor shall require that repairs be made to such vehicle in a particular place or shop or by a particular concern.

(b) In processing any such claim (other than a claim solely involving window glass), the insurer shall not, unless expressly requested by the insured, recommend or suggest repairs be made to such vehicle in a particular place or shop or by a particular concern.

(c) The insurer shall provide (other than a claim solely involving window glass) a copy of its repair estimate to the insured that includes the following disclosure, plainly printed in no less than 12 point type: "PURSUANT TO SECTION 2610 OF THE INSURANCE LAW, AN INSURANCE COMPANY CANNOT REQUIRE THAT REPAIRS BE MADE TO A MOTOR VEHICLE IN A PARTICULAR PLACE OR REPAIR SHOP. YOU HAVE THE RIGHT TO HAVE YOUR VEHICLE REPAIRED IN THE SHOP OF YOUR CHOICE".

§ 2610-a. Rental vehicle reimbursement coverage. (a) For the purposes of this section, "rental vehicle reimbursement coverage" shall mean coverage for the cost of renting a vehicle used as substitute transportation if the insured vehicle is damaged and is temporarily out of use due to a covered loss, until such vehicle is repaired or is declared a total loss.

(b) Whenever a motor vehicle collision or comprehensive loss shall have been suffered by an insured, no insurer providing rental vehicle reimbursement coverage shall require that the insured utilize a particular rental vehicle company, rental vehicle company location or a particular concern.

(c) In processing any such claim, the insurer shall disclose to the insured that the insured has the right, as granted by this section, to utilize any rental vehicle company, rental vehicle company location or a particular concern.

(d) An insurer writing automobile insurance which includes rental vehicle reimbursement coverage shall inform the consumer of his or her right, as granted by this section, to choose a rental vehicle company to utilize in the event that he or she utilizes such coverage. The insurer shall provide the disclosure required under this section to any insured on new and renewal policies. Such disclosure shall be provided in a separate written document, which need not be provided in a separate mailing as another document as long as it is provided on a separate piece of paper, except that for new business it may be provided either in writing or in the same medium as the application for insurance.

§ 2611. HIV written informed consent. (a) No insurer or its designee

shall request or require an individual proposed for insurance coverage to be the subject of an HIV related test without receiving the written informed consent of such individual prior to such testing and without providing general information about AIDS and the transmission of HIV infection.

(b) Written informed consent to an HIV related test shall consist of a written authorization that is dated and includes at least the following:

(1) a general description of the test;

(2) a statement of the purpose of the test;

(3) a statement that a positive test result is an indication that the individual may develop AIDS and may wish to consider further independent testing;

(4) a statement that the individual may identify on the authorization form the person to whom the specific test results may be disclosed in the event of an adverse underwriting decision, which person may be the individual or a physician or other designee at the discretion of the individual proposed for insurance;

(5) the department of health's statewide toll-free telephone number that may be called for futher information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services; and

(6) the signature of the applicant or individual proposed for insurance, or if such individual lacks capacity to consent, the signature of such other person authorized to consent for such individual.

(c) In the event that an insurer's adverse underwriting decision is based in whole or in part on the result of an HIV related test, the insurer shall notify the individual of the adverse underwriting decision and ask the individual to elect in writing, unless the individual has already done so, whether to have the specific HIV related test results disclosed directly to the individual or to such other person as the individual may designate. If the individual elects to receive the HIV related test results directly, the insurer shall advise the individual that he or she may call the department of health's statewide toll-free telephone number for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services and shall also advise such individual to consult

with a physician about the meaning of and need for counseling, where appropriate, as to the HIV related test results.

(d) As used in this section, the following terms shall have the following meanings:

(1) "Adverse underwriting decision" means:

(A) a declination of insurance coverage as applied for; or

(B) an offer to issue insurance coverage at a higher than standard rate.

(2) "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the centers for disease control of the United States public health service.

(3) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

(4) "HIV related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS.

(e) Any person who violates this section shall be subject to the provisions of article twenty-four of this chapter.

(f) Nothing in this section shall be construed to create, impair, alter, limit, modify, enlarge, abrogate or restrict the specific authority of the department to allow or prohibit the use of HIV related tests or the consideration of HIV related test results for insurance coverage purposes.

§ 2612. Discrimination based on being a victim of domestic violence. (a) No individual, insurer or entity subject to the supervision of the superintendent shall solely because a person is or has been a victim of domestic violence:

(1) refuse to issue or renew, deny or cancel any insurance policy or contract;

(2) demand or require a greater premium or payment from any person;

(3) designate domestic violence as a preexisting condition, for which coverage will be denied or reduced;

(4) fix any lower rate or discriminate in the fees or commissions of agents or brokers for writing or renewing such a policy.

(b) The fact that a person is or has been a victim of domestic violence is not a permitted underwriting criterion.

(c) For the purposes of this section, the following terms shall be defined as:

(1) "victim of domestic violence" shall be as defined by subdivision one of section four hundred fifty-nine-a of the social services law.

(2) "insurer" shall mean an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law or a provider issued a special certificate of authority pursuant to section four thousand four hundred three-a of such law, or an agent, representative or designee thereof regulated pursuant to this chapter.

(3) "policy" shall mean a policy of insurance issued pursuant to this chapter, a child health insurance plan issued pursuant to title one-A of article twenty-five of the public health law or medical assistance or health care services provided pursuant to title eleven or eleven-D of article five of the social services law.

(d) The prohibitions contained in subsection (a) of this section shall not preclude an insurer from taking any of the actions described in subsection (a) of this section so long as such insurer relies on underwriting criteria reasonably related to the physical or mental condition of a person, their property or claim history and the decision was based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience. In such case the selection criteria permitted must be based on such principles. The insurer shall notify the insured of its specific reason or reasons for such decision.

(e) An insurer that complies with subsections (a), (f) and (g) of this section and acts reasonably and in good faith shall not be subject to civil or criminal liability on account of compliance with such subsections.

(f) If any person covered by an insurance policy issued to another person as the policyholder delivers to the insurer that issued the policy, at its home office, a valid order of protection against the policyholder, issued by a court of competent jurisdiction in this state,

or, except where the insurance policy was issued by a health insurer as defined in subparagraph (B) of paragraph (1) of subsection (h) of this section, a request to designate an alternative mailing address, telephone number or method of contact for the purpose of receiving claim related information if the person states that disclosure of all or part of the claim related information could endanger the person, the insurer shall be prohibited for the duration of the order, or until the request designating an alternative mailing address, telephone number or other method of contact is cancelled by the requesting person in writing, from disclosing to the policyholder the address, telephone number or other method of contact for the insured, or for any person or entity providing covered services to the insured, any personally identifying information of the insured, or the nature of the covered services provided to the insured, or from mailing, delivering, or otherwise providing claim related information to any mailing address, telephone number, or other method of contact other than as designated by the requesting person pursuant to this subsection. If a child is the covered person, the right established by this subsection may be asserted by, and shall also extend to, the parent or guardian of the child. An insurer may require a person making a request to designate an alternative mailing address, telephone number or other method of contact pursuant to this subsection to: make the request in writing; include in the request a statement that disclosure of all or part of the claim related information to which the request pertains could endanger the person or child; and specify an alternative mailing address, telephone number, or other method of contact. For the purpose of this subsection, "claim related information" means all claim or billing information relating specifically to an insured or person covered by an insurance policy issued by an insurer other than a health insurer as defined in subparagraph (B) of paragraph (1) of subsection (h) of this section. The superintendent, in consultation with the commissioner of health and the office of children and family services and the office for the prevention of domestic violence, shall promulgate rules to guide and enable insurers to guard against the disclosure of the address and location of an insured who is a victim of domestic violence.

(g) If any person covered by a group insurance policy delivers to the insurer that issued the policy, at its home office, (i) a valid order of

protection against another person covered by the group policy, issued by a court of competent jurisdiction in this state, or, except where the insurance policy was issued by a health insurer as defined in subparagraph (B) of paragraph (1) of subsection (h) of this section, a request to designate an alternative mailing address, telephone number or other method of contact for the purpose of receiving claim related information if the person states that disclosure of all or part of the claim related information could endanger the person, the insurer shall be prohibited for the duration of the order, or until the request designating an alternative mailing address, telephone number or other method of contact is cancelled by the requesting person in writing, from disclosing to the person against whom a valid order of protection was issued the address, telephone number or other method of contact for the insured person covered by the order of protection or for any person or entity providing covered services to the insured person covered by the order of protection, any personally identifying information of the insured, or the nature of the covered services provided to the insured, or from mailing, delivering, or otherwise providing claim related information to any mailing address, telephone number, or other method of contact other than as designated by the requesting person pursuant to this subsection. If a child is the covered person, the right established by this subsection may be asserted by, and shall also extend to, the parent or guardian of the child. An insurer may require a person making a request to designate an alternative mailing address, telephone number or other method of contact pursuant to this subsection to: make the request in writing; include in the request a statement that disclosure of all or part of the claim related information to which the request pertains could endanger the person or child; and specify an alternative mailing address, telephone number, or other method of contact. For the purpose of this subsection, "claim related information" means all claim or billing information relating specifically to an insured or person covered by an insurance policy issued by an insurer other than a health insurer as defined in subparagraph (B) of paragraph (1) of subsection (h) of this section. The superintendent, in consultation with the commissioner of health, the office of children and family services and the office for the prevention of domestic violence, shall promulgate rules to guide and enable insurers to guard against the disclosure of

the address and location of an insured who is a victim of domestic violence.

(h)(1) For purposes of this subsection:

(A) "Claim related information" means all claim or billing information relating specifically to an insured, subscriber or person covered by an insurance policy or contract issued by the health insurer.

(B) "Health insurer" means an insurer licensed to write accident and health insurance or salary protection insurance in this state, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law or a provider issued a special certificate of authority pursuant to section four thousand four hundred three-a of such law, or an agent, representative or designee thereof regulated pursuant to this chapter.

(2)(A) A health insurer shall accommodate a reasonable request by a person covered by an insurance policy or contract issued by the health insurer to receive communications of claim related information from the health insurer by alternative means or at alternative locations if the person clearly states that disclosure of all or part of the information could endanger the person.

(B) If a child is covered by an insurance policy or contract issued by the health insurer, then the child's parent or guardian may make a request to the health insurer pursuant to subparagraph (A) of this paragraph.

(3) A health insurer may require: a person to make a request pursuant to paragraph two of this subsection in writing; the request to contain a statement that disclosure of all or part of the claim related information to which the request pertains could endanger the person or child; and the specification of an alternative address, telephone number or other method of contact.

(4) With respect to an insurer authorized to write accident and health insurance in this state, this subsection shall apply only to a policy of accident and health insurance or a policy of salary protection insurance, as defined in subsection (a) of section one thousand one hundred thirteen of this chapter.

(5) Nothing in this subsection shall prevent, hinder, or otherwise

affect the entry of an appropriate order made in the best interests of a child by a court of competent jurisdiction adjudicating disputed issues of child welfare or custody.

(6) Except with the express consent of the person making a request pursuant to subparagraph (A) of paragraph two of this subsection, a health insurer shall not disclose to the policyholder (i) the address, telephone number, or any other personally identifying information of the person who made the request or child for whose benefit a request was made; (ii) the nature of the health care services provided; or (iii) the name or address of the provider of the covered services.

(7) A health insurer that makes reasonable and good faith efforts to comply with this subsection shall not be subject to civil or criminal liability on the ground of non-compliance with this subsection.

(8) The superintendent, in consultation with the commissioner of health, the office of children and family services and the office for the prevention of domestic violence, shall promulgate rules to guide health insurers in guarding against the disclosure of the information protected pursuant to this subsection.

§ 2613. Eligibility for life and disability insurance for persons with a history of any type of cancer. (a) Unless its action is based upon sound actuarial principles or is related to actual or reasonably anticipated experience, no insurer shall refuse to issue any policy of life or non-cancelable disability insurance, or cancel or decline to renew such policy because an individual has had any type of cancer, provided that the initial diagnosis of such disease has occurred at least three years prior to the date of application and that a physician has certified that the disease has not reoccurred in the applicant or the individual proposed for such insurance.

(b) In the case of an adverse underwriting decision, the insurer shall notify the applicant or proposed insured of its specific reason or reasons for such decision.

§ 2614. Discrimination because of past lawful travel. No insurer or entity authorized to offer the kinds of insurance specified in paragraph

one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter, nor any agent, officer or employee of such insurer or entity shall make any distinction or otherwise discriminate between persons, reject an applicant, cancel a policy or demand or require a higher rate of premium for reasons associated with an applicant's or insured's past lawful travel experiences.

§ 2615. Genetic testing written informed consent. (a) No authorized insurer or person acting on behalf of an authorized insurer shall request or require an individual proposed for insurance coverage to be the subject of a genetic test without receiving the written informed consent of such individual prior to such testing, in advance of the test.

(b) Written informed consent to a genetic test shall consist of written authorization that is dated and signed and includes at least the following:

(1) a general description of the test;

(2) a statement of the purpose of the test;

(3) a statement that a positive test result is an indication that the individual may be predisposed to or have the specific disease or condition tested for and may wish to consider further independent testing, consult their physician or pursue genetic counseling;

(4) a general description of each specific disease or condition tested for;

(5) the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease. If no level of certainty has been established, this subparagraph may be disregarded;

(6) the name of the person or categories of persons or organizations to whom the test results may be disclosed;

(7) a statement that no tests other than those authorized shall be performed on the biological sample and that the sample shall be destroyed at the end of the testing process or not more than sixty days after the sample was taken; and

(8) the signature of the individual subject of the test or, if that individual lacks the capacity to consent, the signature of the person authorized to consent for such individual.

(c) A general waiver, wherein consent is secured for genetic testing without compliance with subsection (b) of this section, shall not constitute informed consent.

(d) Any further disclosure of genetic test results to persons or organizations not named on the informed consent requires the further informed consent of the subject of the test.

(e) In the event that an insurer's adverse underwriting decision is based in whole or in part on the results of a genetic test, the authorized insurer shall notify the individual of the adverse underwriting decision and ask the individual to elect in writing, unless the individual has already done so, whether to have the specific test results disclosed directly to the individual or to the individual's physician, at the discretion of the individual.

(f) All records, findings and results of any genetic test performed on any person shall be deemed confidential and may not be disclosed without the written authorization as described in subsection (g) of this section of the person to whom such genetic test relates. This information may not be released to any person or organization not specifically authorized by the individual subject of the test. Unauthorized solicitation or possession of such information shall be unlawful, except for the unintentional possession of such information as part of a health record created prior to the date on which this section shall have become a law and provided no action adverse to the interests of the subject are taken as a result of such possession.

(g) Written authorization to records, findings and/or results of genetic tests that have been performed prior to the effective date of this section, or which was done after the individual had given written informed consent pursuant to this section shall consist of a statement which specifically requests genetic test records, findings and/or results, the person or organizations to whom the records, findings and/or results shall be disclosed, the signature of the individual subject of the records, findings and/or results of the test or, if that person lacks the capacity to consent, the signature of the person authorized to consent for the subject.

(h) No authorized insurer who lawfully possesses information derived from a genetic test on a biological sample from an individual shall incorporate such information into the records of a non-consenting

individual who may be genetically related to the tested individual; nor shall any inferences be drawn, used, or communicated regarding the possible genetic status of the non-consenting individual.

(i) For the purposes of this section, the term "adverse underwriting decision" shall have the same meaning as defined in section twenty-six hundred eleven of this article and the term "genetic test" shall have the same meaning as defined in section seventy-nine-l of the civil rights law.

(j) If the superintendent determines after notice and a hearing that an authorized insurer or a person acting on behalf of an authorized insurer has violated this section, then the superintendent shall levy a fine up to five thousand dollars. Also, any authorized insurer or person acting on behalf of an authorized insurer who violates the provisions of this section shall be subject to the provisions of article twenty-four of this chapter. Violations of this section shall also be subject to the provisions of section one hundred nine of this chapter, except paragraph one of subsection (c) of such section.

§ 2616. Discrimination because of status as a living organ or tissue donor. (a) No insurer or entity authorized to do the kinds of business specified in paragraph one or three of subsection (a) of section one thousand one hundred thirteen of this chapter shall decline to provide or limit coverage of an insured under any life or accident and health insurance policy or otherwise discriminate in the premium rating, offering, issuance, cancellation, amount of coverage or any other condition, based solely upon the status of an insured as a living organ or tissue donor and without additional actuarial risks.

(b) No insurer or entity authorized to do the kinds of business specified in paragraph one or three of subsection (a) of section one thousand one hundred thirteen of this chapter shall preclude an insured from donating all or part of an organ or tissue as a condition or receiving or continuing to receive life or accident and health insurance coverage.

(c) As used in this section, the terms "organ" and "tissue" shall have the same meanings as are provided therefor in section forty-three hundred sixty of the public health law.

§ 2617. Unfair discrimination for the use of prescriptions to block the effects of opioids. No insurer or entity authorized to issue the kinds of insurance specified in paragraphs one or two of subsection (a) of section one thousand one hundred thirteen of this chapter shall refuse to issue a life insurance policy or annuity contract or adjust the amount of premiums, or rates, charged for life insurance policies or annuity contracts for any individual solely because such individual has been prescribed medication used to block the effects of opioids, including, but not limited to, Naloxone and Narcan, unless such action is based on sound actuarial principles or actual or reasonably anticipated experience.

§ 2618. Standards for prompt investigation and settlement of claims. (a) (1) For the purpose of this section, "natural disaster" means the occurrence of widespread catastrophic or severe damage, injury, or loss of life or property resulting from any natural cause, including fire, flood, earthquake, hurricane, tornado, high water, landslide, mudslide, wind, storm, wave action, and ice storm.

(2) This section shall apply to every insurer who writes policies that cover loss of or damage to real property, personal property or other liabilities for loss of, damage to, or injury to persons or property when:

(A) a local state of emergency is declared pursuant to section twenty-four of the executive law, when the governor declares a disaster emergency pursuant to section twenty-eight of the executive law, or when the President issues a major disaster or emergency declaration pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288);

(B) the disaster is a natural disaster or a disaster caused by an act of terrorism; and

(C) the claims are a result of such disaster.

(3) An insurer shall acknowledge the receipt of all claims in writing to the claimant or the claimant's authorized representative in accordance with regulations promulgated by the superintendent;

(4) If the insurer wishes its investigation to include an inspection of damaged or destroyed property, the inspection, whether performed by the insurer, an independent adjuster, or other representative of the insurer, shall occur in accordance with regulations promulgated by the superintendent. Furthermore, where necessary to protect health and safety, immediate repairs to windows, exterior walls, exterior doors, roofs, heating systems, water systems and electrical systems may be made and alternative proof of loss such as photographs, video recordings, inventories and all receipts for repairs or replacement property shall satisfy policy requirements;

(5) A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, the agent notifies the person filing the claim that the agent is not authorized to receive notices of claim; and

(6) An insurer shall furnish to such claimant, or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant in order to investigate such claim in accordance with regulations promulgated by the superintendent.

(b)(1) An insurer shall, within fifteen business days of receipt of a properly executed proof of loss and receipt of all items, statements and forms requested under this section from the claimant, or the claimant's authorized representative, advise the claimant in writing whether the insurer has accepted or rejected the non-commercial claim. When the insurer suspects that the non-commercial claim involves arson, the foregoing fifteen business days shall be read as thirty business days.

(2) An insurer shall be granted a one-time extension of fifteen business days to determine whether a non-commercial claim should be accepted or rejected. If the insurer elects to utilize this extension, it shall so notify the claimant, or the claimant's authorized representative, in writing. Such notification shall include the reasons additional time is needed for the investigation.

(3) (i) If the insurer needs more time to determine whether the non-commercial claim should be accepted or rejected because the insurer is prohibited from accessing the property to investigate the claim, the insurer shall be granted one additional extension of fifteen business days. If the insurer elects to utilize this extension, it shall so

notify the claimant, or the claimant's authorized representative, in writing, setting forth the reasons additional time is needed for the investigation.

(ii) If the insurer needs more time to be able to physically access the property because the insurer is prohibited from accessing it, the insurer shall so notify the claimant, or the claimant's authorized representative, every fifteen business days, in writing, setting forth the reasons additional time is needed for the investigation. When the insurer is no longer prohibited from accessing the property, and the property can be accessed, the insurer shall have no more than fifteen days to adjudicate the claim.

(c) (1) An insurer shall, within fifteen business days of receipt of a properly executed proof of loss and receipt of all items, statements and forms requested under this section from the claimant, or the claimant's authorized representative, advise the claimant in writing whether the insurer has accepted or rejected the commercial claim.

(2) An insurer shall be granted a one-time extension of thirty business days to determine whether a commercial claim should be accepted or rejected. If the insurer elects to utilize this extension, it shall so notify the claimant, or the claimant's authorized representative, in writing, setting forth the reasons additional time is needed for the investigation.

(3) If succeeding the one-time extension of thirty business days the insurer needs more time to determine whether the commercial claim should be accepted or rejected, the insurer shall so notify the claimant, or the claimant's authorized representative, every thirty business days, in writing, setting forth the reasons additional time is needed for the investigation.

(4) Once the claim is accepted by the insurer, the insurer shall advise the claimant, or the claimant's authorized representative, in writing of the amount the insurer is offering to settle the claim. The insurer shall also provide to the claimant, or the claimant's authorized representative, in writing, of all applicable policy provisions regarding the claimant's right to reject the offer and request an appraisal.

(5) In any case where the claim is rejected by the insurer, the insurer shall notify the claimant, or the claimant's authorized

representative, in writing, of all applicable policy provisions and deadlines by which a claimant may sue the insurer. Any notice rejecting any element of a claim involving personal property insurance shall contain the identity and the claims processing address of the insurer, the insured's policy number, the claim number, and information regarding how to file a complaint with the department in accordance with regulations promulgated by the superintendent.

(d) Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than four business days from the receipt of such agreement by the insurer, or from the date of the performance by the claimant of any condition set by such agreement, whichever is later, except as provided in section three hundred thirty-one of this chapter with respect to liens by tax districts on fire insurance proceeds.

(e) The superintendent may promulgate any rules or regulations necessary to implement the provisions of this section.

ARTICLE 27

HOLOCAUST VICTIMS INSURANCE ACT OF 1998

Section 2701. Definitions.
2702. Holocaust claims assistance.
2703. Insurer claims handling.
2704. Rights of action.
2705. Reports from insurers.
2707. Penalty.
2708. Application of section four thousand two hundred twenty-four.
2709. Substantial compliance.
2710. Rules and regulations.
2711. Severability.

§ 2701. Definitions. For the purpose of this article:

(a) "Holocaust victim" shall mean any person, claimant, or the estate, heir, legatee, descendant, survivor, beneficiary, or other such successor-in-interest of such person, who lost his or her life or

property as a result of discriminatory laws, policies, or actions targeted against discrete groups of persons based on race, religion, ethnicity, sexual orientation or national origin, whether or not such person was actually a member of any of the foregoing enumerated groups or because such person assisted or allegedly assisted any of the foregoing groups, between January first, nineteen hundred twenty-nine and December thirty-first, nineteen hundred forty-five in areas under Nazi influence as defined in subsection (f) of this section.

(b) "Person", "control", "holding company", and "holding company system" and any other term used in this article but not otherwise defined shall have the same meaning as it has in article fifteen of this chapter.

(c) "Insurance policy" shall mean any policy of insurance substantially similar to any kind of insurance that was authorized at any time in New York between and including the years nineteen hundred twenty-nine and nineteen hundred forty-five or authorized by the jurisdiction in which the policy was sold at the time it was sold including but not limited to any form of life, accident and health, annuities, property, casualty, education or dowry insurance.

(d) "Proceeds" shall mean the face or other pay-out value of an insurance policy or annuity plus reasonable interest to date of payment as shall be prescribed by regulations promulgated by the superintendent.

(e) "Member of a holding company system" shall include a holding company, a controlled insurer, a controlled person, and any person who alone or in concert with any other persons directly or indirectly controls a holding company or controls a person who controls a holding company.

(f) "Areas under Nazi influence" shall mean the country of Nazi Germany, areas occupied by Nazi Germany, those European countries allied with Nazi Germany, areas occupied by those European countries allied with Nazi Germany, or any other neutral European country or area in Europe under the influence or threat of Nazi invasion.

§ 2702. Holocaust claims assistance. The superintendent shall arrange for a toll-free telephone number available in English as well as other appropriate languages, to assist any person seeking to recover proceeds

from an insurance policy issued to or covering the life or property of a Holocaust victim.

§ 2703. Insurer claims handling. (a) Notwithstanding any inconsistent provision of this chapter, any insurer organized, registered, licensed or accredited to do an insurance business in this state, in receipt of a claim against it arising from an occurrence during the period between January first, nineteen hundred twenty-nine and December thirty-first, nineteen hundred forty-five from an individual that such insurer knows, or reasonably should have known, is a Holocaust victim shall:

(1) diligently and expeditiously investigate such claim;

(2) allow claimants to provide alternative documentation which does not meet the usual standards of proof required by an insurer to substantiate the particular claim, subject to standards established for such documentation as prescribed by regulations promulgated by the superintendent; and

(3) attempt to resolve, settle and, if appropriate, make payments on claims irrespective of any statute of limitations or notice requirements imposed by any law or such insurance policy issued to or covering the life, property or interests of a Holocaust victim, provided that the claim is submitted to the insurer within ten years from the effective date of this article.

(b) Failure to abide by the terms of this section shall constitute a defined violation for purposes of subsection (b) of section two thousand four hundred two of this chapter.

(c) This article shall serve as additional and conclusive notice that the superintendent is currently investigating all claims pertaining to the victims of the Holocaust. Evidence of the intentional destruction or alteration of any records or other materials pertaining to such claim shall be admissible in both administrative and judicial proceedings as evidence in support of any claim being made against the insurer involving the destroyed or altered material. It shall be permissible for an administrative or judicial court to infer that the intentional destruction or alteration of any records or other materials pertaining to a claim was done in order to prevent discovery of information to support any claim of a Holocaust victim.

§ 2704. Rights of action. (a) Notwithstanding any law or agreement among the parties to an insurance policy to the contrary, any action arising from an occurrence during the period between January first, nineteen hundred twenty-nine and December thirty-first, nineteen hundred forty-five brought by a Holocaust victim seeking proceeds of an insurance policy issued to or covering the life or property of a Holocaust victim prior to December thirty-first, nineteen hundred forty-five, shall not be dismissed for failure to comply with any statute of limitations or laches or other similar provision of any applicable law relating to the timeliness of the filing of claims that might prevent a claim from being heard on its merits, or any notice requirements imposed by any insurance policy provided the action is commenced within ten years from the effective date of this article.

(b) With respect to any action arising from an occurrence during the period between January first, nineteen hundred twenty-nine and December thirty-first, nineteen hundred forty-five brought by a Holocaust victim seeking proceeds of an insurance policy issued to or covering the life or property of a Holocaust victim prior to December thirty-first, nineteen hundred forty-five no such action shall be stayed or dismissed pursuant to rule three hundred twenty-seven of the civil practice law and rules.

(c) In recognition of the significant period of time that has passed and in order to effect the goals of substantial justice, the rules regarding the admissibility of evidence, including but not limited to rule forty-five hundred eighteen and section forty-five hundred nineteen of the civil practice law and rules, and principles of law or other rules relating to the admission of hearsay evidence shall be relaxed at the discretion of the trial judge in any action or proceeding authorized by this section.

§ 2705. Reports from insurers. (a) Every insurer organized, registered, accredited or licensed to do an insurance business in this state shall file or shall cause its holding company to file with the superintendent, within one hundred and twenty days of the effective date

of this article, a report setting forth such insurer's plan for complying with the provisions of this article. Any insurer which has determined that it does not have any of the information requested in subsection (b) of this section shall file or cause its holding company to file a report stating that they have no such information. In addition, an insurer may request to be relieved from filing any further reports upon providing evidence satisfactory to the superintendent that such insurer has fulfilled its obligations under this article.

(b) Every insurer organized, licensed, registered or accredited to do an insurance business in this state shall report or shall cause its holding company to report to the superintendent the following information:

(1) whether it is a member of a holding company system including any insurer, any other member, subsidiary or division in each case whether a licensee or not, that could possibly be expected to have issued an insurance policy to a Holocaust victim between January first, nineteen hundred twenty and December thirty-first, nineteen hundred forty-five and a list of each such entity;

(2) the approximate number and the total value of all such insurance policies issued by such insurer or by any other member, subsidiary or division within the reporting insurer's holding company system, which, as of the date of such report, remain unpaid or were paid to, or expropriated by a government located in areas under Nazi influence, that was not the named beneficiary of such insurance policy;

(3) attempts made by the insurer to locate the beneficiaries of any such insurance policies for which no claim of benefits has been made;

(4) if requested by the superintendent and to the extent consistent with applicable laws and confidentiality obligations, with respect to each such insurance policy, the names of the owner, the name of the beneficiary and the face amount or pay-out value;

(5) the number of claims filed by persons who allege or have alleged that they are Holocaust victims and whether each such claim has been paid or payment has been denied;

(6) if requested by the superintendent, an explanation of any denial or pending payment of a claim to any person who alleges or has alleged that he or she is a Holocaust victim;

(7) a summary of the length of time for the processing and disposition

of such a claim by the insurer; and

(8) in the event that the insurer is unable to provide any of the information required by this section, an explanation of the reasons why and whether such information may, in the future, be ascertainable. The reports required by this subsection shall be made within thirty days after the end of the calendar year in which this article shall have become effective and annually thereafter for each of the succeeding ten years except as provided in subsection (a) of this section.

(c) Reports submitted to the superintendent pursuant to this section shall be certified and affirmed under oath as being true and not misleading and as containing the most accurate information available at the time of such report's submission.

(d) The superintendent may waive penalties and fines imposed by this article for those insurers that, through no fault of their own, were unaware that they, or members of a holding company system that includes such insurer, were obligated to file reports pursuant to this article and to comply with the provisions of this article.

(e) The superintendent is authorized to use any power available to the state to compel holding company systems that include issuers of insurance policies to Holocaust victims to submit reports pursuant to this article and to comply with the provisions of this article.

(f) Any insurer which knowingly or recklessly files a false or misleading certification required by this section shall be fined not less than one hundred thousand dollars or such greater amount as the superintendent deems appropriate based upon the degree of misrepresentation, the willfulness of the misconduct and the amount of funds misappropriated. Such insurer also may be barred from further sales of insurance in New York for a period of up to ten years.

§ 2707. Penalty. In addition to any other penalty prescribed by this article or any other provision of this chapter, any insurer or person who violates the provisions of this article will be subject to a civil penalty of up to one thousand dollars for each day each such violation continues except that, if the superintendent finds that such violation has been willful, such insurer shall be fined an amount that the superintendent deems appropriate based on the degree of willful

misconduct and the nature of the violation.

§ 2708. Application of section four thousand two hundred twenty-four. An insurer shall not be considered in violation of section four thousand two hundred twenty-four of this chapter for complying with the provisions of this article.

§ 2709. Substantial compliance. (a) An insurer which, pursuant to the laws of another jurisdiction is required (or whose holding company is required) to report, certify or otherwise disclose information substantially equivalent to that required by section two thousand seven hundred five of this article, may satisfy the requirements of section two thousand seven hundred five of this article by filing with the superintendent within the applicable periods prescribed hereunder, copies of such material filed with such jurisdiction. The determination as to whether the requirements of a given jurisdiction are substantially equivalent to those of section two thousand seven hundred five of this article shall be made by the superintendent in his or her discretion. The superintendent may require that any such filing be supplemented by a schedule or index referring to the specific requirements of section two thousand seven hundred five or the regulations promulgated thereunder.

(b) The superintendent, in his or her discretion, may suspend the application of section two thousand seven hundred five of this article to any insurer upon a finding that such insurer, a subsidiary of such insurer, or any member of the holding company system that includes such insurer, has subjected itself in good faith to the authority of the international commission referenced in a memorandum of intent, dated April eighth, nineteen hundred ninety-eight executed by the superintendent, other United States insurance regulators, worldwide Jewish organizations and insurers, or any successor thereto, and has meaningfully participated in such commission or successor entity in a manner reasonably calculated to effect the prompt investigation and resolution of claims of Holocaust victims and upon a finding by the superintendent that such commission or successor entity is effectively moving toward the swift and equitable resolution of claims made against

such insurer by Holocaust victims.

(c) Each such suspension granted pursuant to subsection (b) of this section shall be valid for a one year period and may be extended annually for additional one year periods upon a finding (i) that such insurer, a subsidiary of such insurer, or any member of the holding company system that includes such insurer, continues to satisfy the requirements set forth in subsection (b) of this section and (ii) that the commission or successor entity is effective in achieving the prompt identification of Holocaust victims to whom insurance policies were issued between January first, nineteen hundred twenty and December thirty-first, nineteen hundred forty-five, and the investigation and resolution of claims of those Holocaust victims. Each insurer who is exempted or seeks continued exemption pursuant to this section shall file such reports or provide such other information as the superintendent may require in his or her discretion.

(d) The superintendent shall have the discretion to discontinue any exemption made in accordance with this section if a reasonable determination is made by the superintendent that the insurer, its subsidiary or division, or the member of the holding company system that includes such insurer, as applicable, is not cooperating fully with such commission or successor entity or that such commission or successor entity is not effective in promptly investigating and resolving such claims.

§ 2710. Rules and regulations. The superintendent, by regulation, shall provide for the implementation of the provisions of this article and for facilitating, monitoring and verifying compliance with this article.

§ 2711. Severability. If any word, clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the word, clause, sentence, paragraph, subdivision, section or part thereof directly involved in the

controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this article would have been enacted even if such invalid provisions had not been included herein.

ARTICLE 28

USE OF CREDIT INFORMATION

Section 2801. Definitions.
2802. Use of credit information.
2803. Dispute resolution and error correction.
2804. Initial notification.
2805. Adverse action notification.
2806. Filing.
2807. Sale of information by consumer reporting agency.
2808. Indemnification.
2809. Severability.

§ 2801. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(a) "Adverse action" shall mean a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

(b) "Affiliate" shall mean any company that controls, is controlled by, or is under common control with another company.

(c) "Applicant" shall mean an individual who has applied to be covered by a personal lines insurance policy with an insurer.

(d) "Consumer" shall mean an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal lines insurance policy or an applicant for such a policy.

(e) "Consumer reporting agency" shall mean any person who, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the

purpose of furnishing consumer reports to third parties.

(f) "Credit information" shall mean any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal lines insurance. Information that is not credit-related shall not be considered "credit information", regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(g) "Credit report" shall mean any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal lines insurance premiums, eligibility for coverage, or tier placement.

(h) "Insurance score" shall mean a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(i) "Personal lines insurance" shall mean property/casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

§ 2802. Use of credit information. An insurer doing business in this state that uses credit information to underwrite or rate risks for personal lines insurance, shall not:

(a) use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

(b) deny a policy of personal lines insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information, provided that an offer by an insurer to provide coverage by writing a policy through an affiliate insurer or a tier within the insurer shall not constitute a denial of a policy;

(c) use credit information to cancel or nonrenew a policy or increase an insured's premium for personal lines insurance on renewal provided

that nothing in this section shall be construed to prohibit an insurer from considering an insured's tier placement pursuant to section two thousand three hundred forty-nine of this chapter or placement with a company within a group of affiliated companies in conjunction with factors other than credit information as part of its renewal process;

(d) take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information;

(e) consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(1) treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer;

(2) excludes the use of credit information as a factor and uses only other underwriting criteria; or

(3) treats the consumer as otherwise approved by the superintendent, if the insurer presents information that such an absence or inability relates to the risk for the insurer;

(f) take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within ninety days from the date the policy is first written;

(g) use credit information unless at least once every thirty-six months, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or insurance score provided, however, that this shall not result in a premium increase for the insured. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a thirty-six-month period. Regardless of the requirements of this subsection:

(1) The insurer shall have the discretion to obtain current credit information upon any renewal, if consistent with its underwriting guidelines provided that such information may be used only to reduce premiums for the insured; and

(2) No insurer need obtain current credit information for an insured, despite the requirements of this subsection, if one of the following applies:

(A) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers; or

(B) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if such use would reduce premiums for the insured;

(h) use any of the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal lines insurance:

(1) credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information;

(2) inquiries relating to insurance coverage, if so identified on a consumer's credit report;

(3) collection accounts with a medical industry code, if so identified on the consumer's credit report;

(4) multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered; or

(5) multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty days of one another, unless only one inquiry is considered.

§ 2803. Dispute resolution and error correction. If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within thirty days of receiving such notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the last thirty-six months of coverage

provided by such insurer.

§ 2804. Initial notification. An insurer writing personal lines insurance which uses credit information in underwriting or rating a consumer, shall disclose such fact to the consumer. The insurer shall provide the disclosure required under this section to any insured on new and renewal policies.

(a) The disclosure must be provided in a separate written document, which need not be provided in a separate mailing as another document as long as it is provided on a separate piece of paper, except that for new business it may be provided either in writing or in the same medium as the application for insurance.

(b) The disclosure must, in clear and specific language, comply with the following:

(1) inform the consumer that it may obtain credit information in connection with the application or renewal;

(2) give an explanation of insurance scoring;

(3) list typical items relative to a consumer's credit history that could affect such score; and

(4) provide the name of the consumer reporting agency supplying the credit data used in determining the score.

(c) Use of one of the following example disclosure statements constitutes compliance with this section:

(1) "In connection with this insurance, we may review your credit report or obtain or use a credit-based insurance score based on information contained in that report. An insurance score uses information from your credit report to help predict how often you are likely to file claims and how expensive those claims will be. Typical items from a credit report that could affect a score include, but are not limited to, the following: payment history, number of revolving accounts, number of new accounts, the presence of collection accounts, bankruptcies and foreclosures. The information used to develop the insurance score comes from (insert name.)"; or

(2) Use of the following example disclosure statement for renewal business constitutes compliance with this section: "In connection with this insurance, we previously used a credit report or obtained or used a

credit-based insurance score based on information contained in that report. We may obtain or use credit information again provided, however, that upon renewal such information may only be used to reduce premiums. An insurance score uses information from your credit report to help predict how often you are likely to file claims and how expensive those claims will be. Typical items from a credit report that could affect a score include, but are not limited to, the following: payment history, number of revolving accounts, number of new accounts, the presence of collection accounts, bankruptcies and foreclosures. The information used to develop the insurance score comes from (insert name.)".

(d) If a new business application is taken over the telephone, an oral disclosure may be provided by one of the following approaches:

(1) As described in subsections (a) through (c) of this section; or

(2) (A) By first disclosing the fact that the insurer may obtain credit information in connection with such application, as indicated in paragraph one of subsection (b) of this section. Use of the following example disclosure constitutes compliance with this provision: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report."; and

(B) If a policy is issued, by supplying the information required under paragraphs two, three and four of subsection (b) of this section. The disclosure must be provided in a separate written document, which need not be provided in a separate mailing as another document as long as it is provided on a separate piece of paper. Use of the following example disclosure constitutes compliance with this provision: "In connection with this insurance, we reviewed your credit report or obtained or used a credit-based insurance score based on information contained in that report. An insurance score uses information from your credit report to help predict how often you are likely to file claims and how expensive those claims will be. Typical items from a credit report that could affect a score include, but are not limited to, the following: payment history, number of revolving accounts, number of new accounts, the presence of collection accounts, bankruptcies and foreclosures. The information used to develop the insurance score comes from (insert name.)".

§ 2805. Adverse action notification. If an insurer takes an adverse action based upon credit information, the insurer shall:

(a) provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a); and

(b) provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third party vendors are deemed to comply with this section.

§ 2806. Filing. (a) Insurers that use insurance scores to underwrite and rate risks must file their scoring models (or other scoring processes) with the superintendent. Any subsequent revision to the scoring models will require the insurer to file a summary of the revision with the superintendent within forty-five days. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

(b) Any filing relating to credit information filed and in the possession of the superintendent shall remain the property of the insurer and shall not be subject to any disclosure or production under article six or six-A of the public officers law or any other law of the state which authorizes or requires the superintendent to disclose or produce records to an outside party. This information is privileged information and is not discoverable or admissible as evidence in any legal action in any civil, criminal or administrative proceeding. The privilege created herein is a matter of substantive law of this state and is not merely a procedural matter governing civil or criminal procedures in the courts of this state and this information shall remain

subject to all applicable statutory or common law privileges.

§ 2807. Sale of information by consumer reporting agency. (a) No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(b) The restrictions provided in subsection (a) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance agent or broker from whom information was received, the insurer on whose behalf such agent or broker acted, or such insurer's affiliates or holding companies.

(c) Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

§ 2808. Indemnification. An insurer shall indemnify, defend and hold agents harmless from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of the agent resulting from obtaining or using credit information and/or insurance scores for an insurer, provided the agent follows the instructions of or procedures established by the insurer, works within the authority granted by the insurer to the agent and complies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

§ 2809. Severability. If any section, paragraph, sentence, clause, phrase, or any part of this article is declared invalid due to an interpretation of or a future change in the federal Fair Credit

Reporting Act or is adjudged by any court of competent jurisdiction to be invalid, such judgment, interpretation or change shall not affect, impair or invalidate the remainder thereof and the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

ARTICLE 29

PHARMACY BENEFIT MANAGERS

Section 2901. Definitions.
2902. Acting without a registration.
2903. Registration requirements for pharmacy benefit managers.
2904. Reporting requirements for pharmacy benefit managers.
2905. Acting without a license.
2906. Licensing of a pharmacy benefit manager.
2907. Revocation or suspension of a registration or license of a pharmacy benefit manager.
2908. Penalties for violations.
2909. Stay or suspension of superintendent's determination.
2910. Revoked registrations or licenses.
2911. Additional obligations.
2912. Change of address.
2913. Applicability of other laws.
2914. Assessments.

§ 2901. Definitions. For purposes of this article:

(a) "Controlling person" is any person or other entity who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of a pharmacy benefit manager.

(b) The terms "covered individual", "health plan", "pharmacy benefit manager" and "pharmacy benefit management services" have the same meanings as defined by section two hundred eighty-a of the public health law. The superintendent is expressly authorized to interpret these terms as if the definitions were stated within this article.

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after June first, two thousand twenty-two and prior to January first, two thousand twenty-four, without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and any regulations promulgated thereunder.

(b) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be liable for restitution and compensatory damages to any health plan, pharmacy or covered individual, or other person harmed by the violation and shall also be subject to a penalty not exceeding of the greater of (1) four thousand dollars for the first violation and ten thousand dollars for each subsequent violation or (2) the aggregate economic gross receipts attributable to all violations.

§ 2903. Registration requirements for pharmacy benefit managers. (a) Every pharmacy benefit manager that performs pharmacy benefit management services on or after June first, two thousand twenty-two and prior to January first, two thousand twenty-four shall register with the superintendent in a manner acceptable to the superintendent, and shall pay a fee of four thousand dollars for each year or fraction of a year in which the registration shall be valid. The superintendent, in consultation with the commissioner of health, may establish, by regulation, minimum registration standards required for a pharmacy benefit manager. The superintendent can reject a registration application filed by a pharmacy benefit manager that fails to comply with the minimum registration standards.

(b) For each business entity, the officer or officers and director or directors named in the application shall be designated responsible for the business entity's compliance with the financial services and insurance laws, rules and regulations of this state.

(c) Every registration will expire on December thirty-first, two thousand twenty-three regardless of when registration was first made.

(d) Every pharmacy benefit manager that performs pharmacy benefit management services at any time prior to June first, two thousand

twenty-two, shall make the registration and fee payment required by subsection (a) of this section on or before June first, two thousand twenty-two. Any other pharmacy benefit manager shall make the registration and fee payment required by subsection (a) of this section prior to performing pharmacy benefit management services.

(e) Registrants under this section shall be subject to examination by the superintendent as often as the superintendent may deem it necessary. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this article and such other regulations as necessary to enforce the provisions of this article.

§ 2904. Reporting requirements for pharmacy benefit managers. (a) (1) (i) On or before July first of each year, every pharmacy benefit manager shall report to the superintendent, in a statement subscribed and affirmed as true under penalties of perjury, the information requested by the superintendent including, without limitation,

(A) any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, other financial or other reimbursements, incentives, inducements, refunds or other benefits received by the pharmacy benefit manager;

(B) the terms and conditions of any contract or arrangement, including other financial or other reimbursements incentives, inducements or refunds between the pharmacy benefit manager and any other party relating to pharmacy benefit management services provided to a health plan including but not limited to, dispensing fees paid to pharmacies;

(C) the aggregated dollar amount of rebates, fees, price protection payments and any other payments the pharmacy benefit manager received from drug manufacturers through rebate contracts;

(D) the portions of the amount in clause (C) of this subparagraph which were:

1. passed on to health plans; or

2. retained by the pharmacy benefit manager; and

(E) for each rebate contract in effect during the reporting period:

1. the names of the contracting parties;

2. the execution date and the term of the contract, including extensions;

3. the name of the drugs and the associated national drug codes covered by the rebate contract, and for each drug:

(I) a summary of the contract terms regarding formulary placement, formulary exclusion, or prior authorization requirements or step edits, of any drugs considered to compete with each drug;

(II) a summary of all terms requiring or incentivizing volume or market share for each drug, including base rebate amounts, bundled rebates and incremental rebates, stated separately, and price concession, stated separately for each drug; and

(III) the total number of prescriptions filled and units dispensed for which a rebate, discount, price concession or other consideration was received by the pharmacy benefit manager for each drug;

4. the rebate percentage and dollar amount retained by the pharmacy benefit manager for every rebate, discount, price concession or other consideration under each rebate contract; and

5. the dollar amount of any other compensation paid by a drug manufacturer to a pharmacy benefit manager for services including distribution management services, data or data services, marketing or promotional services, research programs, or other ancillary services, under each rebate contract.

(ii) For the purposes of this subsection, the term "rebate contract" means any agreement entered into by a pharmacy benefit manager with any drug manufacturer or agent or affiliate of a drug manufacturer that determines any rebate, discount, administrative or other fee, price concession, or other consideration related to the dispensing of prescription drugs for a health plan.

(2) The superintendent may require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe.

(3) The superintendent may address to any pharmacy benefit manager or its officers any inquiry in relation to its provision of pharmacy benefit management services or any matter connected therewith. Every pharmacy benefit manager or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the pharmacy benefit manager, as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(b) In the event any pharmacy benefit manager or person does not submit the report required by paragraph one of subsection (a) of this section or does not provide a good faith response to an inquiry from the superintendent pursuant to paragraph three of subsection (a) of this section within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such pharmacy benefit manager or person not to exceed four thousand dollars per day for each day beyond the date the report is due or the date specified by the superintendent for response to the inquiry.

(c) All information, documents and material disclosed by a pharmacy benefit manager under this section and in the possession or under control of the superintendent shall be deemed confidential and not subject to disclosure except where and as the superintendent determines that disclosure is in the public interest. This subsection shall not apply to information, documents and materials where they are in the possession and under the control of a person or entity other than the superintendent.

§ 2905. Acting without a license. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after January first, two thousand twenty-four without having authority to do so by virtue of a license issued in force pursuant to the provisions of this article.

(b) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be liable for restitution and compensatory damages to any health

plan, pharmacy, covered individual or other person harmed by the violation and further shall be subject to a penalty not exceeding the greater of (1) four thousand dollars for the first violation and ten thousand dollars for each subsequent violation or (2) the aggregate economic gross receipts attributable to all violations, as determined by the superintendent at a hearing.

§ 2906. Licensing of a pharmacy benefit manager. (a) The superintendent may issue a pharmacy benefit manager's license to any person, firm, association or corporation who or that has complied with the requirements of this article, including regulations promulgated by the superintendent. The superintendent, in consultation with the commissioner of health, shall establish, by regulation, minimum standards for the issuance of a license to a pharmacy benefit manager.

(b) The minimum standards established under this subsection shall contain both prerequisites for the issuance of a license and requirements for maintenance of a license and shall address, without limitation:

(1) conflicts of interest between pharmacy benefit managers and health plans or insurers;

(2) deceptive practices in connection with the performance of pharmacy benefit management services;

(3) anti-competitive practices in connection with the performance of pharmacy benefit management services;

(4) unfair claims practices in connection with the performance of pharmacy benefit management services;

(5) pricing models used by pharmacy benefit managers both for their services and for the payment of services to the pharmacy benefit manager;

(6) standards and practices used in the creation of pharmacy networks and contracting with network pharmacies and other providers, including promotion and use of independent and community pharmacies and patient access and minimizing excessive concentration and vertical integration of markets; and

(7) protection of consumers.

(c) For each business entity, the officer or officers and director or

directors named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(d)(1) Before a pharmacy benefit manager's license shall be issued or renewed, the prospective licensee shall properly file in the office of the superintendent an application therefor in such form or forms and supplements thereto as the superintendent prescribes, and pay a fee of eight thousand dollars for each year or fraction of a year in which a license shall be valid.

(2) Every pharmacy benefit manager's license shall expire thirty-six months after the date of issue. Every license issued pursuant to this section may be renewed for the ensuing period of thirty-six months upon the filing of an application in conformity with this subsection.

(e) If an application for a renewal license shall have been filed with the superintendent at least two months before its expiration, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant.

(f) The superintendent may refuse to issue a pharmacy benefit manager's license if, in the superintendent's judgment, the applicant or any member, principal, officer or director of the applicant, is not trustworthy and competent to act as or in connection with a pharmacy benefit manager, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(g) Licensees and applicants for a license under this section shall be subject to examination by the superintendent as often as the superintendent may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and such other regulations as necessary.

(h) The superintendent may issue a replacement for a currently in-force license that has been lost or destroyed. Before the replacement license shall be issued, there shall be on file in the office of the superintendent a written application for the replacement license,

affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of eight hundred dollars.

(i) No pharmacy benefit manager shall engage in any practice or action that a health plan is prohibited from engaging in pursuant to this chapter.

§ 2907. Revocation or suspension of a registration or license of a pharmacy benefit manager. (a) The superintendent may revoke, or may suspend for a period the superintendent determines the registration or license of any pharmacy benefit manager if, after notice and hearing, the superintendent determines that the registrant or licensee or any member, principal, officer, director, or controlling person of the registrant or licensee, has:

(1) violated any insurance laws, section two hundred eighty-a of the public health law or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of his or her dealings in such capacity after such registration or license has been issued or renewed pursuant to this article;

(2) provided materially incorrect, materially misleading, materially incomplete or materially untrue information in the registration or license application;

(3) obtained or attempted to obtain a registration or license through misrepresentation or fraud;

(4)(A) used fraudulent, coercive or dishonest practices;

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

(D) demonstrated financial irresponsibility in the conduct of business in this state or elsewhere;

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

(6) intentionally misrepresented the terms of an actual or proposed insurance contract;

(7) admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) had a pharmacy benefit manager registration or license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(9) failed to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

(10) ceased to meet the requirements for registration or licensure under this article.

(b) Before revoking or suspending the registration or license of any pharmacy benefit manager pursuant to the provisions of this article, the superintendent shall give notice to the registrant or licensee and shall hold, or cause to be held, a hearing not less than ten days after the giving of such notice.

(c) If a registration or license pursuant to the provisions of this article is revoked or suspended by the superintendent, then the superintendent shall forthwith give notice to the registrant or licensee.

(d) The revocation or suspension of any registration or license pursuant to the provisions of this article shall terminate forthwith such registration or license and the authority conferred thereby. For good cause shown, the superintendent may delay the effective date of a revocation or suspension to permit the registrant or licensee to satisfy some or all of its contractual obligations to perform pharmacy benefit management services in the state.

(e)(1) No individual, corporation, firm or association whose registration or license as a pharmacy benefit manager has been revoked pursuant to subsection (a) of this section, and no firm or association of which such individual is a member, and no corporation of which such individual is an officer or director, and no controlling person of the registrant or licensee shall be entitled to obtain any registration or license under the provisions of this article for a minimum period of one year after such revocation, or, if such revocation be judicially reviewed, for a minimum period of one year after the final determination thereof affirming the action of the superintendent in revoking such license.

(2) If any such registration or license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation or any controlling person of the

registrant or licensee shall be entitled to obtain any registration or license under this article for the same period of time, unless the superintendent determines, after notice and hearing, that such member, officer or director was not personally at fault in the matter on account of which such registration or license was revoked.

(f) If any corporation, firm, association or person aggrieved shall file with the superintendent a verified complaint setting forth facts tending to show sufficient ground for the revocation or suspension of any pharmacy benefit manager's registration or license, and the superintendent finds the complaint credible, then the superintendent shall, after notice and a hearing, determine whether such registration or license shall be suspended or revoked.

(g) The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter against any person or entity who is under investigation for or charged with a violation of this chapter, even if the person's or entity's registration or license has been surrendered, or has expired or has lapsed by operation of law.

(h) A registrant or licensee subject to this article shall report to the superintendent any administrative action taken against the registrant or licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

§ 2908. Penalties for violations. (a) The superintendent, in addition to any other power conferred by law, may in any one proceeding by order, require the registrant or licensee who violates the provisions of this article or section two hundred eighty-a of the public health law, or any regulation promulgated thereunder to make restitution and pay

compensatory damages, in an amount to be determined by the superintendent, to any person injured by the unlawful actions of said registrant or licensee and to pay to the people of this state a penalty in a sum not exceeding the greater of (1) four thousand dollars for each offense and ten thousand dollars for each subsequent violation or (2) the aggregate gross receipts attributable to all offenses.

(b) Upon the failure of such a registrant or licensee to pay the penalty ordered pursuant to subsection (a) of this section within twenty days after the mailing of the order, postage prepaid, registered, and addressed to the last known place of business of the licensee, unless the order is stayed by an order of a court of competent jurisdiction, the superintendent may revoke the registration or license of the registrant or licensee or may suspend the same for such period as the superintendent determines.

§ 2909. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil practice law and rules, to review the action of the superintendent in suspending or revoking or refusing to renew any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay shall not be extended for a longer period unless the court shall determine, after a preliminary hearing of which the superintendent is notified forty-eight hours in advance, that a stay of the superintendent's action pending the final determination or further order of the court will not unduly injure the interests of the people of the state.

§ 2910. Revoked registrations or licenses. (a)(1) No person, firm, association, corporation or other entity subject to the provisions of this article whose registration or license under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States shall become employed or appointed by a pharmacy benefit manager as an officer, director, manager, controlling person or for other services, without the prior

written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(2) No person, firm, association, corporation or other entity subject to the provisions of this article shall knowingly employ or appoint any person or entity whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States, as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(3) No corporation or partnership subject to the provisions of this article shall knowingly permit any person whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state, or territory of the United States, to be a shareholder or have an interest in such corporation or partnership, nor shall any such person become a shareholder or partner in such corporation or partnership, without the prior written approval of the superintendent.

(b) The superintendent may approve the employment, appointment or participation of any such person whose registration or license has been revoked:

(1) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants or licensees, or the registrant or licensee proposing employment or appointment of such person; or

(2) if such person has filed an application for reregistration or relicensing pursuant to this article and the application for reregistration or relicensing has not been approved or denied within one hundred twenty days following the filing thereof, unless the superintendent determines within the said time that employment or appointment of such person by a registrant or licensee in the conduct of a pharmacy benefit management business would not be in the public interest.

(c) The provisions of this section shall not apply to the ownership of shares of any corporation registered or licensed pursuant to this article if the shares of such corporation are publicly held and traded in the over-the-counter market or upon any national or regional securities exchange.

§ 2911. Additional obligations. (a) A pharmacy benefit manager shall assist a health plan in answering any inquiry made under section three hundred eight of this chapter.

(b) No pharmacy benefit manager shall violate any provisions of the public health law applicable to pharmacy benefit managers.

(c) No pharmacy benefit manager shall permit any subcontractor, affiliate, subsidiary, or other individual or entity performing pharmacy benefit management services for a pharmacy benefit manager to take any action which would violate any provision of law if taken by the pharmacy benefit manager. A pharmacy benefit manager shall be responsible for the actions of any subcontractor, affiliate, subsidiary, or other individual or entity who violates any provision of this article in performance of any pharmacy benefit management services for such pharmacy benefit manager whether or not the pharmacy benefit manager was aware of, or sanctioned, the conduct.

§ 2912. Change of address. A registrant or licensee under this article shall inform the superintendent by a means acceptable to the superintendent of a change of address within thirty days of the change.

§ 2913. Applicability of other laws. Nothing in this article shall be construed to exempt a pharmacy benefit manager from complying with the provisions of articles twenty-one and forty-nine of this chapter and articles forty-four and forty-nine and section two hundred eighty-a of the public health law, section three hundred sixty-four-j of the social services law, or any other provision of this chapter or the financial services law.

§ 2914. Assessments. Notwithstanding section two hundred six of the financial services law, pharmacy benefit managers that file a registration with the department or are licensed by the department shall be assessed by the superintendent for the operating expenses of the department that are attributable to regulating such pharmacy benefit managers in such proportions as the superintendent shall deem just and reasonable.

ARTICLE 31

INSURANCE CONTRACTS - GENERAL

Section 3101. Simplified comprehensive policies of insurance.
3102. Requirements for the use of readable and understandable insurance policies.
3103. Non-conforming contracts.
3104. Contract provisions required by laws of other jurisdictions.
3105. Representations by the insured.
3106. Warranty defined; effect of breach.
3107. Sale of insurance policies by vending machine.
3108. Reinsurance contracts excepted.
3109. False statements in applications for membership in fraternal benefit societies.
3110. Withdrawal of any policy form.
3111. Special provisions relating to senior citizens.
3112. Automatic bank withdrawal agreements; notification required.
3113. Consent of and notification of an irrevocable beneficiary under a court order of divorce or separation.
3114. Hate crimes; coverage refusal.

§ 3101. Simplified comprehensive policies of insurance. Simplified policies of insurance providing broad coverage of all or various combinations of risks may be approved by the superintendent and issued by insurers notwithstanding any provision of this chapter, and

notwithstanding those provisions of any other law which specify the content of insurance policies, provided that such policies shall be subject to regulations promulgated by the superintendent specifying the standards which must be met by insurers for issuing such policies and assuring to policyholders and claimants protections not less favorable than they would be entitled to under a substantially similar policy which is not subject to this section.

§ 3102. Requirements for the use of readable and understandable insurance policies. (a) Definitions. In this section "insurance policy" means any:

(1) form subject to approval under either section three thousand two hundred one or four thousand three hundred eight of this chapter;

(2) comprehensive health services plan as defined in section four thousand four hundred one of the public health law;

(3) contract of insurance for owners of dwellings consisting of not more than four dwelling units, and for household furnishings and personal property contained in any household unit, written for a divisible or indivisible premium which provides coverage for the peril of fire and extended coverage with or without any other kind of insurance as provided pursuant to subsection (a) of section one thousand one hundred thirteen of this chapter;

(4) contract of insurance insuring against losses or liabilities arising out of the ownership, operation, or use of a motor vehicle predominantly used for non-business purposes, when a natural person is the named insured.

(b) Exclusions. (1) This section shall not apply to:

(A) any insurance policy which has been determined to be a security subject to federal jurisdiction;

(B) certificates issued pursuant to a group life or accident and health insurance policy or group annuity contract issued to an employer covering persons employed in more than one state;

(C) any group insurance policy covering a group of one hundred or more lives, other than dependents, at date of issue, and a group credit life insurance policy or a group credit accident and health insurance policy; provided, however, this shall not exempt any certificate issued pursuant

to a group insurance policy delivered or issued for delivery in this state;

(D) any group annuity contract which serves as a funding vehicle for pension, profit sharing or deferred compensation plans; provided, however, this shall not exempt any certificate issued pursuant to such group annuity contract;

(E) any insurance policy of life and accident and health insurance used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, an insurance policy approved prior to October first, nineteen hundred eighty-two;

(F) the renewal of an insurance policy of life and accident and health insurance made, issued or delivered on a form provided prior to October first, nineteen hundred eighty-two;

(G) any insurance policy issued pursuant to article sixty-three of this chapter;

(H) any funding agreement issued pursuant to section three thousand two hundred twenty-two of this chapter; or

(I) any service contract issued pursuant to article seventy-nine of this chapter.

(2) No other statute of this state or provision of this chapter establishing language simplification standards shall apply to any insurance policy.

(3) Any non-English language insurance policy made, issued or delivered in this state on a risk located or resident in this state shall be deemed to be in compliance with subparagraph (D) of paragraph one of subsection (c) of this section if the insurer certifies that such insurance policy is translated from an English language insurance policy which does comply with such subparagraph.

(c) Readability requirements. (1) In addition to any other requirements of law, no insurance policy, except as set forth in subsection (b) of this section, shall be made, issued or delivered in this state on a risk located or resident in this state, unless:

(A) it is written in a clear and coherent manner;

(B) wherever practicable, it uses words with common and everyday meanings to facilitate readability and to aid the insured or policyholder in understanding the coverage provided;

(C) it has been filed with and approved by the superintendent;

(D) the text achieves a minimum score of forty-five on the Flesch reading ease test or an equivalent score on any other comparable test as provided in paragraph three of this subsection;

(E) it is printed, except for specification pages, schedules and tables, in not less than ten point type, and except for applications, specification pages, schedules and tables, such type is at least one point leaded;

(F) it is appropriately divided and captioned and presented in meaningful sequence; each section to contain an underlined, boldface or otherwise conspicuous title or caption at the beginning that indicates the nature of the subject matter included in or covered by the section;

(G) it contains a table of contents or an index of the principal sections of the insurance policy if the insurance policy has more than three thousand words or if the insurance policy has more than three pages regardless of the number of words;

(H) it has margins that are adequate for the purposes of readability; and

(I) it is printed in such manner that it includes sufficient contrast of ink and paper to be legible.

(2) For the purposes of this subsection, a Flesch reading ease test score shall be measured by the following method:

(A) For an insurance policy containing ten thousand words or less of text, the entire form shall be analyzed. For an insurance policy containing more than ten thousand words, the readability of two hundred word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least twenty printed lines.

(B) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multipled by a factor of 1.015.

(C) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(D) The sum of the figures computed under subparagraphs (B) and (C) hereof subtracted from 206.835 equals the Flesch reading ease score for the insurance policy.

(E) For purposes of subparagraphs (B), (C) and (D) hereof, the following procedures shall be used:

(i) a contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;

(ii) a unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(iii) a syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(F) In this subsection "text" includes all printed matter except the following:

(i) the name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables; and

(ii) any language which is drafted to conform to the requirements of any state or federal law, regulation or agency interpretation; any language required by any collectively bargained agreement; any medical terminology; and words which are defined in the insurance policy; and any language required by law or regulation; provided, however, the insurer identifies the language or terminology excepted by this subparagraph and certifies in writing that the language or terminology is entitled to be excepted by this subparagraph.

(3) Any other reading test may be designated by the superintendent for use as an alternative to the Flesch reading ease test.

(4) Filings subject to this subsection shall be certified by an officer of the insurer that they meet the minimum reading ease score on the test used or state that the score is lower than the minimum required but should be approved in accordance with subsection (d) of this section. To confirm the accuracy of any certification, the superintendent may require the submission of further information to verify the certification in question.

(5) At the option of the insurer, riders, endorsements, applications and other forms may be scored as separate forms or as part of the insurance policy with which they may be used.

(d) Lower score permitted. The superintendent may authorize a lower score than the Flesch reading ease score required in subparagraph (D) of paragraph one of subsection (c) of this section whenever, in the superintendent's sole discretion, he finds that a lower score:

(1) nevertheless reflects a readable and an understandable insurance policy which is consistent with the purposes of this section;

(2) is warranted by the nature of a particular insurance policy or type or class of insurance policies; or

(3) is caused by certain language which is drafted to conform to the requirements of any state law, regulation, agency or departmental interpretation.

(e) Other laws. (1) Any insurance policy meeting the requirements of subparagraphs (D) through (I) of paragraph one of subsection (c) of this section may be approved notwithstanding the provisions of any other laws which specify the content of insurance policies, if in the opinion of the superintendent the insurance policy provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

(2) This section shall not prohibit the use of words or phrases or contractual provisions required by state or federal law, rule or regulation or by a governmental instrumentality or by any collectively bargained agreement.

(f) Prohibition of non-conforming policies. Except as provided in subsection (b) of this section:

(1) no insurance policy described in paragraph one or two of subsection (a) of this section shall be made, issued or delivered in this state on a risk located or resident in this state, unless the policy complies with the requirements of this section;

(2) no insurance policy described in paragraph three or four of subsection (a) of this section and no renewal or extension certificate in connection therewith shall be made, issued or delivered in this state unless the insurance policy complies with the requirements of this section.

§ 3103. Non-conforming contracts. (a) Except as otherwise specifically provided in this chapter, any policy of insurance or contract of annuity delivered or issued for delivery in this state in violation of any of the provisions of this chapter shall be valid and binding upon the insurer issuing the same, but in all respects in which its provisions are in violation of the requirements or prohibitions of this chapter it

shall be enforceable as if it conformed with such requirements or prohibitions.

(b) No policy of insurance or contract of annuity delivered or issued for delivery in this state shall provide that the rights or obligations of the insured or of any person rightfully claiming thereunder, with respect to:

(1) a policy of life, accident and health insurance or contract of annuity upon a person resident in this state,

(2) a policy of insurance upon property then in this state, or

(3) the liabilities to be incurred by the insured as a result of activity then carried on by the insured in this state,

shall be governed by the laws of any jurisdiction other than this state. This subsection shall not apply to policies of marine insurance.

(c) In any action to recover under the provisions of any policy of insurance or contract of annuity delivered or issued for delivery in this state which the superintendent is authorized by this chapter to approve if in his opinion its provisions are more favorable to policyholders, the court shall enforce such policy or contract as if its provisions were the same as those specified in this chapter unless the court finds that its actual provisions were more favorable to policyholders at the date when the policy or contract was issued.

§ 3104. Contract provisions required by laws of other jurisdictions. (a) Any foreign or alien insurer authorized to do business in this state may, with the approval of the superintendent, include in any life, accident and health insurance policy or contract of annuity delivered or issued for delivery in this state any provisions required by the laws of the jurisdiction in which such insurer is domiciled if such provisions are not substantially in conflict with the laws of this state.

(b) Any domestic insurer may include in any policy of insurance or contract of annuity issued for delivery in another jurisdiction and governed by the laws thereof, any provision required by the laws of such other jurisdiction applicable to such policy or contract.

§ 3105. Representations by the insured. (a) A representation is a

statement as to past or present fact, made to the insurer by, or by the authority of, the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(b)(1) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.

(2) With respect to a policy of hospital, medical, surgical, or prescription drug expense insurance subject to articles thirty-two or forty-three of this chapter, no misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless the misrepresentation was also intentional.

(c) In determining the question of materiality, evidence of the practice of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible.

(d) A misrepresentation that an applicant for life or accident and health insurance has not had previous medical treatment, consultation or observation, or has not had previous treatment or care in a hospital or other like institution, shall be deemed, for the purpose of determining its materiality, a misrepresentation that the applicant has not had the disease, ailment or other medical impairment for which such treatment or care was given or which was discovered by any licensed medical practitioner as a result of such consultation or observation. If in any action to rescind any such contract or to recover thereon, any such misrepresentation is proved by the insurer, and the insured or any other person having or claiming a right under such contract shall prevent full disclosure and proof of the nature of such medical impairment, such misrepresentation shall be presumed to have been material.

§ 3106. Warranty defined; effect of breach. (a) In this section "warranty" means any provision of an insurance contract which has the effect of requiring, as a condition precedent of the taking effect of

such contract or as a condition precedent of the insurer's liability thereunder, the existence of a fact which tends to diminish, or the non-existence of a fact which tends to increase, the risk of the occurrence of any loss, damage, or injury within the coverage of the contract. The term "occurrence of loss, damage, or injury" includes the occurrence of death, disability, injury, or any other contingency insured against, and the term "risk" includes both physical and moral hazards.

(b) A breach of warranty shall not avoid an insurance contract or defeat recovery thereunder unless such breach materially increases the risk of loss, damage or injury within the coverage of the contract. If the insurance contract specified two or more distinct kinds of loss, damage or injury which are within its coverage, a breach of warranty shall not avoid such contract or defeat recovery thereunder with respect to any kind or kinds of loss, damage or injury other than the kind or kinds to which such warranty relates and the risk of which is materially increased by the breach of such warranty.

(c) This section shall not affect the express or implied warranties under a contract of marine insurance in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on, over or under any seas or inland waters, nor shall it affect any provision in an insurance contract requiring notice, proof or other conduct of the insured after the occurrence of loss, damage or injury.

§ 3107. Sale of insurance policies by vending machine. (a) Any provision in a policy of accident insurance, requiring the signature of the insured, where such insurance is sold by a vending machine, shall be inoperative and of no effect, unless a notice shall have been placed upon such vending machine, containing letters each at least one-half inch high, advising that the signature of the insured must be placed upon such policy or contract, at time of purchase, to make such policy or contract valid.

(b) No insurance shall be offered for sale, issued or sold by or from any vending machine or appliance or any other medium, device or object designed or used for vending purposes, herein called a device, except as

provided in this section.

(c) A licensed agent may solicit applications for and issue policies of accident insurance or baggage insurance on personal effects by means of mechanical vending machines or other coin operated devices supervised by him and placed at airports, railroad stations or bus stations or other places to meet the convenience of the public, subject to the provisions of this section.

(d) Each policy to be sold by or from a device shall be reasonably suited for sale and issuance through such a device, and the location of such device shall be one that is of material convenience to the public.

(e) No policy of insurance, issued through any such device shall be for a period of time longer than ten days, or for the duration of a one-way or round trip, as applicable.

§ 3108. Reinsurance contracts excepted. The provisions of this article shall not apply to contracts of reinsurance, except as otherwise provided by law.

§ 3109. False statements in applications for membership in fraternal benefit societies. No applicant, officer, solicitor, examining physician, surgeon or other person shall knowingly or wilfully make any false or fraudulent statements or representations in or with reference to any application for membership or reinstatement or any other documentary or other proof for the purpose of obtaining or reinstating membership in or benefit from any fraternal benefit society, order or association, any corporation, association or society transacting the business of life or casualty insurance or both, upon the co-operative or assessment plan, or a corporation for the insurance of domestic animals.

§ 3110. Withdrawal of any policy form. (a) Whenever by the provisions of this chapter the superintendent is authorized to give approval of any form of insurance policy or contract, the superintendent may, after notice and hearing given to the insurer that submitted such form for approval, withdraw an approval previously given, if the use of such form

is contrary to the requirements applicable to such form at the time of such withdrawal. Any such withdrawal shall be effective at the expiration of such period, not less than ninety days after the giving of notice of withdrawal, as the superintendent shall in such notice prescribe.

(b) Whenever by the provisions of this chapter an insurer may use a policy form without obtaining the prior approval of the superintendent, the superintendent may, after notice and hearing given to the insurer, order the insurer to cease using such policy form, if the use of such form is contrary to the requirements applicable to such form at the time of the effective date of such order. Any such order shall be effective at the expiration of such period, not less than ninety days after the giving of a notice of cessation, as the superintendent shall in such notice prescribe.

§ 3111. Special provisions relating to senior citizens. (a) Every insurer that has in force any policy of insurance subject to the provisions of section three thousand four hundred twenty-five of this chapter shall permit senior citizen insureds to designate a third party to whom the insurer shall transmit notices of cancellation, nonrenewal and conditional renewal. The senior citizen insured shall notify the insurer that a third party has been so designated. Such notification shall be delivered to the insurer by certified mail, return receipt requested, and shall be effective not later than ten business days from the date of receipt by the insurer. The notification must contain, in writing, an acceptance by the third party designee to receive notices of cancellation, nonrenewal and conditional renewal from the insurer. Should the third party designee desire to terminate his or her status as a third party designee, such designee shall provide written notice to both the insurer and the senior citizen insured. Should the senior citizen insured desire to terminate the third party designation, the insured shall provide written notice to the insurer. The transmission to the third party designee of any notice of cancellation, nonrenewal or conditional renewal shall be in addition to a copy of such document transmitted to the senior citizen insured and when a third party is so designated all such notices shall be mailed in an envelope clearly

marked on its face with the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". Designation as a third party shall not constitute acceptance of any liability on the third party for services provided to such senior citizen. The insurer shall notify its senior citizen insureds annually in writing of the availability of the third party designee notice procedure and provide information on how the insured can commence this procedure, however, such notice need not be provided once a senior citizen has made a designation.

(b) Every insurer that has in force a premium paying individual life insurance policy on the life of a senior citizen insured, who has made a designation in accordance with paragraph one of subsection (b) of section three thousand two hundred eleven of this chapter, shall upon appropriate notification as described herein, provide such senior citizen with a copy of the notice of cancellation for nonpayment of premiums before the lapse date of the policy. The senior citizen insured shall notify the insurer that in addition to the person designated in accordance with paragraph one of subsection (b) of section three thousand two hundred eleven of this chapter, a copy of such notices of cancellation shall be transmitted to the senior citizen insured and when a third party is so designated all such notices shall be mailed in an envelope clearly marked on its face with the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". Such notification to the insurer shall be in writing delivered to the insurer by certified mail, return receipt requested and shall be effective not later than ten business days from the date of receipt by the insurer. Should the senior citizen insured desire to terminate receipt of such notices of cancellation, such senior citizen shall provide written notice to the insurer. The insurer shall at the time the senior citizen insured makes a designation in accordance with paragraph one of subsection (b) of section three thousand two hundred eleven of this chapter inform the senior citizen in writing about the notice procedure and provide information on how the insured can commence this procedure.

(c) Every insurer, corporation organized under article forty-three of this chapter or organization certified pursuant to article forty-four of the public health law that has in force a health insurance policy or medicare supplemental insurance policy as defined in section three thousand two hundred eighteen of this chapter the premiums for which are

paid directly to the insurer by the senior citizen insured shall permit senior citizen insureds to designate a third party to whom the insurer shall transmit notices of nonpayment of premiums due or notice of cancellation for nonpayment of premiums, as determined by the insurer. The senior citizen shall notify the insurer that a third party has been so designated. Such notification shall be delivered to the insurer by certified mail, return receipt requested, and shall be effective not later than ten business days from the date of receipt by the insurer. The notification must contain, in writing, an acceptance by the third party designee to receive such notices of cancellation. Should the third party designee desire to terminate his or her status as a third party designee, such designee shall provide written notice to both the insurer and the senior citizen insured. Should the senior citizen insured desire to terminate the third party designation, the insured shall provide written notice to the insurer. The transmission to the third party designee of any such notice of cancellation shall be in addition to a copy of such document transmitted to the senior citizen insured and when a third party is so designated all such notices shall be mailed in an envelope clearly marked on its face with the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". Designation as a third party shall not constitute acceptance of any liability on the third party for services provided to such senior citizen. The insurer shall notify its senior citizen insureds annually in writing of the availability of the third party designee notice procedure and provide information on how the insured can commence this procedure; however, such notice need not be provided once a senior citizen has made a designation.

(d) In the case of a medicare supplemental insurance policy as defined in section three thousand two hundred eighteen of this chapter offered by or through a group the premiums for which are paid to the insurer by the group policyholder or group remitting agent, the group policyholder or group remitting agent shall permit senior citizen insureds to designate a third party to whom the group policyholder or group remitting agent shall transmit notices of nonpayment of premiums due or notice of cancellation for nonpayment of premiums, as determined by the group policyholder or group remitting agent. The senior citizen shall notify the group policyholder or group remitting agent that a third

party has been so designated. Such notification shall be delivered to the group policyholder or group remitting agent by mail, and shall be effective not later than ten business days from the date of receipt by the group policyholder or group remitting agent. The notification must contain, in writing, an acceptance by the third party designee to receive such notices of cancellation. Should the third party designee desire to terminate his or her status as a third party designee, such designee shall provide written notice to both the group policyholder or group remitting agent and the senior citizen insured. Should the senior citizen insured desire to terminate the third party designation, the insured shall provide written notice to the group policyholder or group remitting agent. The transmission to the third party designee of any such notice of cancellation shall be in addition to a copy of such document transmitted to the senior citizen insured and when a third party is so designated all such notices shall be mailed in an envelope clearly marked on its face with the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". Designation as a third party shall not constitute acceptance of any liability on the third party for services provided to such senior citizen. The group policyholder or group remitting agent shall notify its senior citizen insureds annually in writing of the availability of the third party designee notice procedure and provide information on how the insured can commence this procedure; however, such notice need not be provided once a senior citizen has made a designation.

(e) Every insurer that has in force a long-term care insurance policy as defined in section one thousand one hundred seventeen of this chapter the premiums for which are paid directly to the insurer by the senior citizen insured, except a policy that qualifies as a long-term care insurance contract as defined in Section 7702B of the Internal Revenue Code, shall permit senior citizen insureds to designate a third party to whom the insurer shall transmit notices of nonpayment of premiums due or notice of cancellation for nonpayment of premiums; provided that notice of cancellation for nonpayment of premium shall be sent no later than thirty days before the effective date of such cancellation. The senior citizen insured shall notify the insurer that a third party has been so designated. Such notification shall be delivered to the insurer either in the same envelope as the senior citizen insured's premium payment or

by certified mail, return receipt requested, and shall be effective not later than ten business days from the date of receipt by the insurer. The notification must contain, in writing, an acceptance by the third party designee to receive such notices of cancellation. Should the third party designee desire to terminate his or her status as a third party designee, such designee shall provide written notice to both the insurer and the senior citizen insured. Should the senior citizen insured desire to terminate the third party designation, the insured shall provide written notice to the insurer. The transmission to the third party designee of any such notice of cancellation shall be in addition to a copy of such document transmitted to the senior citizen insured and when a third party is so designated all such notices shall be mailed in an envelope clearly marked on its face with the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". Designation as a third party shall not constitute acceptance of any liability on the third party for services provided to such senior citizen. The insurer shall notify its senior citizen insureds not less than annually in writing of the availability of the third party designee notice procedure and provide information on how the insured can commence this procedure. If a senior citizen insured has not made a third party designation, the insurer shall include a copy of the third party designation form with each premium statement sent to the senior citizen insured. If a senior citizen insured has made a designation, the insurer shall confirm with the senior citizen insured that the third party designee's contact information is correct. Upon receipt of a designation or termination of a designation, the insurer shall verify the designation or cancellation of designation with the senior citizen insured. Such verification may, but is not required to be, written and the insurer may use telephony to obtain an oral confirmation from the senior citizen insured so long as the insurer provides the senior citizen insured with written confirmation of the oral verification.

(f) For purposes of this section, "senior citizen insured" shall mean a New York resident who is the policyowner or the insured and is age sixty-five or older. The superintendent may promulgate regulations necessary to carry out the purposes of this section.

§ 3112. Automatic bank withdrawal agreements; notification required. Any insurer licensed to issue insurance in the state who has an automatic bank withdrawal agreement with an insured for the payment of insurance premiums for any type of insurance shall give the insured at least fifteen days advance written notice of any increase in policy premiums prior to any automatic bank withdrawal of an increased premium.

§ 3113. Consent of and notification of an irrevocable beneficiary under a court order of divorce or separation. In any case where a policy owner has, pursuant to an order of separation or divorce, designated his or her spouse or children as the irrevocable beneficiary of a policy of insurance subject to the provisions of section three thousand two hundred three of this chapter, and a copy of such order has been served, by registered mail, on the home office of the insurer specifying the name and mailing address of the spouse or children, such insurer shall:

(a) prohibit the policy holder from borrowing from the cash value or changing the named beneficiary of such insurance policy without the written consent of the irrevocable beneficiary; and

(b) provide written notification to the irrevocable beneficiary in the event that such insurance policy is scheduled to lapse due to non-payment of premium.

ARTICLE 32

INSURANCE CONTRACTS - LIFE, ACCIDENT AND HEALTH, ANNUITIES

Section 3201. Approval of life, accident and health, credit unemployment, and annuity policy forms.

3202. Withdrawal of approval of policy forms.

3203. Individual life insurance policies; standard provisions as to contractual rights and responsibilities of policyholders and insurers.

3204. Policy to contain entire contract; statements of applicant to be representations and not warranties; alterations.

3205. Insurable interest in the person; consent required; exceptions.

3206. Policies which provide for an adjustable maximum rate of interest on policy loans.
3207. Life insurance contracts by or for the benefit of minors; on the lives of minors, limitations on amount.
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3209. Life insurance, annuities and funding agreements disclosure requirements.
3210. Incontestability after reinstatement.
3211. Notice of premium due under life or disability insurance policy; notice to assignees of non-payment of premium.
3212. Exemption of proceeds and avails of certain insurance and annuity contracts.
3213. Payment of proceeds.
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3215. Disability benefits in connection with life insurance and annuities.
3216. Individual accident and health insurance policy provisions.
3217. Minimum standards in the form, content and sale of accident and health insurance; policies and subscriber contracts.
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3217-j. Utilization review determinations for medically fragile children.
3218. Medicare supplemental insurance policies.
3219. Annuity and pure endowment contracts and certain group

annuity certificates; standard provisions as to contractual rights and responsibilities of contract holders, certificate holders and insurers.

3220. Group life insurance policies; standard provisions.

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

3222. Funding agreements.

3223. Group annuity contracts; standard provisions as to contractual rights and responsibilities of contract holders, certificate holders and annuitants, and insurers.

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3224-b. Rules relating to the processing of health claims and overpayments to physicians.

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3225. Eligibility for health insurance in cases of exposure to DES.

3226. Reinsurance contracts excepted.

3227. Interest upon surrenders, policy loans and other funds.

3228. Individual accident and health insurance policies; premium refund at death of insured.

3229. Minimum benefit standards for certain long term care plans.

3230. Accelerated payment of the death benefit or special surrender value under a life insurance policy.

3231. Rating of individual and small group health insurance policies; approval of superintendent.

3231*2. Health insurance policies and subscriber contracts; prohibited claims.

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3232-a. Certification of creditable coverage.

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3234. Pre-existing condition provisions in group and blanket disability policies.
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3236. Public health law assessments.
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3243. Discrimination because of sex or marital status in hospital, surgical or medical expense insurance.
3244. Explanation of benefits forms relating to claims under certain accident and health insurance policies.
3245. Liability to providers in the event of an insolvency.

§ 3201. Approval of life, accident and health, credit unemployment, and annuity policy forms. (a) In this article, "policy form" means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto, affording benefits of the kinds of insurance specified in paragraph one, two, three or twenty-four of subsection (a) of section one thousand one hundred thirteen of this chapter, a group annuity certificate to which subsection (a) of section three thousand two hundred nineteen of this article applies, and a funding agreement authorized by section three thousand two hundred twenty-two of this article. The term "policy form" shall not include an agreement, special rider, or endorsement relating only to the manner of distribution of benefits or to the reservation of rights and benefits used at the request of the individual policyholder,

contract holder or certificate holder.

(b) (1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law. A group life, group accident, group health, group accident and health or blanket accident and health insurance certificate evidencing insurance coverage on a resident of this state shall be deemed to have been delivered in this state, regardless of the place of actual delivery, unless the insured group is of the type described in: (A) section four thousand two hundred sixteen, except paragraph four where the group policy is issued to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry with respect to an employer principally located within the state, paragraph twelve, thirteen or fourteen of subsection (b) thereof; (B) section four thousand two hundred thirty-five except subparagraph (D) where the group policy is issued to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry with respect to an employer principally located within the state, subparagraph (K), (L) or (M) of paragraph one of subsection (c) thereof; or (C) section four thousand two hundred thirty-seven (except subparagraph (F) of paragraph three of subsection (a) thereof; of this chapter; and where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business. With regard to any certificate deemed to have been delivered in this state by virtue of this paragraph, the superintendent shall (i) require that the premiums charged be reasonable in relation to the benefits provided, except in cases where the policyholder pays the entire premium; (ii) have power to issue regulations prescribing the required, optional and prohibited provisions in such certificates; (iii) establish an accelerated certificate form approval procedure available to an insurer which includes a statement in its policy form submission letter that it is the company's opinion that the certificate form or forms comply with applicable New York law and regulations. The superintendent, upon receipt of such a filing letter, shall grant conditional approval of such certificate form or forms in reliance on the aforementioned statement by the company upon the condition that the company will retroactively modify such certificate

form or forms, to the extent necessary, if it is found by the superintendent that the certificate form fails to comply with applicable New York laws and regulations. The superintendent may, with regard to the approval of any certificate deemed to have been delivered in this state by virtue of this paragraph, approve such certificate if the superintendent finds that the certificate affords insureds protections substantially similar to those which have been provided by certificates delivered in this state. Any regulations issued by the superintendent pursuant to this paragraph may not impose stricter requirements than those applicable to similar policies and certificates actually delivered in this state.

(2) No unallocated group annuity contract or funding agreement, or policy form for accident and health insurance or any other policy form specified by the superintendent pursuant to regulation shall be issued by a domestic insurer or fraternal benefit society for delivery outside this state unless it has been filed with the superintendent.

(3) In exercising the authority granted by this subsection and by subsection (c) hereof, with respect to a policy or certificate form under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two or section four thousand five hundred eighteen of this chapter, the superintendent shall take into account the tax aspects of the policy form as they relate to all parties concerned.

(4) (A) No credit insurance or credit unemployment insurance policy form shall be issued unless it and its premium rates have been filed with and approved by the superintendent. In this section "credit insurance" and "credit unemployment insurance" mean insurance on a debtor, including an intended borrower, pursuant to a program as defined in paragraph three of subsection (b) of section four thousand two hundred sixteen of this chapter for defraying the costs of attendance of a student at a college or university, in connection with a specified loan or other credit transaction to provide payment to the creditor in the event of the death of the debtor or indemnity to the creditor for the installment payments on the indebtedness becoming due while the debtor is disabled as defined in the policy, or payment to the creditor for the installment payments on the indebtedness becoming due while the debtor is unemployed as set forth in section three thousand four hundred

thirty-six of this chapter.

(B) The superintendent shall from time to time prescribe regulations which, among other things, shall require that, in the event of the termination of the insurance prior to the scheduled maturity date of the indebtedness or the last maturing instalment thereof, there shall be an appropriate refund by the insurer to the policyholder of any amount collected from or charged to the policyholder for such terminated insurance, and an appropriate refund or credit by the policyholder or creditor to the debtor of an amount collected from or charged to the debtor for such terminated insurance, if such refund amounts to one dollar or more.

(5) Notwithstanding the other provisions of this section, on and after June first, nineteen hundred eighty no policy form of industrial life insurance, industrial accident insurance or industrial health insurance shall be approved by the superintendent for delivery or issuance for delivery in this state.

(6) (A) As an alternative procedure to the policy form filing requirements of paragraph (1) of this subsection, an insurer has the option to file an expedited policy form approval application with the superintendent pursuant to this paragraph. If this option is elected, the filing shall include the proposed policy form, including rates as required, and all necessary supporting material requested by the superintendent pursuant to rule, and a certification signed by an officer of the insurer, who is knowledgeable with respect to the law and regulation applicable to the type of policy form, that such form is in compliance with the applicable law and regulations to the best of his or her knowledge and belief.

Within ninety days of receipt of a filing, the superintendent shall, in writing, either approve, submit a detailed list to the insurer requesting all additional information necessary to make a determination on the filing, or deny such filing, otherwise, such filing shall be deemed approved. Any denial issued by the superintendent shall state the reasons for such disapproval. If an insurer does not provide the additional information requested by the superintendent, or respond to the superintendent's objections within forty-five days of receipt of such request or denial, then such filing shall be deemed denied and such

filing may not be resubmitted for a period not to exceed ninety days from the date that such information or response was due. The forty-five day limit for providing such additional information or response may be extended at the option of the superintendent.

In the event that an insurer properly submits the additional information or response, then such filing shall be deemed approved forty-five days after receipt of such information or response by the superintendent, unless the insurer is notified in writing prior to such date that the filing has been denied. Such denial shall state the reasons for such disapproval and cannot be based on any objection not specified in the superintendent's initial review of the filing, unless the objection arises from a modification of the policy forms made by the insurer in addressing the objections or new material submitted by the insurer. Notwithstanding anything to the contrary contained in this section, the superintendent may, at any time, before the filing is either deemed approved, affirmatively approved, or denied, raise objections to the policy form that is based on the explicit requirements of this chapter and any applicable regulations.

The superintendent shall, as soon as practicable, but no later than sixty days after receipt of the filing, notify the insurer if its filing is incomplete or fails to comply with applicable statutory or regulatory requirements. Such notice shall indicate that the filing is being returned with no action by the superintendent and that the period for the superintendent's substantive review has not commenced.

(B) Nothing contained in this paragraph shall prohibit the superintendent from requiring an insurer to retroactively modify or withdraw a form approved pursuant to the expedited filing procedure if such form is found to fail to conform with the requirements of this chapter, provided that the order to withdraw or modify such form is issued in accordance with the provisions of section three thousand one hundred ten or section three thousand two hundred two of this chapter.

(C) In addition to any penalties for violations contained in this chapter, any insurer which receives approval under this subsection for a form which is found to fail to comply with the provisions of this chapter shall be ineligible to apply for an expedited review under this

subsection for a period not to exceed one year.

(7) Notwithstanding any other provision of this section, an approved policy form that has been revised may continue to be delivered or issued for delivery in this state without further approval from the superintendent, provided that the policy form is revised solely to reflect:

(A) a change in the investment options of a separate account offered under the policy form, in accordance with an amended statement as to the methods of operation of the separate account approved by the superintendent pursuant to subsection (e) of section four thousand two hundred forty of this chapter, and further provided that an informational filing, in a form acceptable to the superintendent, identifying the policy forms that have been revised and the investment options offered in each policy form, is submitted to the superintendent no later than sixty days after the amended statement as to the methods of operation of the separate account has been approved; or

(B) any other type of change to a class or classes of policy forms for which the superintendent waives or otherwise modifies the filing and approval requirements of this section provided, however, that such determination to waive or otherwise modify shall be published in written guidance issued by the superintendent after such determination has been made.

(c) (1) The superintendent may disapprove any policy form for delivery or issuance for delivery in this state if he finds that the same contains any provision or has any title, heading, backing or other indication of the contents of any or all of its provisions, which is likely to mislead the policyholder, contract holder or certificate holder.

(2) The superintendent may disapprove any life insurance policy form, or any form of annuity contract or group annuity certificate, or any form of funding agreement for delivery or issuance for delivery in this state, if its issuance would be prejudicial to the interests of policyholders or members or it contains provisions which are unjust, unfair or inequitable.

(3) The superintendent may disapprove any accident and health insurance policy form for delivery or issuance for delivery in this state if the benefits provided therein are unreasonable in relation to

the premium charged or any such form contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state.

(4) The superintendent shall not approve any life insurance policy form containing any war or travel exclusion or restriction, for delivery or issuance for delivery in this state, unless such policy form shall have printed or stamped across its face in red and in capital letters not smaller than twelve point type, or in an equally prominent manner established at the discretion of the superintendent and promulgated through regulations, the following:

"Read your policy (certificate) carefully.

"Certain (war, travel) risks are not assumed.

_____

(state which or both)

In case of any doubt write your company (society) for further explanation."

(5) The superintendent shall not approve any annuity or life insurance policy form which is subject to the provisions of section four thousand two hundred twenty, four thousand two hundred twenty-one or four thousand five hundred eleven of this chapter, unless a detailed statement of the method used by the insurer in calculating any cash surrender value and any paid-up nonforfeiture benefit in the policy form is stated therein or, in lieu thereof, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy form is delivered, and unless a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available on any anniversary beyond the last anniversary for which such value and benefits are consecutively shown in the policy form is included therein, and, with respect to policy forms under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two or section four thousand five hundred eighteen of this chapter, the insurer shall also furnish such further information to the superintendent as the superintendent may require.

(6) (a) The superintendent may disapprove any policy form specified in

paragraph two of subsection (b) of this section issued by a domestic life insurer or fraternal benefit society for delivery outside the state if its issuance would be prejudicial to the interests of its policyholders or members.

(b) Except for the policy forms specified in paragraph two of subsection (b) of this section, every domestic life insurer and fraternal benefit society shall file annually with the superintendent a list identifying and describing the policy forms issued by the insurer or fraternal benefit society for delivery outside the state in a form prescribed by the superintendent. If the superintendent determines that the issuance of a policy form has been or may be prejudicial to the interests of policyholders or members, the superintendent may take any action he or she deems appropriate, including issuing an order, after a hearing, to cease and desist issuing the policy form.

(7) If any policy of individual accident and health insurance is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the superintendent that any such policy form is not subject to approval or disapproval by such official, the superintendent may by ruling require that such policy form meet the standards set forth in subsections (c) and (d) of section three thousand two hundred sixteen of this article.

(8) Without limitation on his other powers and duties under this section, the superintendent shall not approve any credit insurance or credit unemployment insurance policy forms or premium rates if the premium rates are unreasonable in relation to the benefits provided.

(9) Each insurer shall file with the superintendent of financial services any change in the premium rates for policies authorized under subparagraph (J) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, and the same shall be subject to his approval.

(10) The superintendent shall not approve any form of life insurance policy that is subject to the provisions of section four thousand two hundred twenty-one of this chapter or any form of annuity contract that is subject to the provisions of section four thousand two hundred twenty-three of this chapter if such form of policy or contract provides

for the adjustment of any cash surrender benefit or policy loan value in accordance with a market-value adjustment formula, unless there shall have been filed with the superintendent a memorandum, in form and substance satisfactory to the superintendent, describing the market-value adjustment formula and stating that, in the opinion of the insurer, the formula provides reasonable equity to terminating and continuing policy and contract holders and to the insurer and complies with the nonforfeiture provisions of this chapter.

(11) (A) The superintendent shall not approve a life insurance policy which provides for accelerated payment of death benefits or special surrender values pursuant to subparagraph (B), (C), (D), (E) or (F) of paragraph one of subsection (a) of section one thousand one hundred thirteen of this chapter unless it also provides for such accelerated payments or special surrender values pursuant to subparagraph (A) of paragraph one of subsection (a) of such section.

(B) The superintendent shall promulgate a regulation establishing rules for advertising, disclosure, benefit levels, benefit eligibility, payment of long term care benefits, nonforfeiture, and reserves for accelerated payment of death benefits or special surrender values provided under a life insurance policy. The regulation shall establish reasonable disclosure requirements concerning the percentage of the death benefit payable when accelerated payment of the death benefit or special surrender value occurs, the impact of accelerated payment of the death benefit or special surrender value on eligibility for public assistance (as determined by the commissioner of social services), the prohibition that no health care facility as defined in section twenty of the public health law can require any person to accelerate payment of a death benefit or obtain a special surrender value as a condition of admission, providing or continuing care, and notice of possible tax obligations.

(12) The superintendent shall promulgate a regulation relating to waiver of premium for unemployment as authorized by paragraph one of subsection (a) of section one thousand one hundred thirteen of this chapter establishing minimum standards for benefit levels, benefits eligibility and exclusions. The premium charged shall be reasonable in relation to the benefit provided.

(d) The superintendent shall, within a reasonable time after the

filing of any policy form requiring approval, notify the insurer filing the form of his approval or disapproval of it.

§ 3202. Withdrawal of approval of policy forms. The superintendent may, in accordance with section three thousand one hundred ten of this chapter, withdraw an approval previously given to a policy form pursuant to section three thousand two hundred one of this article. The superintendent may also withdraw an approval in the case of any such policy form (i) pertaining to accident and health insurance, if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, contrary to law or to the public policy of this state, or (ii) pertaining to life insurance, annuity contract, group annuity certificate, or funding agreement, if in his judgment the use of such form would be prejudicial to the interests of policyholders or members, or it contains provisions which are unjust, unfair or inequitable.

§ 3203. Individual life insurance policies; standard provisions as to contractual rights and responsibilities of policyholders and insurers. (a) All life insurance policies, except as otherwise stated herein, delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to policyholders:

(1) that, for policies in which the amount and frequency of premiums may vary, after payment of the first premium, the policyholder is entitled to a sixty-one day grace period, beginning on the day when the insurer determines that the policy's net cash surrender value is insufficient to pay the total charges necessary to keep the policy in force for one month from that day, within which to pay sufficient premium to keep the policy in force for three months from the date the insufficiency was determined. For all other policies, after payment of the first premium, the policyholder is entitled to a thirty-one day grace period or of one month following any subsequent premium due date within which to make payment of the premium then due. During such grace

period, the policy shall continue in full force;

(2) that if the death of the insured occurs within the grace period provided in the policy, the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred, and if the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred, provided such premium was not waived under any policy provision for waiver of premiums benefit. This paragraph shall not apply to single premium or paid-up policies;

(3) that the policy shall be incontestable after being in force during the life of the insured for a period of two years from its date of issue, and that, if a policy provides that the death benefit provided by the policy may be increased, or other policy provisions changed, upon the application of the policyholder and the production of evidence of insurability, the policy with respect to each such increase or change shall be incontestable after two years from the effective date of such increase or change, except in each case for nonpayment of premiums or violation of policy conditions relating to service in the armed forces. At the option of the insurer, provisions relating to benefits for total and permanent disability and additional benefits for accidental death may also be excepted;

(4) that the policy, together with the application therefor if a copy of such application is attached to the policy when issued, shall constitute the entire contract between the parties; but in the case of policies that provide that the death benefit or other policy provisions may be changed by written application or by the written notice of exercise of one or more options provided in the policy, or automatically by the terms of the policy, the policy may also contain a provision that when such written application or notice of exercise of an option is accepted by the insurer or a notice of any change is issued by the insurer and, in each case, a copy of such application or notice is returned by mail or delivered to the policyholder at the policyholder's last post office address known to the insurer, such application or notice shall become part of the entire contract between the parties;

(5) that if the age of the insured has been misstated, any amount

payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age;

(6) that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy;

(7) (A) that, in the case of policies which provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter or under which cash surrender values are adjusted in accordance with a market-value adjustment formula or which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy, specifies the mortality table, interest rate and method used in calculating cash surrender values and any paid-up nonforfeiture benefits available under the policy;

(B) that, in the case of all other policies, specifies the cash surrender values and other options available in the event of default in a premium payment after premiums have been paid for a specified period, together with a table showing, in figures, all options available during each of the policy's first twenty years. Such options shall comply with the requirements of subsection (a) of section four thousand two hundred twenty or section four thousand two hundred twenty-one of this chapter;

(8) (A) that, for a policy not in default and where three full years' premiums have been paid or, in the case of a policy where the policyholder may vary the amount and frequency of premiums to be paid to the insurer, after three years from the date of issue of the policy, the policyholder shall be entitled to a loan in an amount not exceeding the loan value, under the conditions specified in section four thousand two hundred twenty-two of this chapter. However, a policyholder shall be entitled to a loan from an equity index account that credits additional amounts less frequently than annually at any time the equity index policy has a loan value;

(B) that the sole security for the loan shall be assignment or pledge of the policy;

(C) that, unless the policy provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter or provides for the adjustment of the policy loan value in accordance with a market-value adjustment formula or

causes on a basis guaranteed in the policy unscheduled changes in benefits or premiums or provides an option for changes in benefits or premiums other than a change to a new policy, the policy shall contain a table showing the loan values, if any, available during each of the policy's first twenty years;

(D) that, in making a loan, the insurer may reduce the loan value (in addition to the indebtedness deducted in determining such value) by any unpaid premium balance for the current policy year;

(E) that, if the loan is made or repaid on a date other than the anniversary of the policy, the insurer may collect interest for the portion of the current policy year on a pro rata basis;

(F) that, at the option of the insurer, the loan shall bear interest (i) at a maximum rate of not more than seven and four-tenths per centum per annum if payable in advance or the equivalent effective rate of interest if otherwise payable, or (ii) at a rate not in excess of an adjustable maximum rate established from time to time by the insurer as permitted by law. If the policy provides for an adjustable rate, the policy shall specify the regular intervals at which the interest rate is to be determined which shall be at least once every twelve months but not more frequently than once in any three month period;

(G) the policy may further provide: (i) that if the interest on the loan is not paid when due, it shall be added to the existing loan, and shall bear interest at the applicable rate or rates payable on the loan determined in accordance with the provisions of the policy, and (ii) subject to subsection (e) of section three thousand two hundred six of this article that when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the policy's loan value and if at least thirty days' prior notice shall have been given in the manner provided in section three thousand two hundred eleven of this article, then the policy shall terminate and become void;

(H) any policy which provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter may also provide that if any indebtedness is owed to the insurer on any part of the loan value which would otherwise be credited with additional amounts, such additional amounts may be reduced so that the total amounts credited on such part are so credited at a rate that is up to two percent per annum less than the applicable

loan interest rate charged or at such other rate as the superintendent, upon the insurer's demonstrating justification therefor, may allow;

(I) this paragraph eight shall not apply to term insurance;

(J) this paragraph eight shall not apply to any policy qualified for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code of 1986, as amended, to the extent such application would prevent such qualification;

(9) a table showing the amounts of the applicable installment or annuity payments, if the policy proceeds are payable in installments or as an annuity;

(10) that the policy shall be reinstated at any time within three years from the date of default, unless the cash surrender value has been exhausted or the period of extended insurance has expired, if the policyholder makes application, provides evidence of insurability, including good health, satisfactory to the insurer, pays all overdue premiums with interest at a rate not exceeding six per centum per annum compounded annually, and pays or reinstates any other policy indebtedness with interest at a rate not exceeding the applicable policy loan rate or rates determined in accordance with the policy's provisions. This provision shall be required only if the policy provides for termination or lapse in the event of a default in making a regularly scheduled premium payment;

(11) that upon surrender of the policy, together with a written request for cancellation, to the insurer during a period of not less than ten days nor more than thirty days from the date the policy was delivered to the policy owner, the insurer shall refund either (i) any premium paid for the policy, including any policy fees or other charges or (ii) if the policy provides for the adjustment of the cash surrender benefit in accordance with a market-value adjustment formula and if the policy or a notice attached to it so provides, the amount of the cash surrender benefit provided under the policy as so adjusted assuming no surrender charge plus the amount of all fees and other charges deducted from any premium paid or from the policy value; provided, however, that a policy sold by mail order must contain a provision permitting the policy owner a thirty day period for such surrender. A provision to this effect shall appear in the policy or in a notice attached to it;

(12) in any policy under which additional amounts may be credited

pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that states the guaranteed factors of mortality, expense and interest, and a statement of the method used by the insurer in calculating actual policy values;

(13) in any policy under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that such additional amounts shall be nonforfeitable after the effective date of their crediting except for any charges imposed under the policy which are not greater than those allowed under subsection (n-1) or any market value adjustment made pursuant to subsection (n-2) of section four thousand two hundred twenty-one of this chapter; and

(14) in any policy under which additional amounts may be credited for any period pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that the policy shall state the frequency at which additional amounts are credited, which shall be no less frequently than annually, except that policies that credit additional amounts in an equity index account may do so in such account no less frequently than every three years;

(15) that states on the policy data or policy specifications page of a participating cash value policy that dividends are not guaranteed and the insurer has the right to change the amount of dividend to be credited to the policy which may result in lower dividend cash values than were illustrated, or, if applicable, require more premiums to be paid than were illustrated.

(16) that states on the policy data or policy specifications page of a life insurance policy subject to subsection (b) of section four thousand two hundred thirty-two of this chapter, to the extent applicable, that additional amounts are not guaranteed and the insurer has the right to change the amount of interest credited to the policy and the amount of cost of insurance or other expense charges deducted under the policy which may require more premium to be paid than was illustrated or the cash values may be less than those illustrated.

(17) that states on the policy data or policy specification page the minimum guarantee interest rate used to determine the guaranteed policy values.

(b) (1) A life insurance policy delivered or issued for delivery in

this state may exclude or restrict liability in the event of death occurring while the insured is resident in a specified foreign country or countries, but shall not contain any provision excluding or restricting liability in the event of death caused in a certain specified manner, except as a result of:

(A) conditions specified in subsection (c) hereof, subject to the terms of such subsection;

(B) suicide within two years from the date of issue of the policy;

(C) aviation under conditions specified in the policy;

(D) hazardous occupations specified in the policy, provided death occurs within two years from the date of issue of the policy.

(2) The superintendent may approve provisions that vary from subparagraphs (A) through (D) of paragraph one hereof and subsection (c) hereof, whenever he deems such substitute provisions to be substantially the same or more favorable to policyholders.

(3) If a death occurs that is subject to an exclusion or restriction pursuant to this subsection or subsection (c) hereof, the insurer shall pay the reserve on the face amount of the policy, computed according to the mortality table and interest rate specified in the policy, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued; provided that if the policy shall have been in force for not more than two years, the insurer shall pay the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

(c) (1) A life insurance policy delivered or issued for delivery in this state may contain provisions excluding or restricting liability in the event of death as a result of:

(A) war or an act of war, if the cause of death occurs while the insured is serving in any armed forces or attached civilian unit and death occurs no later than six months after the termination of such service;

(B) the special hazards incident to service in any armed forces or attached civilian unit, if the cause of death occurs during the period of such service while the insured is outside the home area, and if death

occurs outside the home area or within six months after the insured's return to the home area while in such service or within six months after the termination of such service, whichever is earlier;

(C) war or an act of war, within two years from the date of issue of the policy, if the cause of death occurs while the insured is outside the home area but is not serving in any armed forces or attached civilian unit, and death occurs outside the home area or within six months after the insured's return to the home area.

(2) The superintendent may, by regulation, prescribe reasonable conditions relating to the use of provisions permitted by paragraph one hereof. The provisions of subsection (b) hereof shall apply to any policy containing any provision permitted by this subsection.

(3) As used in this subsection, the term:

(A) "armed forces" means the military, naval, or air forces of any country, international organization, or combination of countries;

(B) "attached civilian unit" means a civilian non-combatant unit serving with any armed forces;

(C) "home area" means the fifty states of the United States, the District of Columbia, and Canada;

(D) "war" includes any war declared or undeclared, and armed aggression resisted by any armed forces;

(E) "act of war" means any act peculiar to military, naval, or air operations in time of war; and

(F) "special hazards incident to service", includes those hazards resulting in the insured's death being presumed by reason of being missing, in action, or otherwise, or the insured's death from disease or injury, accidental or otherwise, to which a person serving in, or with, any armed forces or attached civilian units is exposed in the line of duty.

(4) In permitting war exclusions, it is the legislative intent that such exclusions are not to be construed or interpreted as exclusions because of the status of the insured as a member of any armed forces or attached civilian units, or because of the presence of the insured as a civilian in a combat area or area adjacent thereto. Such permissible exclusions shall be construed and interpreted according to the fair import of their terms so as not to exclude deaths due to diseases or accidents which are common to the civilian population and are not

attributable to special hazards to which a person serving in such forces or units is exposed in the line of duty.

(5) Any such war exclusion shall terminate six months after the end of the war in which the insured was engaged or the war which the insured was likely to engage in at the time of application for this policy, after the discharge, release or separation of the insured from active military service, after the demobilization of the insured, or after the insured permanently leaves the war area, whichever occurs first. The end of war shall be determined by an order of the president of the United States or by federal law or shall be deemed to occur on the effective date of an agreement or declaration to end all hostilities which has been adopted or accepted by all armed forces involved therein, or in the absence of such an agreement or declaration at the end of ninety continuous days from the end of all hostilities.

(d) (1) Subsections (b) and (c) hereof shall not apply to any provision in a life insurance policy for additional benefits in the event of accidental death.

(2) If a policy provides that the death benefit may be increased or other policy provisions changed upon the application of the policyholder and the production of evidence of insurability, the policy may also provide that the two-year exclusions permitted under subparagraph (B) or (D) of paragraph one of subsection (b) hereof or subparagraph (C) of paragraph one of subsection (c) hereof shall run from the date of issue of the policy except that it shall run from the effective date of each subsequent increase or change with respect to each such increase or change.

(e) For policies that credit additional amounts in an equity index account less frequently than annually: (1) if the policy holder requests a full surrender of a policy prior to the expiration of the equity index crediting period, the insurer shall provide a statement to the policyholder, prior to processing the surrender, to the effect that: (A) no additional interest based on the equity index will be credited, since the equity index crediting period has not yet expired, and that only the guaranteed interest will be credited to the account; and (B) the policyholder is advised to consider alternatives to a full surrender of the policy prior to the crediting of additional interest based on the equity index, such as a policy loan or, if available, a partial

withdrawal of the policy; (2) in determining the additional amount to be credited to the policy in accordance with an equity index, the insurer shall include, in the calculation of the credit, any amounts withdrawn, including for policy loans, from the equity index account for the period of time prior to their withdrawal; (3) the policy shall include an option that credits additional amounts at least annually; and (4) the policy may provide that the amounts to be paid upon the exercise of a policy loan may be secured by the value of the policy's equity index account or by the general account of the insurer.

(f) Any of the provisions of this section, or portions thereof, exclusive of paragraph eleven of subsection (a) of this section, that do not apply to a single premium, nonparticipating, or term policy, shall to that extent not be incorporated in such policy. This section shall not apply to group life insurance.

§ 3204. Policy to contain entire contract; statements of applicant to be representations and not warranties; alterations. (a) (1) Every policy of life, accident or health insurance, or contract of annuity, delivered or issued for delivery in this state, shall contain the entire contract between the parties, and nothing shall be incorporated therein by reference to any writing, unless a copy thereof is endorsed upon or attached to the policy or contract when issued.

(2) No application for the issuance of any such policy or contract shall be admissible in evidence unless a true copy was attached to such policy or contract when issued.

(3) Such policy or contract cannot be modified, nor can any rights or requirements be waived, except in a writing signed by a person specified by the insurer in such policy or contract.

(b) Subsection (a) hereof shall not apply to a table or schedule of rates, premiums or other payments which is on file with the superintendent for use in connection with such policy or contract.

(c) All statements made by, or by the authority of, the applicant for the issuance, reinstatement or renewal of any such policy or contract shall be deemed representations and not warranties.

(d) No insertion in or other alteration of any written application for any such policy or contract shall be made by any person other than the

applicant without his written consent, except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

(e) If any policy of life, accident and health insurance delivered or issued for delivery in this state is reinstated or renewed, or if any such policy of life insurance provides that a change in the death benefit or other policy provisions may be made on application or by the written notice of exercise of one or more options provided in the policy, and the insured or the beneficiary or assignee of such policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal or change in the death benefit or other policy provisions or of the written notice of exercise of such an option, the insurer shall, within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application or notice. If such copy is not delivered or mailed, the insurer shall be precluded from introducing such application or notice as evidence in any action or proceeding based upon or involving such policy or its reinstatement, renewal or change.

(f) Any waiver of the provisions of this section shall be void.

§ 3205. Insurable interest in the person; consent required; exceptions. (a) In this section:

(1) The term, "insurable interest" means:

(A) in the case of persons closely related by blood or by law, a substantial interest engendered by love and affection;

(B) in the case of other persons, a lawful and substantial economic interest in the continued life, health or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured.

(2) The term "contract of insurance upon the person" includes any policy of life insurance and any policy of accident and health insurance.

(3) The term "person insured" means the natural person, or persons,

whose life, health or bodily safety is insured.

(b) (1) Any person of lawful age may on his own initiative procure or effect a contract of insurance upon his own person for the benefit of any person, firm, association or corporation. Nothing herein shall be deemed to prohibit the immediate transfer or assignment of a contract so procured or effectuated.

(2) No person shall procure or cause to be procured, directly or by assignment or otherwise any contract of insurance upon the person of another unless the benefits under such contract are payable to the person insured or his personal representatives, or to a person having, at the time when such contract is made, an insurable interest in the person insured.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, a Type B charitable, educational or religious corporation formed pursuant to paragraph (b) of section two hundred one of the not-for-profit corporation law, or its agent, may procure or cause to be procured, directly or by assignment or otherwise, a contract of life insurance upon the person of another and may designate itself or cause to have itself designated as the beneficiary of such contract.

(4) If the beneficiary, assignee or other payee under any contract made in violation of this subsection receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the person insured, the person insured or his executor or administrator may maintain an action to recover such benefits from the person receiving them.

(c) No contract of insurance upon the person, except a policy of group life insurance, group or blanket accident and health insurance, or family insurance, as defined in this chapter, shall be made or effectuated unless at or before the making of such contract the person insured, being of lawful age or competent to contract therefor, applies for or consents in writing to the making of the contract, except in the following cases:

(1) A wife or a husband may effectuate insurance upon the person of the other.

(2) Any person having an insurable interest in the life of a minor under the age of fourteen years and six months or any person upon whom such minor is dependent for support and maintenance, may effectuate a

contract of insurance upon the life of such minor, in an amount which shall not exceed the limits specified in section three thousand two hundred seven of this article.

(d) In addition to any other basis under which either an employer, or an irrevocable trust established by one or more employers or one or more employers and one or more labor unions, have an insurable interest in the lives of any of its employees or retirees or those of its subsidiaries or affiliated companies, an employer or such a trust shall have an insurable interest in the lives of any such employees or retirees who are participants or who are eligible to participate, upon the satisfaction of age, service or similar eligibility criteria, in an employee benefit plan, established or maintained by an employer as defined by the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., provided that:

(1) The employer providing for insurance coverage or causing such coverage to be issued under this subsection: (A) prior to or at the commencement of any such coverage notifies prospective insureds in writing that coverage is being obtained on their lives, requires that prospective insureds consent in writing to such coverage, provides each consenting insured the right to have any coverage on his/her life issued under the authority of this subsection discontinued at any time and describes in the notice the method the insured may use to terminate coverage; (B) at the time any insured employee's employment terminates, notifies the employee of the right to discontinue such coverage, provided, however, that no such notification shall be required if the insured employee possesses a present or prospective right to receive any of the benefits under an employee benefit plan being financed, in whole or in part, by such life insurance coverage; and (C) at any time after the termination of an insured employee's employment and upon the termination of an employee benefit plan being financed, in whole or in part, by such life insurance coverage or a reduction of the benefits provided thereunder, notifies the employee of the right to discontinue such coverage.

(2) At the time coverage is issued, the total amount of insurance coverage issued to date to the employer or trust under authority of this subsection shall not exceed the costs of employee and/or retiree benefits already incurred in connection with such employee benefit plan

since the earliest date coverage on an employee or retiree was issued under this subsection, plus the projected future cost of such benefits as established by the employer.

(3) The amount of coverage insuring the life of each such employee or retiree and the selection of the employees or retirees to be insured is based purely on nondiscriminatory factors such as age, premium amount or some other nondiscriminatory factor, and not on conditions or terms of employment other than participation in an employee benefit plan described herein.

(4) If subsequent to issuance of the policy or policies providing life insurance coverage pursuant to this subsection, the insurer providing the coverage is replaced by another insurer, the employer shall notify each insured employee or retiree of such replacement.

(5) During the first five years subsequent to issuance of the policy or policies providing life insurance pursuant to this subsection, the policyholder does not undertake a pattern of borrowing likely to require all or a substantial part of the cash values of the policies to be pledged as security against repayment of such loans, unless such borrowing was incurred because of an unforeseen substantial loss of income or unforeseen increase in financial obligations.

(e) If, pursuant to subparagraph (A) of paragraph one of subsection (d) of this section, the employer receives from the employee or retiree written notice that he or she rejects the issuance of the insurance, the employer shall notify the insurer of such rejection and the insurance shall not be issued, or if the insurance has already been issued and the employee elects to have the existing coverage terminated, the employee shall notify the insurer of the election to terminate coverage in writing, and upon receipt of such written notice from the employee, the insurance shall not be continued in effect and shall terminate upon receipt of such written notice from the employee. In such event, the insurer shall pay any amounts which are payable to the employer or trust policy owner as the result of such termination of coverage, pursuant to the terms and conditions of coverage. Unless the employee or retiree complies with the requirements of this subsection, neither the employee, retiree nor his or her successor in interest, may contest the validity of the coverage.

§ 3206. Policies which provide for an adjustable maximum rate of interest on policy loans. (a) In this section:

(1) The term "policy" includes: (i) life insurance policies subject to the provisions of item (ii) of subparagraph (F) of paragraph eight of subsection (a) of section three thousand two hundred three of this article, and (ii) annuity contracts subject to the provisions of subsection (c) of section three thousand two hundred nineteen of this article, and (iii) certificates issued by a fraternal benefit society subject to the provisions of paragraph six of subsection (a) of section four thousand five hundred ten of this chapter, and (iv) annuity certificates subject to section four thousand five hundred thirteen of this chapter, when such policies, contracts, or certificates provide for loans with adjustable rates of interest.

(2) The term "policy loan" includes any cash loans and any premium loans made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.

(3) The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the insurer.

(4) The term "published monthly average" means:

(A) the Monthly Average Corporates yield shown in Moody's Corporate Bond Yield Averages published by Moody's Investors Service Inc., or any successor thereto; or

(B) in the event that the Moody's Corporate Bond Yield Averages -- Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the superintendent.

(b) The adjustable maximum rate of interest on policy loans for each policy will be determined at the regular intervals specified in the policy. At the intervals specified in the policy:

(1) the rate being charged may be increased whenever such increase as determined under subsection (c) hereof would increase that rate by one-half per centum or more per annum; and

(2) the rate being charged must be reduced whenever such reduction as determined under subsection (c) hereof would decrease that rate by one-half per centum or more per annum.

(c) The rate of interest charged on a policy loan made under such a

policy shall not exceed the higher of the following:

(1) the published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(2) the rate used to compute the cash surrender values under the policy during the applicable period plus one per centum per annum.

(d) The insurer shall for any such policy:

(1) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(2) notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in paragraph three hereof;

(3) send to policyholders with loans reasonable advance notice of any increase in the rate; and

(4) include in the notices required above the substance of the pertinent policy provisions permitting an adjustable maximum interest rate on policy loans established from time to time by the insurer as permitted by law, and specifying the frequency at which the interest rate is to be determined by the insurer as permitted by law.

(e) No policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(f) Participating policies issued under the provisions of this section shall constitute one or more dividend classifications, as established by the board of directors of the insurer, separate from dividend classifications established for other participating policies issued by the insurer.

(g) No provision of law regulating the maximum rate of interest which may be charged, taken or received, other than section 190.40 or section 190.42 of the penal law shall apply to any loan made pursuant to the provisions of this section.

(h) The provisions of this section shall not be made to apply to any policy issued before January first, nineteen hundred eighty-three unless the policyholder agrees in writing to the applicability of such

provisions. Any holder of a policy issued before January first, nineteen hundred eighty-three which is of a classification determined by the insurer as eligible may request the insurer to make the provisions of this section applicable to such policy; the superintendent may require justification of the eligibility standard determined by the insurer.

§ 3207. Life insurance contracts by or for the benefit of minors; on the lives of minors, limitations on amount. (a) A minor above the age of fourteen years and six months shall be deemed competent to enter into a contract for, be the owner of, and exercise all rights relating to, a policy of life insurance upon the life of the minor or upon the life of any person in whom the minor has an insurable interest, but the beneficiary of such policy may be only the minor or the parent, spouse, brother, sister, child or grandparent of the minor.

(b) An insurer may deliver or issue for delivery in this state a policy or policies of life insurance upon the life of a minor under the age of fourteen years and six months, provided that such policy or policies are effectuated by a person or persons having an insurable interest in the life of such minor or by a person or persons upon whom such minor is dependent for support and maintenance and provided further that an insurer shall not knowingly issue such a policy or policies for an amount which, together with the amount of life insurance under any other policy or policies then in force upon the life of such minor, is in excess of the limit of fifty thousand dollars or the limit of fifty per centum or the limit of twenty-five per centum in the case of a minor under the age of four years and six months of the amount of life insurance in force upon the life of the person effectuating the insurance at the date of issue of the policy on the life of such minor, whichever limit is the greater, and any amount of life insurance on the life of such minor not in excess of such limit when issued shall not be deemed to be in excess thereof by reason of any reduction thereafter in the amount of life insurance in force upon the life of the person effectuating the insurance.

(c) An insurer may deliver or issue for delivery in this state a policy or policies of life insurance upon the life of a minor under the age of fourteen years and six months for an amount or amounts of life

insurance which may be in excess of the limit specified in subsection (b) of this section if the policy or policies are effectuated and the premiums paid by a person or persons having an insurable interest in the life of the minor and if the minor is not dependent upon such person or persons for support and maintenance.

(d) (1) If an insurer shall deliver or issue for delivery in this state any policy of life insurance on the life of a minor for an amount in excess of the limit prescribed by subsection (b) of this section, the amount under such policy which is in excess shall not be valid, or payable as a claim by death, so long as and to the extent that it continues to be in excess, provided that no such insurance shall be deemed to be in excess on or after the date upon which the minor attains the age of fourteen years and six months.

(2) The insurer which issues such excess amount, determined by priority of date of issue of policies if there is more than one policy, shall upon demand therefor or upon the death of the insured and upon proof satisfactory to the insurer that such excess exists at the time of such demand or death refund with interest, at the rate assumed in the valuation of the policy, the premiums paid less dividends allowed, on the amount of insurance that is in excess at the date of such demand or death, and such excess insurance and all of the obligations of the insurer thereunder shall terminate. Any indebtedness to the insurer on any excess insurance shall be deducted by the insurer from such refund.

(3) If only a part of the amount of insurance under such a policy is in excess of such limits, the refund shall bear the same proportion to the total premiums paid less dividends allowed under such policy as the amount of such excess insurance bears to the amount of insurance in force under the policy at the date of such refund, and the amount or amounts thereafter payable under such policy shall be reduced in the same proportion.

(4) If an insurer shall have made payment as a death claim of an amount in excess of such limits without having had proof satisfactory to it that such insurance was in excess, such insurer shall not be liable for the refund specified above.

(f) Notwithstanding the foregoing limitations, any domestic life insurance company may issue for delivery in another state or foreign country any policy which is governed by the laws of such state or

country for any amount not prohibited by the laws of such other state or country.

(g) The amount of life insurance within the meaning of this section shall not be deemed to include return premium benefits or the return of cash value or any additional benefits payable in the event of death by accident, any variable death benefit above the guaranteed minimum death benefit provided under a variable life insurance policy, or any additional insurance provided by the application of dividends or by the application of additional amounts credited to a policy pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter.

§ 3208. Antedating of life insurance policies and burial agreements prohibited. (a) No insurer shall knowingly deliver or issue for delivery in this state any policy of life insurance that purports to have been issued or to have taken effect more than six months before the date on which the application therefor was made, if thereby the premium is reduced below the premium that would be payable thereon as determined by the insured's birthday nearest the date on which the application was made.

(b) No agent, other representative of an insurer or broker shall prepare, submit or accept in this state any application for life insurance dated earlier than the date on which the application was made by the insured or the applicant, if thereby the premium is reduced as above stated.

(c) This section shall not be construed to invalidate any contract made in violation of the provisions hereof; nor to prohibit the exchange, alteration or conversion of any policy of life insurance as of the original date thereof if the amount of insurance of the new policy does not exceed the greater of that of the original policy or that which the premium paid for the original policy would have purchased if the new policy had been originally applied for; nor to prohibit the exercise of any conversion privilege contained in any policy.

(d) No person, firm, association, society, or corporation engaged in this state in the business of providing for the payment of funeral, burial or other expenses of deceased members, whether or not it be

subject to the other provisions of this chapter, and no insurer shall:

(1) deliver or issue for delivery in this state any contract or policy whereby the benefit or any part thereof accruing under such contract or policy, upon the death of such member or of the person insured, shall be payable to a designated or restricted funeral director or funeral directing concern or other person engaged in such trade or business, or to any official or designated group of them; or

(2) pay any such benefit or any part thereof to any funeral director or funeral directing concern or other person engaged in such trade or business or to any official or designated group of them, without the consent of the person or persons entitled to such benefits, or to pay any commission or other consideration to any funeral director or funeral directing concern or employee thereof to induce such person to sell or offer to sell any contract or policy of insurance designated or marketed as payable for funeral or burial expenses upon the death of the insured; or

(3) in any way deprive the personal representative or family of the deceased of the advantages of competition in procuring and purchasing supplies and services in connection with the funeral and burial arrangements of such deceased.

§ 3209. Life insurance, annuities and funding agreements disclosure requirements. (a) Except as hereafter exempted, this section shall apply to any solicitation, negotiation or procurement of life insurance, annuities or funding agreements occurring within this state. This section shall apply to any issuer of life insurance or annuity contracts or funding agreements, including fraternal benefit societies and the life insurance department of a savings and insurance bank. Unless otherwise specifically included, this section shall not apply to: credit life insurance; group life insurance; life insurance policies, annuity contracts, and funding agreements issued in connection with pension and welfare plans as defined by and to the extent covered by the federal Employee Retirement Income Security Act of 1974 (ERISA); funding agreements issued to other than individuals pursuant to subsection (b) of section three thousand two hundred twenty-two of this article; and any group annuity unless at least one certificate is subject to

paragraph two of subsection (b) of section four thousand two hundred twenty-three of this chapter.

(b) (1) No policy of life insurance shall be delivered or issued for delivery in this state after the applicable effective date, as set forth in subsection (n) of this section, unless the prospective purchaser has been provided with the following:

(A) a copy of the most recent buyer's guide and the preliminary information required by subsection (d) of this section, at or prior to the time an application is taken. When sales solicitations are made by mail, without the involvement of an agent or broker, each initial solicitation must include a copy of the buyer's guide unless the policy for which application is made provides for a period of at least thirty days within which the applicant may return the policy for an unconditional refund of the premiums paid, in which event the buyer's guide must be delivered with the policy or prior to delivery of the policy; in addition, such solicitation must alert the prospective purchaser of the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and

(B) a policy summary upon delivery of the policy.

(2) No annuity contract or life insurance policy or certificate with an equity index account shall be delivered or issued for delivery in this state unless, no later than at the time of application, the prospective purchaser has been provided with a disclosure statement containing the following:

(A) a statement in bold type to the effect that the equity index account provides benefits linked to an external equity index and does not participate directly in the equity market;

(B) a statement identifying the equity index used in the equity index formula, together with a description of any alternate index should the initial index no longer be publicly available;

(C) a statement indicating whether paid dividends are included in changes in the equity index, together with a description of how such dividends, or lack thereof, would affect the changes in the equity index; the statement must provide the average dividend rate over the lesser of ten years or the calculable life of the index;

(D) a statement fully describing the equity index formula;

(E) a statement explaining and illustrating the equity index formula

including any features of the equity index formula subject to change after issuance of the contract, policy or certificate;

(F) a statement identifying the initial minimum guaranteed interest rate for the minimum accumulation value of an equity index account and any withdrawal charge;

(G) a statement identifying the initial current and the minimum specified participation rate, i.e., how much of the increase in the index will be used to calculate the indexed linked interest rate, if any;

(H) a statement identifying the initial current and the minimum upper limit or cap on the indexed linked interest rate, if any;

(I) for a life insurance policy crediting additional amounts in accordance with an equity index less frequently than annually, a statement to the effect that: if the policyholder requests a full surrender of a policy prior to the expiration of the equity index crediting period, no additional interest based on the equity index will be credited and that only the guaranteed interest will be credited to the account; and the policyholder is advised to consider alternatives to a full surrender of the policy prior to the expiration of the equity index crediting period, such as a policy loan or, if available, a partial withdrawal of the policy; and

(J) other disclosure information the superintendent deems appropriate.

(3) No participating dividend-paying paid-up deferred annuity contract shall be delivered or issued for delivery in this state unless a prospective purchaser is provided with a disclosure statement, no later than at the time of application, containing the following:

(A) a statement indicating that dividends are not guaranteed under the participating dividend-paying paid-up deferred annuity contract and the income is therefore not guaranteed to increase from the dollar amount set at the time of issue; and

(B) a statement indicating that the initial income under a participating dividend-paying paid-up deferred annuity contract may be lower than the initial income under a fully guaranteed paid-up deferred annuity contract.

(c) Every insurer must provide, to any policyholder who so requests, a policy summary for each in-force premium-paying policy for which no policy summary has ever been furnished. The insurer may charge the

policyholder a reasonable fee for preparation of this summary, subject to guidelines specified in rules promulgated by the superintendent.

(d) The preliminary information shall be in writing and include, to the extent applicable, the following:

(1) the name and address of the insurance agent or broker or, if no agent or broker is involved, a statement of the procedure to be followed in order to receive responses to inquiries concerning the preliminary information;

(2) the full name and home office, administrative office or branch or agency office address of the company in whose name the life insurance policy is to be written;

(3) the date of the preliminary information and the generic name, the initial amount of insurance and the initial annual premium for the basic policy;

(4) the total guaranteed cash surrender values for the basic policy, at the end of the tenth and twentieth policy years or at the end of the premium-paying period if earlier. These values may be shown on a per thousand or per unit basis;

(5) the effective policy loan annual percentage interest rate, if the policy would contain this provision, and whether this rate is applied in advance or in arrears, adjustable or fixed;

(6) for the life insurance policies described in paragraph one of subsection (n) of this section, life insurance cost indexes and the equivalent level annual dividend for the basic policy for ten and twenty years, but in no case beyond the premium-paying period;

(7) in addition, the applicant shall be advised that, when the policy is issued, a complete policy summary, including cost data, based on the benefits, premiums and dividends of the policy as issued, will be furnished; and that, following the receipt of the policy and policy summary, there will be a period of not less than ten days within which the applicant may return the policy for an unconditional refund of the premiums paid; and

(8) notwithstanding the foregoing, no applicant for life insurance shall be prevented or delayed in effecting or applying for coverage by the requirements of this section. In such cases where prior to application it is impractical to provide any items prescribed by this section, such items may be estimated in good faith or furnished as soon

thereafter as practical prior to delivery of policy.

(e) A policy summary shall include the following:

(1) a prominently placed title as follows:

"STATEMENT OF POLICY COST AND BENEFIT INFORMATION";

(2) the name and address of the insurance agent or broker, or, if no agent or broker is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary;

(3) the full name and home office, administrative office or branch or agency office address of the company in whose name the life insurance policy is to be or has been written;

(4) the generic name of the basic policy and each rider;

(5) for the life insurance policies described in paragraph one of subsection (n) of this section, the following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which life insurance cost indexes are displayed and at least one age from sixty through sixty-five or maturity, whichever is earlier:

(A) the annual premium for the basic policy;

(B) the annual premium for each optional rider;

(C) guaranteed amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

(D) total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

(E) cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. Dividends need not be displayed beyond the twentieth policy year; and

(F) guaranteed endowment amounts payable under the policy which are not included in guaranteed cash surrender values above;

(6) the effective policy loan annual percentage interest rate if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy provides for an adjustable loan interest rate, the policy summary shall so state, shall set forth the frequency at which the rate is to be determined for that policy, and

shall describe the index upon which the maximum rate is based at the time the policy is issued;

(7) for the life insurance policies described in paragraph one of subsection (n) of this section:

(A) life insurance cost indexes for ten and twenty years but in no case beyond the premium-paying period. Separate indexes are to be displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than twelve months and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life;

(B) the equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed;

(8) a policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed; in addition, the summary shall, for the life insurance policies described in paragraph one of subsection (n) of this section, include a statement in close proximity to the equivalent level annual dividend as follows: "An explanation of the intended use of the equivalent level annual dividend is included in the buyer's guide";

(9) a statement in close proximity to the life insurance cost indexes as follows:

"AN EXPLANATION OF THE INTENDED USE OF THESE INDEXES IS PROVIDED IN THE BUYER'S GUIDE"; and

(10) the date on which the policy summary is prepared.

(f) The policy summary must be a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph five of subsection (e) of this section shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for

each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

(g) Every insurer shall maintain, at its home office or principal office, a complete file containing one copy of each policy summary form authorized by the insurer for use pursuant to this section.

(h) An agent or broker shall inform a prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent or broker, and inform the prospective purchaser of the full name of the insurer which he is representing. In sale situations in which an agent or broker is not involved, the insurer shall identify its full name.

(i) As used in this section, "buyer's guide" means a separate document published and disseminated by insurers. The language therein shall be promulgated by the superintendent, and shall, to the extent practicable and in the public interest as determined by the superintendent, be consistent with the latest version of a buyer's guide as adopted by the national association of insurance commissioners.

(j) For life insurance policies, except term life insurance policies, which are to be issued to qualify for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code of 1986, as amended, a written notice shall be delivered to the proposed insured in a manner satisfactory to the superintendent at or prior to the time an application is taken and shall read as follows: "The purchase of a life insurance policy with cash value, which qualifies for special tax treatment under section 403(b) of the Internal Revenue Code of 1986, as amended, may not be appropriate for individuals seeking to maximize the accumulation of funds for retirement or for individuals seeking life insurance coverage primarily to provide a survivorship benefit for the spouse in the event of death prior to retirement. If an individual needs coverage to continue after retirement, current tax laws require the commencement of taxable distributions under the tax sheltered annuity plan (TSA) no later than age seventy and one-half which may necessitate some adjustment in the cash value life insurance policy or may result in increased insurance costs in future policy years. You should consult with your tax advisor before purchasing life insurance with cash value as part of a tax

sheltered annuity (TSA)."

(k) The superintendent shall promulgate by regulation the contents and allowable format of the preliminary information and the information to appear in the policy summary. The superintendent shall also promulgate by regulation standards governing the content, format and use of illustrations of individual life insurance policies and certain group life insurance policies and certificates, life insurance policies subject to section four thousand two hundred thirty-two of this chapter, variable life insurance policies under which the death benefits and cash values vary in accordance with the unit values of investments held in a separate account and individual annuities, individual funding agreements, variable annuities, and group annuity contracts if any certificate is issued to which paragraph two of subsection (b) of section four thousand two hundred twenty-three of this chapter applies. The illustration regulation shall be consistent, to the greatest extent practicable and in the public interest as determined by the superintendent, with the illustration regulations as adopted by the national association of insurance commissioners. The superintendent in developing regulations to govern the content and format of the preliminary information, policy summary and illustrations shall ensure that such forms are presented in an easy, concise and meaningful way to enable consumers to understand the operation of the policy or contract.

(l) An insurer of any life insurance policy or annuity contract subject to this section shall notify the superintendent whether its policies or contract forms have been or will be marketed with or without an illustration. For those policies and contracts marketed with an illustration which complies with the regulations promulgated pursuant to subsection (k) of this section, no preliminary information or policy summary shall be required. For those policies which are not marketed with an illustration, the preliminary information and policy summary shall be provided pursuant to the provisions of this section.

(m) The superintendent, by regulation, shall determine the applicability of the illustration regulation promulgated pursuant to subsection (k) of this section to group life insurance policies and group annuities and funding agreements. Such determination shall be consistent, to the greatest extent practicable and in the public interest, with the illustration regulations as adopted by the national

association of insurance commissioners.

(n) The effective dates of this section as applied to policies of life insurance, annuity contracts, and funding agreements shall be as follows:

(1) for individual life insurance policies, certain group life insurance policies and certificates and life insurance policies subject to section four thousand two hundred thirty-two of this chapter, January first, nineteen hundred ninety-eight;

(2) for annuities and funding agreements, the date of promulgation of regulations by the superintendent pursuant to subsection (k) of this section but not later than June thirty, nineteen hundred ninety-eight;

(3) for variable life insurance policies and variable annuities, the date of promulgation of regulations by the superintendent but not later than January first, nineteen hundred ninety-nine.

No less than three months prior to promulgating the regulations required to implement subsection (k) of this section pursuant to paragraphs two and three of this subsection, the superintendent shall hold public hearings on such regulations.

§ 3210. Incontestability after reinstatement. Any policy of life or non-cancellable disability insurance or contract of annuity delivered or issued for delivery in this state that is reinstated shall be incontestable after the same period following reinstatement and with the conditions and exceptions provided in the policy or contract with respect to incontestability.

§ 3211. Notice of premium due under life or disability insurance policy; notice to assignees of non-payment of premium.

(a) (1) No policy of life insurance or non-cancellable disability insurance delivered or issued for delivery in this state, and no life insurance certificate delivered or issued for delivery in this state by a fraternal benefit society, shall terminate or lapse by reason of default in payment of any premium, installment, or interest on any policy loan in less than one year after such default, unless, for

scheduled premium policies, a notice shall have been duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due, or for life insurance policies in which the amount and frequency of premiums may vary, no earlier than and within thirty days after the day when the insurer determines that the net cash surrender value under the policy is insufficient to pay the total charges that are necessary to keep the policy in force. A separate notice shall not be required for insurance that is supplemental to a policy of life insurance.

(2) If a life insurance policy or life insurance certificate provides that the policyholder or certificate holder may vary the amount and frequency of premiums to be paid to the insurer, premiums, installments and interest on loans will be considered due on the day when the failure of the insurer or fraternal benefit society to receive an amount of premium, installment or interest on loan would cause such policy or certificate to terminate or lapse, and the failure to pay such amount shall be considered a default.

(b) The notice required by paragraph one of subsection (a) hereof shall:

(1) be duly mailed to the last known address of the policyowner, or if any other person shall have been designated in writing to receive such notice, then to such other person;

(2) state the amount of such payment, the date when due, the place where and the person to whom it is payable; and shall also state that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit.

(c) If the payment demanded by such notice shall be made within the time limited therefor, it shall be taken to be in full compliance with the requirements of the policy in respect to the time of such payment. The statement of any officer, employee or agent of such insurer, or of any one authorized to mail such notice, subscribed and affirmed by him as true under the penalties of perjury, stating facts which show that the notice required by this section has been duly addressed and mailed shall be presumptive evidence that such notice has been duly given.

(d) No action shall be maintained to recover on any life insurance

policy, or on any such non-cancellable contract of permanent and total disability insurance, which has lapsed because of default in making such payment (except an action to recover the cash surrender value or nonforfeiture benefit) unless the action is instituted within two years from the date of such default.

(e) (1) An assignee of a policy of life insurance under an assignment made in this state may request the insurer to give such assignee notice of non-payment of any premium due on such policy.

(2) The request must be made before default in payment of premium, and must be in writing, mailed to the home office of the insurer and specify the name and address of the assignee, the name of the insured and the policy number.

(3) When the request is made as provided herein the right of such assignee to the cash surrender value or other nonforfeiture benefit under the policy shall continue as it existed on the date of default until the expiration of ten days after the mailing of notice of such default to the last known address of the assignee.

(4) Upon termination of the assignee's rights under the assignment, the assignee shall promptly mail a release thereof to the insurer.

(5) This subsection shall not be construed to affect the contractual rights of assignees.

(f) This section shall not apply to:

(1) Any policy of group insurance.

(2) Any policy of insurance requiring the payment of premiums monthly or at shorter intervals, provided in the case of policies of life insurance the insurer issuing such policy elects with respect to all such policies to mail a written notice within six months after termination or lapse to the insured or to any other person who shall have been designated in writing to receive such notice, stating the type and amount of any automatic nonforfeiture benefit in force.

(g) In the case of life insurance policies to which this section is applicable and which contain a cash surrender value, the insurer must provide an annual notification that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner. Such notification shall include a statement that the insured has the right to request an updated policy illustration based, in respect to a

participating policy, on the then current dividend scale, and in respect to a policy subject to subsection (a) of section four thousand two hundred thirty-two of this chapter, on the then current mortality, interest and expense assumptions. The notification pertaining to the cash surrender value shall be set out in a conspicuous manner and shall include the address to which the policyowner may make a written inquiry. Any notice or statement which informs a policyowner of the policy's cash surrender value at least annually shall be deemed to comply with the requirements of this subsection.

(h) In the case of life insurance policies described in paragraph two of subsection (f) of this section and which contain a cash surrender value, the notification requirement of subsection (g) of this section will apply in cases where the insurer voluntarily sends a notice of the premium due.

§ 3212. Exemption of proceeds and avails of certain insurance and annuity contracts. (a) In this section:

(1) The term "proceeds and avails", in reference to policies of life insurance, includes death benefits, accelerated payments of the death benefit or accelerated payment of a special surrender value, cash surrender and loan values, premiums waived, and dividends, whether used in reduction of premiums or in whatever manner used or applied, except where the debtor has, after issuance of the policy, elected to receive the dividends in cash.

(2) An annuity contract includes any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether such sums are payable to one or more persons, jointly or otherwise, but does not include payments under a life insurance policy at stated times during life or lives, or for a specified term or terms.

(3) The term "creditor" includes every claimant under a legal obligation contracted or incurred after December thirty-first, nineteen hundred thirty-nine.

(4) The term "execution" includes execution by garnishee process and every action, proceeding or process whereby assets of a debtor may be subjected to the claims of creditors.

(b) (1) If a policy of insurance has been or shall be effected by any person on his own life in favor of a third person beneficiary, or made payable otherwise to a third person, such third person shall be entitled to the proceeds and avails of such policy as against the creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts of the person effecting the insurance.

(2) If a policy of insurance has been or shall be effected upon the life of another person in favor of the person effecting the same or made payable otherwise to such person, the latter shall be entitled to the proceeds and avails of such policy as against the creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts of the person insured. If the person effecting such insurance shall be the spouse of the insured, he or she shall be entitled to the proceeds and avails of such policy as against his or her own creditors, trustees in bankruptcy and receivers in state and federal courts.

(3) If a policy of insurance has been or shall be effected by any person on the life of another person in favor of a third person beneficiary, or made payable otherwise to a third person, such third person shall be entitled to the proceeds and avails of such policy as against the creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts of the person insured and of the person effecting the insurance.

(4) (A) The person insured pursuant to paragraph one of this subsection or the person effecting the insurance other than the spouse of the insured pursuant to paragraph two hereof, and the person effecting the insurance pursuant to paragraph three hereof, or the executor or administrator of any such persons, or a person entitled to the proceeds or avails of such policy in trust for such persons shall not be deemed a third person beneficiary, assignee or payee.

(B) A policy shall be deemed payable to a third person beneficiary if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the person insured by paying the death benefits to a third person.

(5) This section shall be applicable whether or not the right is reserved in any such policy to change the designated beneficiary and

whether or not the policy is made payable to the person whose life is insured if the beneficiary, assignee or payee shall predecease such person; and no person shall be compelled to exercise any rights, powers, options or privileges under such policy.

(6) If a policy of insurance has been or shall be effected by any person on his own life or upon the life of another person, the policyowner shall be entitled to any accelerated payments of the death benefit or accelerated payment of a special surrender value permitted under such policy as against the creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts of the policyowner.

(c) (1) No money or other benefits payable or allowable under any policy of insurance against disability arising from accidental injury or bodily infirmity or ailment of the person insured, shall be liable to execution for the purpose of satisfying any debt or liability of the insured, whether incurred before or after the commencement of the disability, except as provided in subsection (e) hereof.

(2) With respect to debts or liabilities incurred for necessaries furnished the insured after the commencement of disability, the exemption shall not include any income payment benefits payable as a result of any disability of the insured, and with respect to all other debts or liabilities incurred after the commencement of disability of the insured, the exemption of income payment benefits payable as a result of any disability of the insured shall not at any time exceed payment at a rate of four hundred dollars per month for the period of such disability.

(3) When a policy provides for lump sum payment because of a dismemberment or other specific loss of insured, such payment shall be exempt from execution of insured's creditors.

(4) This subsection shall not affect the assignability of any benefit otherwise assignable.

(d) (1) The benefits, rights, privileges and options which, under any annuity contract are due or prospectively due the annuitant, who paid the consideration for the annuity contract, shall not be subject to execution.

(2) The annuitant shall not be compelled to exercise any such rights, powers or options contained in the annuity contract, nor shall creditors

be allowed to interfere with or terminate the contract, except as provided in subsection (e) hereof and except that the court may order the annuitant to pay to a judgment creditor or apply on the judgment in installments, a portion of such benefits that appears just and proper to the court, with due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(3) The benefits, rights, privileges or options accruing under such contract to a beneficiary or assignee shall not be transferable nor subject to commutation. If the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant shall apply with respect to such beneficiary or assignee.

(4) The benefits, rights, privileges or options accruing under an annuity contract funding a structured settlement which would otherwise be nontransferable under this subsection may be transferred in accordance with title seventeen of article five of the general obligations law. As used in this paragraph the term "structured settlement" means an arrangement for periodic payments of damages for personal injuries established by settlement or judgment in resolution of a tort claim; and the term "periodic payments" shall include scheduled future lump sum payments.

(e) (1) Every assignment or change of beneficiary or other transfer is valid, except in cases of transfer with actual intent to hinder, delay or defraud creditors, as defined by article ten of the debtor and creditor law. In such cases creditors shall have all the remedies provided by such article ten.

(2) (A) Subject to the statute of limitations, the amount of premiums or other consideration paid with actual intent to defraud creditors as provided in article ten of the debtor and creditor law, together with interest on such amount, shall enure to the benefit of creditors from the proceeds of the policy or contract; but the insurer issuing such policy or contract shall be discharged of liability thereunder by making payments in accordance with its terms, or in accordance with any assignment, change of beneficiary or other transfer, unless before any such payment such insurer shall have received written notices, by or on behalf of any such creditor, of a claim to recover any benefits on the

ground of a transfer or payment made with intent to defraud such creditor.

(B) The notice shall specify the amount claimed or sufficient facts to enable the insurer to ascertain such amount, the insurance or annuity contract, the person insured or annuitant, and the transfers or payments sought to be avoided on the ground of fraud.

(3) (A) Notwithstanding any inconsistent provision of this section or other law, any right of subrogation to benefits to which a local social services district, the department of social services, or the commissioner of health or his designee, shall be entitled shall be valid and enforceable to the extent benefits are available under any individual accident and health insurance, group or blanket accident and health insurance, or noncancellable disability insurance policy, or any subscriber contract made by a corporation subject to the provisions of article forty-three of this chapter, except that no such right of subrogation shall be enforceable if such benefits may be claimed by the department of social services, an appropriate social services official or the commissioner of health or his designee, by agreement or other established procedure, directly from an insurance carrier.

(B) The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt by the carrier issuing such insurance of written notice from the department of social services, a local social services district, or the commissioner of health or his designee, of the exercise of subrogation rights.

(C) No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. An insurer shall not deny a claim made in conformance with paragraph (b) of subdivision two of section three hundred sixty-seven-a of the social services law solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to obtain prior authorization, or a failure to present proper documentation at the point-of-sale that is the basis of the claim.

(4) No terms of any policy or contract which directly or indirectly

prevent or prohibit the assignment of rights under any policy or contract prevent a local social services district, the department of social services, or the commissioner of health or his designee, from claiming benefits to which it shall be subrogated. The right of subrogation attaches to any benefits paid or provided under any policy, plan or contract upon receipt of written notice of the exercise of such subrogation rights.

(f) This section shall likewise apply to group insurance policies or annuity contracts, to the certificates or contracts of fraternal benefit societies, and to the policies or contracts of cooperative life and accident insurance companies.

§ 3213. Payment of proceeds. Where the proceeds of a policy of life insurance delivered or issued for delivery in this state are payable, according to its terms, to two or more beneficiaries without designation of their respective interests, the proceeds shall be paid to such beneficiaries in equal portions.

§ 3214. Interest upon proceeds of life insurance policies and annuity contracts. (a) If an action to recover the proceeds due under a policy of life insurance or contract of annuity delivered or issued for delivery in this state results in a judgment against the insurer, interest thereon shall be paid from the date of the death of the insured or annuitant in connection with a death claim on a policy of life insurance or contract of annuity and from the date of maturity of an endowment contract to the date the verdict is rendered or the report or decision is made, computed pursuant to the provisions of subsection (c) hereof, and thereafter in accord with the provisions of sections five thousand two and five thousand three of the civil practice law and rules.

(b) If an action to recover is commenced and a settlement is reached before the verdict is rendered or the report or decision is made, interest on the settlement shall be paid from the date of the death of the insured or annuitant in connection with a death claim on such a policy of life insurance or contract of annuity and from the date of

maturity of an endowment contract to the date of payment computed under the provisions of subsection (c) hereof.

(c) If no action has been commenced, interest upon the principal sum paid to the beneficiary or policyholder shall be computed daily at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option, from the date of the death of an insured or annuitant in connection with a death claim on such a policy of life insurance or contract of annuity and from the date of maturity of an endowment contract to the date of payment and shall be added to and be a part of the total sum paid.

(d) This section shall not require the payment of interest for any period during which an insurer is required to pay interest under any state or federal law pertaining to interpleader.

(e) This section shall not apply to policies or contracts issued prior to September first, nineteen hundred seventy-five, which contain specific provisions to the contrary.

§ 3215. Disability benefits in connection with life insurance and annuities. (a) No policy of life insurance or contract of deferred annuity, which provides benefits by reason of the disability of the insured, including waiver of premium, shall 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 policyholders:

(1) That disability benefits be paid or allowed only in case of total disability and defining total disability in either of the following forms:

(A) Total disability is incapacity of the insured, resulting from injury or disease, to engage in any occupation for remuneration or profit. Such a policy shall be known and described as a "total disability" policy or contract.

(B) Total disability, shall exist whenever the insured's average monthly earned income for a period of four months next preceding has, as a result of the insured's injury or disease, not exceeded one-fourth of his former earned income averaged monthly for a period (next preceding said four months) which shall be prescribed in the policy and shall be

not less than twelve months. Such a policy shall be known and described as an "earned income disability" policy or contract.

(2) That disability benefits will be paid or allowed only in case such total disability is also permanent as defined in either of the following forms:

(A) If such policy is a total disability policy, as defined in paragraph one hereof, a provision that total disability which has been continuous for a period specified in the contract, and which shall be not less than four months nor more than one year, shall be deemed to be permanent only with respect to determining the commencement of disability benefits.

(B) If such policy is an earned income disability policy, as defined in paragraph one hereof, a provision that total disability shall be deemed to continue as long as the insured's earned monthly income shall, as a result of injury or disease, not exceed one-fourth of his average monthly earned income as determined at the commencement of total disability.

(3) That written notice of claim be given to the insurer during the lifetime of the insured and during the period of total disability. Failure to give such notice 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.

(4) That there be reasonable requirements as to the time, method and form of proof of disability and as to the continuance of disability, including an examination of the insured by the insurer at reasonable intervals. Failure to furnish proof of disability within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(5) That the contract of disability insurance shall be incontestable after it shall have been in force, during the lifetime of the insured and without the occurrence of total disability of the insured, for a period of three years from date of issue, except for nonpayment of premiums and except for the conditions of the contract relating to military or naval service.

(b) Any provision in such policy or contract that total disability resulting from any specified cause shall be excluded from coverage, shall contain only the following exclusions:

(1) (A) a provision terminating disability coverage when the insured becomes a member of the military, naval or air forces of any country at war, declared or undeclared; or

(B) a provision terminating disability coverage when the insured becomes a member of any auxiliary or civilian non-combatant unit serving with the military, naval or air forces of any country at war, declared or undeclared; or

(C) a provision excluding from coverage disability commencing within five years from the date of issue of the policy as a result of an act of war or any act incident thereto, whether such war be declared or undeclared, provided such act takes place while the insured is outside the geographical limits specified in the policy.

(2) A provision excluding from the coverage disability resulting from aviation under conditions specified in the policy.

(3) A provision excluding from the coverage disability directly resulting from injuries wilfully and intentionally self-inflicted.

(c) No policy or contract shall contain any provision set forth in this subsection, unless it conforms substantially to the following:

(1) Any provision excluding from the coverage disability resulting from disease or injury occurring before the date of issue of the policy or contract, except provisions excluding from the coverage a specific disease or injury by name or description, shall be applicable only to such disability commencing not later than two years after date of issue.

(2) A provision for a reasonable adjustment of income disability benefits if the aggregate monthly amount of such benefits payable to the insured, under all contracts of insurance, exceeds a specified percentage not to exceed one hundred percent of the average monthly earned income of the insured as may be ascertained in any reasonable manner.

(d) No such policy shall provide that the face amount of life insurance shall be reduced because of any disability benefits paid, except that such policy may provide, in lieu of income payments, an annuity certain for a period of not more than ten years, the value of which at its inception shall be equal to the face amount of insurance,

with the provision that upon recovery such annuity shall cease and the insurance shall be restored at a proportionate premium for an amount equal to the present value of the instalments not yet due.

(e) No such policy which provides income disability benefits shall contain any provision whereby the income disability benefits shall exceed a monthly rate equal to one percent of the face amount of the policy, such face amount not to include any additional benefits payable in case of accidental death and of any pure endowment benefits.

(f) No such contract which provides income disability benefits shall contain any provision whereby monthly income disability benefits exceed one-twelfth of the annual annuity which would ordinarily be payable thereunder at age seventy.

(g) The provisions of this section shall not apply to any group life insurance policies or group annuity contracts.

(h) Within the meaning of this section:

(1) "waiver of premiums" includes refund of waived premiums, if paid;

(2) "income payments" means payments made monthly or at less frequent regular intervals in addition to waiver of premiums and to all benefits otherwise provided by the contract;

(3) "disability benefits" means waiver of premiums, or both waiver of premium and income payments, whichever may be specified in the contract;

(4) "income disability benefits" means income payments contingent upon total disability of the insured.

§ 3216. Individual accident and health insurance policy provisions.

(a) In this section the term:

(1) "Policy of accident and health insurance" includes any individual policy or contract covering the kind or kinds of insurance described in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter.

(2) "Indemnity" means benefits promised.

(3) "Family" may include the policyholder's spouse, or dependent children, or any other person dependent upon the policyholder.

(4) "Dependent children" (A) shall include any children under a specified age which shall not exceed age nineteen except:

(i) Any unmarried dependent child, regardless of age, who is incapable

of self-sustaining employment by reason of mental illness, or developmental disability as defined in the mental hygiene law, or physical handicap and who became so incapable prior to the age at which dependent coverage would otherwise terminate, shall be included in coverage subject to any pre-existing conditions limitation applicable to other dependents; or

(ii) Any unmarried student at an accredited institution of learning may be considered a dependent child until attaining age twenty-three for a policy other than hospital, medical, surgical, or prescription drug expense insurance; or

(iii) Any married or unmarried child shall be considered a dependent child until attaining age twenty-six without regard to financial dependence, residency with the policyholder, student status, or employment, for a policy of hospital, medical, surgical, or prescription drug expense insurance.

(B) may include, at the option of the insurer, any unmarried child until attaining age twenty-five for a policy other than hospital, medical, surgical, or prescription drug expense insurance.

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

(b) No policy of accident and health insurance, including non-cancellable disability insurance, except as provided in subsection (h) hereof, shall be delivered or issued for delivery in this state until the rate manual showing rates, rules and classifications of risks for use in connection with such accident and health insurance policies or with riders or endorsements thereon, has been filed with the

superintendent.

(c) No policy of accident and health insurance shall be delivered or issued for delivery to any person in this state unless:

(1) The entire money and other considerations therefor are expressed therein.

(2) The time at which the insurance takes effect and terminates is expressed therein.

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, members of a family, as defined herein, upon the application of an adult member of the family who shall be deemed the policyholder.

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

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

(C) Any family coverage shall provide that coverage of newborn infants, including newly born infants adopted by the insured or subscriber if such insured or subscriber takes physical custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law

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

(5) (A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to that person by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within sixty days after such insurance shall have terminated, an individual conversion policy that contains the essential health benefits package described in paragraph three of subsection (f) of section three thousand two hundred seventeen-i of this article. The insurer shall offer one policy at each level of coverage as defined in subsection (b) of section three thousand two hundred seventeen-i of this article. The individual may choose any such policy offered by the insurer. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of this subparagraph through the offering of policies that comply with this subparagraph by

another insurer, corporation or health maintenance organization within the insurer's holding company system, as defined in article fifteen of this chapter. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

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

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

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

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

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

(6) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred

twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions).

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

(8) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof.

(9) It contains no provision purporting to make any portion of the charter, rules, constitution, or by-laws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the superintendent.

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

(11) The age limit or date or period, if any, after which the coverage provided by the policy will not be effective or the age limit, date or period after which the policy may not be renewed is stated in a renewal

provision set forth on the first page of the policy or as a separate provision bearing an appropriate caption on the first page of the policy or in a brief description in not less than fourteen-point bold face type set forth on the first page of the policy. Nothing herein contained shall limit or restrict the right of the insurer to continue the policy after the age or period so stated.

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

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

(13) Any persons covered by the policy who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon written request, to have their coverage suspended during a period of active duty as described herein. The policy shall provide that the insurer will refund any unearned premiums for the period of such suspension. Persons covered by the policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within sixty days after the date of termination of the period of active duty, with no limitations or conditions imposed as a result of such period of active duty except as set forth in subparagraphs (A) and (B) herein. Coverage shall be retroactive to the date of termination of the period of active duty. Such right of resumption provided for herein shall be in addition to other existing rights granted pursuant to state and federal laws and regulations and shall not be deemed to qualify or limit such rights in any way. No exclusion or waiting period may be imposed in connection with coverage of a health or physical condition of a person entitled to such right of resumption, or a health or physical condition of any other person who is covered by the policy unless:

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

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

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

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

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

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

(15) Every policy delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall provide space on any enrollment, renewal or initial online portal process setup forms required of an insured or applicant for insurance, except forms issued by the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of paragraph (a) of subdivision five of section forty-three hundred ten and paragraph (v) of subdivision one of section two hundred six of the public health law, required of an insured or applicant for insurance so that the insured or applicant shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment or renewal form and that the following is stated on the form in clear and conspicuous type:

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

(d) Each policy of accident and health insurance delivered or issued for delivery to any person in this state shall contain the provisions specified herein in the words in which the same appear in this subsection, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different

wording approved by the superintendent which are not less favorable in any respect to the insured or the beneficiary. Each provision contained in the policy shall be preceded by the applicable caption herein or, at the insurer's option, by such appropriate captions or subcaptions as the superintendent may approve.

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

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

(B) TIME LIMIT ON CERTAIN DEFENSES:

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

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

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

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

(ii) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy

shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

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

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

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

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

(D) REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of the premium by the insurer or by any agent or broker duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent or broker requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only

loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

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

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

notice is actually given.)

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

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

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

(I) PAYMENT OF CLAIMS: Any indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. (The

following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $---------- (insert an amount which shall not exceed one thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

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

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

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

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

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

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

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

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

required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

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

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

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

or, in lieu thereof:

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

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

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

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

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "--- OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of

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

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

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by

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

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

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

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

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

(J) ILLEGAL OCCUPATION: The insurer shall not be liable for any loss

to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

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

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

(4) The provisions which are the subject of paragraphs one and two of this subsection, or any corresponding provisions which are used in lieu thereof in accordance with such paragraphs, shall be printed in the consecutive order of the provisions in such paragraphs or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(5) The word "insured", as used in this section, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(6) The superintendent may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this section as are necessary, proper or advisable to the administration of this section. This provision shall not abridge any other authority granted the superintendent by law.

(e) The acknowledgment by any insurer of the receipt of notice given under any policy covered by this section, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the

investigation of any claim thereunder, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(f) If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(g)(1) No insurer shall refuse to renew a policy of hospital, surgical or medical expense insurance, an individual converted policy, or any other policy in which one-third or more of the total premium is allocable to hospital, surgical or medical expense benefits, or any combination thereof (but not including insurance against accidental injury only), except for one or more of the following reasons:

(A) nonpayment of premiums,

(B) fraud in applying for the policy or in applying for any benefits under the policy or intentional misrepresentation of material fact under the terms of the coverage,

(C) discontinuance of a class of policies in accordance with paragraph two of this subsection, except that no insurer or organization certified pursuant to article forty-four of the public health law shall refuse to renew the policies of insureds holding contracts which provide major medical or similar comprehensive type coverage in effect prior to June first, two thousand one who are ineligible to purchase policies offered pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this chapter due to the provisions of section 42 USC 1395ss in effect on January first, two thousand one, and who are eligible for Medicare benefits by reason of disability.

(i) Coverage shall be reinstated only for such insureds terminated on

or after January first, two thousand one and such coverage shall be reinstated on a prospective basis only, irrespective of any pre-existing conditions.

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

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

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

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

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

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

refusal to renew permitted by this subsection as he may deem necessary for the proper administration of this subsection.

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

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

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

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

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

(E) The superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of subparagraph (C) of this paragraph through the offering of policies at each level of coverage as defined in subsection (b) of section three thousand two hundred seventeen-i of this article that contains the essential health benefits package described in paragraph three of subsection (e) of section three thousand two hundred seventeen-i of this article by another insurer, corporation or health maintenance organization within the insurer's same holding company system, as defined in article fifteen of this chapter.

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

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

(B) the insurer provides written notice of such discontinuance to each

covered individual at least one hundred eighty days prior to the date of termination of such coverage;

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

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

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

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

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

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

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

(2) Any policy or contract of reinsurance.

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

subparagraph (J) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter.

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

(5) Any policy of a co-operative life and accident insurance company except as was provided in section two hundred thirty-seven of the former insurance law.

(6) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as provide additional benefits in case of death or dismemberment or loss of sight by accident, or as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

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

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

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

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

(4) If a policy provides for reimbursement for psychiatric or psychological services or for diagnosis and treatment of mental health conditions however defined in the policy, the insured shall be entitled to reimbursement for such services, diagnosis or treatment whether

performed by a physician, psychiatrist, a certified and registered psychologist, or a nurse practitioner when the services rendered are within the lawful scope of their practice.

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

(6) Every policy which provides coverage for in-patient hospital care shall provide coverage for home care to residents in this state. Such home care coverage shall be included at the inception of all new policies and, with respect to all other policies, at any anniversary date of the policy subject to evidence of insurability.

(A) Home care means the care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, would otherwise have been required if home care was not provided, and the plan covering the home health service is established and approved in writing by such physician. Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law and shall consist of one or more of the following:

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

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

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

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

(B) Coverage may be subject to an annual deductible of not more than fifty dollars for each person covered under the policy and may be

subject to a coinsurance provision which provides for coverage of not less than seventy-five percent of the reasonable charges for such services. For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits, but not less than forty such visits in any calendar year or in any continuous period of twelve months for each person covered under the contract; four hours of home health aide service shall be considered as one home care visit.

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

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

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

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

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

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

(8) Every policy which provides coverage for in-patient surgical care shall include coverage for a second surgical opinion by a qualified physician on the need for surgery.

(9)(A) Every policy that provides coverage for inpatient hospital care shall also include coverage for services to treat an emergency condition in hospital facilities:

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

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

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

(iv) if the emergency services are provided by a non-participating

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

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

(C) For purposes of this paragraph, an "emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(D) For purposes of this paragraph, "emergency services" means, with respect to an emergency condition: (i) a medical screening examination as required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, to stabilize the patient.

(E) For purposes of this paragraph, "to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).

(10) (A) (i) Every policy which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital,

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

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

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

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

* (C) Coverage provided under this paragraph for care and treatment during pregnancy shall include medically necessary transvaginal ultrasounds when recommended by nationally recognized clinical practice guidelines. For the purposes of this subparagraph, "nationally

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

* NB Effective January 1, 2027

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

(11) (A) Every policy that provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(i) upon the recommendation of a physician, a mammogram, which may be provided by breast tomosynthesis, at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

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

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

(iv) upon the recommendation of a physician, screening and diagnostic imaging, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging, recommended by nationally recognized clinical practice guidelines for the detection of breast cancer. For the purposes of this item, "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

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

coinsurance. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

* NB Effective until January 1, 2027

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

* NB Effective January 1, 2027

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

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

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

(ii) with respect to women, such additional preventive care and

screenings for mammography not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

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

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

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

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

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

(11-c) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker precision medical testing for the purposes of diagnosis, treatment, or appropriate management of, or ongoing monitoring to guide treatment decisions for, an insured's disease or condition when one or more of the following recognizes the efficacy and appropriateness of biomarker precision medical testing for diagnosis, treatment, appropriate management, or guiding treatment decisions for an insured's disease or condition:

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

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

(iii) nationally recognized clinical practice guidelines; or

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

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

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

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

(ii) "Biomarker precision medical testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests and multi-plex panel tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration.

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

(12) (A) Every policy which provides coverage for prescribed drugs approved by the food and drug administration of the United States government for the treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided,

however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

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

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

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

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

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

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

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

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

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

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

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

(13) (A) Every policy which provides coverage for hospital care shall not exclude coverage for hospital care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility.

(B) Every policy which provides coverage for surgical and medical care shall not exclude coverage for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility.

(C) Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(i) For purposes of this subparagraph, "iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

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

(13-a) Every policy that provides coverage for prescription fertility drugs and requires or permits prescription drugs to be purchased through a network participating mail order or other non-retail pharmacy shall provide the same coverage for prescription fertility drugs when such drugs are purchased from a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance through a contractual network agreement, to the same reimbursement amount, as well as the same applicable terms and conditions, that the insurer has established for a network participating mail order or other non-retail pharmacy. In such case, the policy shall not impose any fee, co-payment, co-insurance, deductible or other condition on any insured who elects to purchase prescription fertility drugs through a network participating non-mail order retail pharmacy that it does not impose on any insured who purchases prescription fertility drugs through a network participating mail order or other non-retail pharmacy.

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

(15) (A) Every policy that provides hospital, surgical or medical care coverage or provides reimbursement for laboratory tests or reimbursement for diagnostic X-ray services shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older.

(B) For purposes of subparagraphs (A) and (C) of this paragraph, cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

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

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, every policy that provides hospital, surgical or medical care coverage,

except for a grandfathered health plan under subparagraph (E) of this paragraph, shall provide coverage for the following cervical cytology screening services, and such coverage shall not be subject to annual deductibles or coinsurance:

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

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

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

(15-a) (A) Every policy which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the

diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

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

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

physician as medically necessary. Nor shall anything herein be construed as prohibiting the limitation of such services, where covered, to specified settings other than offices, such as hospitals or to services provided by such professionals as part of a home care agency's services.

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

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

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

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

(iii) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus,

polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b, which meet the standards approved by the United States public health service for such biological products.

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

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

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

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

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved, or that are recommended by the commissioner of health to the superintendent utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians and/or other similar nationally or internationally recognized scientific organizations;

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

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

(v) all FDA-approved contraceptive drugs, devices, and other products, including all over-the-counter contraceptive drugs, devices, and

products as prescribed or as otherwise authorized under state or federal law; voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and identified in the comprehensive guidelines supported by the health resources and services administration and thereby incorporated in the essential health benefits benchmark plan; patient education and counseling on contraception; and follow-up services related to the drugs, devices, products, and procedures covered under this clause, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Except as otherwise authorized under this clause, a contract shall not impose any restrictions or delays on the coverage required under this clause. However, where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, a contract is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this clause. If the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a contract shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. (a) This coverage shall include emergency contraception without cost sharing when provided pursuant to a prescription, or order under section sixty-eight hundred thirty-one of the education law or when lawfully provided over-the-counter. (b) If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final. The superintendent shall promulgate regulations establishing a process, including timeframes, for an insured, an insured's designee or an insured's health care provider to request coverage of a non-covered contraceptive drug, device, or product. Such regulations shall include a requirement that insurers use an exception form that shall meet criteria established by the superintendent. (c) This coverage must allow for the dispensing of up to twelve months worth of a contraceptive at one time. (d) For the purposes of this clause, "over-the-counter contraceptive products" shall mean

those products provided for in comprehensive guidelines supported by the health resources and services administration as of January twenty-first, two thousand nineteen.

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

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

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

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

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

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

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

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

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

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

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

(ii) In the case of a policy that does not provide financial incentives for, and does not require, the insured to receive covered services from health care providers participating in a provider network

maintained by or under contract with the insurer, the policy shall include coverage for a second medical opinion from a specialist at no additional cost to the insured beyond what the insured would have paid for comparable services covered under the policy.

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

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

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

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

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

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

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

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

amend or otherwise modify such sections.

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

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

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

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

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

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

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

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

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

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

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

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

* (21) Every policy that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low

protein, contain modified protein, or are amino acid based that are medically necessary.

* NB There are 2 par (21)'s

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

(C) Every policy which includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive-type coverage, other than a "managed care product" as defined in subparagraph (D) of this paragraph, shall provide coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic

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

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

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

* NB There are 2 par (21)'s

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

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

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

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

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

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

(E) As used in this paragraph:

(i) "Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement shall be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (II) serious impairment to such person's bodily functions; (III) serious dysfunction of any bodily organ or part of such person; (IV) serious disfigurement of such person; or (V) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(ii) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity,

including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (II) serious impairment to such person's bodily functions; (III) serious dysfunction of any bodily organ or part of such person; (IV) serious disfigurement of such person; or (V) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(25) (A) Every policy which provides coverage for hospital or surgical coverage shall not exclude coverage for screening, diagnosis and treatment of medical conditions otherwise covered by the policy solely because the treatment is provided to diagnose or treat autism spectrum disorder.

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

(C) For purposes of this paragraph:

(i) "autism spectrum disorder" means any pervasive developmental

disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders.

(ii) "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

(ix) "treatment of autism spectrum disorder" shall include the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:

(1) behavioral health treatment;

(2) psychiatric care;

(3) psychological care;

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

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

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

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

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

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

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

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

(J) For purposes of this paragraph:

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

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

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

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

(26)(A) No managed care health insurance policy that provides coverage for hospital, medical or surgical care shall provide that services of a participating hospital will be covered as out-of-network services solely on the basis that the health care provider admitting or rendering services to the insured is not a participating provider.

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

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

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

(27) No policy delivered or issued for delivery in this state which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).

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

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

* (30)(A) Every policy that provides hospital, major medical or

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

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

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

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission. The facility shall perform daily clinical review of the patient, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient

treatment is medically necessary for the patient. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(F) For purposes of this paragraph:

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

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

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for

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

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

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

* NB Effective until January 1, 2027

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

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

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

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

obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance-related and addictive disorder benefits.

(F) For purposes of this paragraph:

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

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

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

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

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

* NB Effective January 1, 2027

* NB There are 2 par (30)'s

* (30) Every policy that provides medical coverage that includes coverage for physician services in a physician's office and every policy that provides major medical or similar comprehensive-type coverage shall include coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. The coverage required by this paragraph shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits as defined in subsection (a) of section three thousand two hundred seventeen-i of this article.

* NB There are 2 par (30)'s

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

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

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

(D) A policy providing coverage for substance use disorder services pursuant to this paragraph shall provide up to twenty outpatient visits

per policy or calendar year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy pursuant to this paragraph. The coverage required by this paragraph shall include treatment as a family member pursuant to such family member's own policy provided such family member:

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the

evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(G) For purposes of this paragraph:

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

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

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

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

(H) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici

Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

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

(J) (i) This clause shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this clause, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(ii) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the

purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective until January 1, 2027

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

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

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

(D) A policy providing coverage for substance-related and addictive disorder services pursuant to this paragraph shall provide up to twenty outpatient visits per policy or calendar year to an individual who identifies themselves as a family member of a person suffering from substance-related and addictive disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy pursuant to this paragraph. The coverage required by this paragraph shall include

treatment as a family member pursuant to such family member's own policy provided such family member:

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of addiction services and supports and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(G) For purposes of this paragraph:

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

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

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

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

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

(I) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care in a crisis stabilization center shall not be subject to

preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(J) (i) This clause shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this clause, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(ii) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective January 1, 2027

* (31-a) (A) No policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

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

* NB Effective until January 1, 2027

* (31-a) (A) No policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance-related and addictive disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance-related and addictive disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

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

* NB Effective January 1, 2027

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

treatment medication.

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

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

* NB There are 2 par (33)'s

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

* NB There are 2 par (33)'s

(34) Health care forensic examinations performed pursuant to section

twenty-eight hundred five-i of the public health law covered under the policy shall not be subject to annual deductibles or coinsurance.

(35) (A) Every policy delivered or issued for delivery in this state that provides coverage for inpatient hospital care or coverage for physician services shall provide coverage for the diagnosis and treatment of mental health conditions as follows:

* (i) where the policy provides coverage for inpatient hospital care, such policy shall include benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

*(i) where the policy provides coverage for inpatient hospital care, such policy shall include benefits for: inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law; sub-acute care in a residential facility licensed or operated by the office of mental health; outpatient care provided by a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or by a facility operated by the office of mental health; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by the office of mental health or the office of addiction services and supports; outpatient and inpatient care for critical time intervention services and outpatient care for assertive community treatment services provided by facilities issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, beginning no later than thirty days following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of

a hospital licensed pursuant to article twenty-eight of the public health law; or, for care provided in other states, to similarly licensed or certified hospitals, facilities, or licensed, certified or designated providers; and

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

(B) Coverage required by this paragraph may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy.

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

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

(E) For purposes of this paragraph:

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

(ii) "predominant" means that a financial requirement or treatment

limitation is the most common or frequent of such type of limit or requirement;

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

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

* (iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another

generally recognized independent standard of current medical practice such as the international classification of diseases.

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

(F) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici

Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

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

under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

* (I) This subparagraph shall apply to mobile crisis intervention services providers licensed, certified, or designated by the office of mental health or the office of addiction services and supports. For purposes of this subparagraph, "mobile crisis intervention services" means mental health and substance use disorder services consisting of: (1) telephonic crisis triage and response; (2) mobile crisis response to provide intervention and facilitate access to other behavioral health services; and (3) mobile and telephonic follow-up services after the initial crisis response until the insured is stabilized, provided to an insured who is experiencing, or is at imminent risk of experiencing, a behavioral health crisis, which includes instances in which an insured cannot manage their primarily psychiatric or substance use related symptoms without de-escalation or intervention. Mobile crisis intervention services do not include services provided to an insured after the insured has been stabilized.

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

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

provider.

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

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

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the policy.

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

(ii) The office of mental health shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of mental health. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

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

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

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

(i) The WHO Model Lists of Essential Medicines;

(ii) The WHO Abortion Care Guidance; or

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

* NB There are 2 par (36)'s

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

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

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

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

(iv) The insured has notified, in writing, the insurer at least thirty days in advance of the proposed date or dates of such out-of-network dialysis treatment. The notice shall include the authorization required by clause (iii) of this subparagraph. In the event the insured must

travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has reasonable opportunity to review the travel and treatment plans of the insured;

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

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

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

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

* NB There are 2 par (36)'s

* (37) Any policy that provides coverage for prescription drugs shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of a prescription drug to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of

whether the minimum deductible under 26 USC 223 has been satisfied. This paragraph only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective until January 1, 2027

* (37) Any policy that provides coverage for prescription drugs shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of a prescription drug to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the plan deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the plan deductible has been satisfied. This paragraph only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective January 1, 2027

* NB There are 2 par (37)'s

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

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

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

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

* NB There are 2 par (37)'s

(38) Every policy that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or

physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

* (39) No policy that provides coverage for antiretroviral prescription drugs prescribed for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) shall subject such drugs to prior authorization.

* NB There are 2 par (39)'s

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

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

* NB There are 2 par (39)'s

(40) (A) Every policy that provides coverage for physician services, medical, major medical or similar comprehensive-type coverage shall, upon the referral of a physician, provide coverage for comprehensive neuropsychological examinations for dyslexia when performed by a health

care professional licensed, certified, or authorized pursuant to title eight of the education law and acting within their scope of practice and in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy.

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

* (41) (A) Every policy which provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs shall include coverage for inhalers for the treatment of asthma if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

(B) Coverage shall be provided for one form of rescue and one form of maintenance inhaler that shall not be subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.

(C) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 par (41)'s

* (41) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for follow-up screening or diagnostic services for lung cancer upon the recommendation of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, and as recommended by nationally recognized clinical practice guidelines for the detection of lung cancer.

(B) Notwithstanding any other provision of law, any policy that provides coverage required by this paragraph shall not impose patient cost sharing for follow-up screening or diagnostic services for lung cancer.

(C) For the purposes of this paragraph, "nationally recognized clinical practice guidelines" means evidence-based, peer reviewed

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

(D) Nothing in this paragraph shall be construed to prevent medical management or utilization review of the services, including preauthorization, to ensure that such services are consistent with nationally recognized clinical practice guidelines for the detection of lung cancer.

(E) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 par (41)'s

(j) (1) Every insurer issuing a policy of accident and health insurance for delivery in this state which provides coverage for in-patient hospital care must make available and, if requested by the policyholder, provide coverage for care in a nursing home. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at any anniversary date of the policy subject to evidence of insurability.

(A) In this paragraph nursing home care means the continued care and treatment of a covered person who is under the care of a physician but only if (i) the care is provided in a nursing home as defined in section twenty-eight hundred one of the public health law or a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, (ii) the covered person has been in a hospital for at least three days immediately preceding admission, and (iii) further hospitalization would otherwise be necessary. The aggregate of the number of covered days of care in a hospital and the number of covered days of care in a nursing home, with two days of care in a nursing home equivalent to one day of care in a hospital, may not exceed the number of covered days of hospital care provided under the contract in a benefit period. The level of benefits to be provided for nursing home care must be reasonably related to the benefits provided

for hospital care.

(B) Ambulatory care means care in hospital out-patient facilities, as a hospital is defined in section twenty-eight hundred one of the public health law or subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq, and physicians' offices. Ambulatory care in hospital out-patient facilities means services for diagnostic X-rays, laboratory and pathological examinations, physical therapy and radiation therapy, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy, provided that such services and medications are (i) related to and necessary for the treatment or diagnosis of the patient's illness or injury, (ii) ordered by a physician and (iii) in the case of physical therapy, services are to be furnished in connection with the same illness for which the patient had been hospitalized or in connection with surgical care, but in no event need benefits be provided for physical therapy which commences more than six months after discharge from a hospital or the date surgical care was rendered, and in no event need benefits for physical therapy be provided after three hundred sixty-five days from the date of discharge from a hospital or the date surgical care was rendered. Ambulatory care in physicians' offices means services for diagnostic X-rays, radiation therapy, laboratory and pathological examinations, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy, provided that such services and medications are related to and necessary for the treatment or diagnosis of the patient's illness or injury, and ordered by a physician. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies, at any anniversary date of the policy subject to evidence of insurability.

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

(3) Consistent with federal law, every insurer issuing a policy of accident and health insurance for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, 42 USC §§ 1395 et seq., shall make available and, if requested by the insured, provide coverage for at least ninety days of care in a nursing home as defined in section twenty-eight hundred one of the public health law, except where such coverage would duplicate coverage that is available under the aforementioned subchapter XVIII. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies, at each anniversary date of the policy.

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

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

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

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

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

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

(m) An insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section if the benefits must be covered as essential health benefits. For any policy issued within the health benefit exchange established by this state, an insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section. For purposes of this subsection, "essential health benefits" shall have the meaning set forth in subsection (a) of section three thousand two hundred seventeen-i of this article.

* (n) With respect to high deductible health plans offered in conjunction with a health savings account, if application of any cost sharing requirements would result in health savings account ineligibility under section two hundred twenty-three of the internal revenue code, such coverage may be subject to the plan's annual deductible.

* NB Effective January 1, 2027

§ 3217. Minimum standards in the form, content and sale of accident and health insurance; policies and subscriber contracts. (a) The superintendent shall issue such regulations he deems necessary or desirable to establish minimum standards, including standards of full and fair disclosure, for the form, content and sale of accident and health insurance policies and subscriber contracts of corporations organized under this article and article forty-three of this chapter or entities licensed pursuant to article forty-four of the public health law. With regard to contracts issued pursuant to such articles which incorporate a usual and customary or reasonable form of reimbursement, such regulations shall require such schedules to be updated periodically, to accurately reflect geographic differences in costs and that information be furnished to insureds regarding the method upon which the usual and customary or reasonable charge is determined and the percentile of charges upon which the schedule is based. Such regulations shall also require, in addition to such other information as the superintendent deems necessary, the disclosure of the reimbursement for a particular elective surgical procedure or treatment, upon written request by an insured, subscriber or enrollee. Such regulations may

apply to all, any portion or reasonable classifications of such policies or contracts.

(b) The purposes of such minimum standards shall include any or all of the following:

(1) reasonable standardization and simplification of coverages to facilitate understanding and comparisons;

(2) elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purchase of such policies or contracts or with the settlement of claims;

(3) elimination of deceptive practices in connection with the sale of such policies or contracts;

(4) elimination of provisions which may be contrary to the health care needs of the public, as certified to the superintendent by the commissioner of health; and

(5) elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders.

(c) Prior to the issuance of regulations pursuant to this section, the superintendent shall afford the public, including the companies affected thereby, reasonable opportunity for comment and shall obtain the views, in writing, of the commissioner of health and the secretary of state.

(d) When a regulation adopted pursuant to this section so provides, all forms of such policies or contracts which are not in compliance with such regulation shall be deemed to be disapproved for use without any further or additional notice after a date to be specified in such regulation which date shall not be less than sixty days following its effective date.

(e) When a regulation adopted pursuant to this section so provides, any such policy or contract which does not comply with the regulation shall, when issued after a date not less than sixty days from the effective date of such regulation, be construed, and the insurer or corporation shall be liable, as if the policy or contract did comply with the regulation.

(f) Violation of any regulation adopted pursuant to this section shall be a violation of this chapter for purposes of section one hundred nine of this chapter.

§ 3217-a. Disclosure of information. The requirements of this section shall apply to all comprehensive, expense-reimbursed health insurance contracts; managed care health insurance contracts; or any other health insurance contract or product for which the superintendent deems such disclosure appropriate.

(a) Each insurer subject to this article shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the insurance contract or certificate, the terms of the insurance contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

(1) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(2) a description of all prior authorization or other requirements for treatments and services;

(3) a description of utilization review policies and procedures, used by the insurer, including:

(A) the circumstances under which utilization review will be undertaken;

(B) the toll-free telephone number of the utilization review agent;

(C) the time frames under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(D) the right to reconsideration;

(E) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(F) the right to designate a representative;

(G) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;

(H) a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this chapter, of the external

appeal process established pursuant to title two of article forty-nine of this chapter and the time frames for such appeals; and

(I) further appeal rights, if any;

(4) a description prepared annually of the types of methodologies the insurer uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between an insurer and a health care provider;

(5) an explanation of an insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services;

(6) an explanation, where applicable, of an insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without required authorization, or when a procedure, treatment or service is not a covered benefit;

(7) a description of the grievance procedures to be used to resolve disputes between an insurer and an insured, including: the right to file a grievance regarding any dispute between an insured and an insurer; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which insureds may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(8) a description of the procedure for obtaining emergency services. Such description shall include a definition of emergency services, notice that emergency services are not subject to prior approval, and shall describe the insured's financial and other responsibilities

regarding obtaining such services including when such services are received outside the insurer's service area, if any;

(9) where applicable, a description of procedures for insureds to select and access the insurer's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) where applicable, a description of the procedures for changing primary and specialty care providers within the insurer's network of providers;

(11) where applicable, notice that an insured enrolled in a managed care product or in a comprehensive policy that utilizes a network of providers offered by the insurer may obtain a referral or preauthorization for a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular health care needs of the insured and the procedure by which the insured can obtain such referral or preauthorization;

(12) where applicable, notice that an insured enrolled in a managed care product or a comprehensive policy that utilizes a network of providers offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that an insured enrolled in a managed care product or a comprehensive policy that utilizes a network of providers offered by the insurer with (A) a life-threatening condition or disease, or (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that an insured enrolled in a managed care product or a comprehensive policy that utilizes a network of providers offered by the insurer with (A) a life-threatening condition or disease, or (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged

period of time, may request access to a specialty care center and the procedure by which such access may be obtained;

(15) a description of how the insurer addresses the needs of non-English speaking insureds;

(16) notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization;

(16-a) where applicable, notice that an insured shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

* (17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

* NB Effective until January 1, 2027

* (17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance-related and addictive disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and (C) in the case of physicians, board

certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

* NB Effective January 1, 2027

(18) a description of the method by which an insured may submit a claim for health care services;

(19) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

(20) information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services; and

(21) the most recent comparative analysis performed by the insurer to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under those acts.

(b) Each insurer subject to this article, upon request of an insured, or prospective insured, shall:

(1) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the insurer;

(2) provide a copy of the most recent annual certified financial statement of the insurer, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) provide a copy of the most recent individual, direct pay

subscriber contracts;

(4) provide information relating to consumer complaints compiled pursuant to section two hundred ten of this chapter;

(5) provide the procedures for protecting the confidentiality of medical records and other insured information;

(6) where applicable, allow insureds and prospective insureds to inspect drug formularies used by such insurer; and provided further, that the insurer shall also disclose whether individual drugs are included or excluded from coverage to an insured or prospective insured who requests this information;

(7) provide a written description of the organizational arrangements and ongoing procedures of the insurer's quality assurance program, if any;

(8) provide a description of the procedures followed by the insurer in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) provide individual health practitioner affiliations with participating hospitals, if any;

(10) upon written request, provide specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination pursuant to subsection (c-1), subsection (c-2) and subsection (c-3) of section forty-nine hundred three of this chapter, and, where appropriate, other clinical information which the insurer might consider in its utilization review and the insurer may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the insurer, the insured or prospective insured shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization. Such clinical review criteria, and other clinical information shall also be made available to a health care professional as defined in subsection (f) of section forty-nine hundred of this chapter, on behalf of an insured and upon written request;

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the insurer for participation in the insurer's network for

a managed care product;

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act;

(13) disclose whether a health care provider scheduled to provide a health care service is an in-network provider; and

(14) with respect to out-of-network coverage, disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service. The insurer shall also inform the insured through such disclosure that such approximation is not binding on the insurer and that the approximate dollar amount that the insurer will pay for a specific out-of-network health care service may change.

(c) Nothing in this section shall prevent an insurer from changing or updating the materials that are made available to insureds.

(d) As to any program where the insured must select a primary care provider, if a participating primary care provider becomes unavailable to provide services to an insured, the insurer shall provide written notice within fifteen days from the time the insurer becomes aware of such unavailability to each insured who has chosen the provider as their primary care provider. If an insured enrolled in a managed care product is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such insured, and the insurer is aware of such ongoing course of treatment, the insurer shall provide written notice within fifteen days from the time that the insurer becomes aware of such unavailability to such insured. Each notice shall also describe the procedures for continuing care pursuant to subsections (e) and (f) of section forty-eight hundred four of this chapter and for choosing an alternative provider.

(e) For purposes of this section, a "managed care product" shall mean a contract which requires that all 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 designated health care provider chosen by the insured (i.e. a primary care gatekeeper), 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, in the case of (i) an individual health insurance contract, or (ii) a group health insurance contract covering

no more than three hundred lives, imposing a coinsurance obligation of more than twenty-five percent upon services received outside of the insurer's managed care provider network, and which has been sold to five or more groups, a managed care product shall also mean a contract which requires that all 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 designated health care provider chosen by the insured (i.e. a primary care gatekeeper), 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.

(f) For purposes of this section, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law.

(g) (1) As used in this subsection:

(A) "Pharmacy benefit manager" shall have the meanings set forth in section two hundred eighty-a of the public health law.

(B) "Cost-sharing information" means the amount an insured is required to pay to receive a drug that is covered under the insured's insurance policy.

(C) "Covered/coverage" means those health care services to which an insured is entitled under the terms of the insurance policy.

(D) "Electronic health record" means a digital version of a patient's paper chart and medical history that makes information available instantly and securely to authorized users.

(E) "Electronic prescribing system" means a system that enables prescribers to enter prescription information into a computer prescription device and securely transmit the prescription to pharmacies

using a special software program and connectivity to a transmission network.

(F) "Electronic prescription" means an electronic prescription as defined in section thirty-three hundred two of the public health law.

(G) "Prescriber" means a health care provider licensed to prescribe medication or medical devices in this state.

(H) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (i) is capable of integrating with prescribers' electronic prescribing system and, if feasible, electronic health record systems; and (ii) complies with the technical standards adopted by an American National Standards Institute (ANSI) accredited standards development organization.

(I) "Authorized third party" shall include a third party legally authorized under state or federal law subject to a Health Insurance Portability and Accountability Act (HIPAA) business associate agreement.

(2) The provisions of this section shall not apply to any health plan that exclusively serves individuals enrolled pursuant to a federal or state insurance affordability program, including the medical assistance program under title eleven of article five of the social services law, child health plus under section twenty-five hundred eleven of the public health law, the basic health program under section three hundred sixty-nine-gg of the social services law, or a plan providing services under title XVIII of the federal social security act.

(3) An insurer subject to this article or pharmacy benefit manager shall, upon request of the insured, the insured's health care provider, or an authorized third party on the insured's behalf, made to the insurer or pharmacy benefit manager, furnish the cost, benefit, and coverage data required by this subsection to the insured, the insured's health care provider, or the authorized third party and shall ensure that such data is: (A) current no later than one business day after any change to the cost, benefit, or coverage data is made; (B) provided through an RTBT when the request is made by the insured's health care provider; and (C) in a format that is easily accessible to the requestor.

(4) When providing the data required by paragraph three of this subsection, the insurer or pharmacy benefit manager shall use established industry content and transport standards published by:

(A) a standards developing organization accredited by the American National Standards Institute (ANSI), including, the National Council for Prescription Drug Programs (NCPDP), ASC X12, Health Level 7; or

(B) a relevant federal or state governing body, including the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology; or

(C) another format deemed acceptable to the department which provides the data prescribed in paragraph three of this subsection and in the same timeliness as required by this section.

(5) A facsimile shall not be considered an acceptable electronic format pursuant to this subsection.

(6) Upon a request made pursuant to paragraph three of this subsection, the insurer or pharmacy benefit manager shall provide the following data for any drug covered under the insured's insurance policy:

(A) insured-specific eligibility information;

(B) insured-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage and cost-sharing data for the prescribed drug and clinically-appropriate alternatives, when appropriate;

(C) insured-specific cost-sharing information that describes variance in cost-sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the insured's benefit; and

(D) applicable utilization management requirements.

(7) Any insurer or pharmacy benefit manager shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term. An insurer or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

(8) An insurer and pharmacy benefit manager shall not, except as may be required or authorized by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required; nor shall an insurer or pharmacy benefit manager penalize a health care provider for disclosing such information to an insured or legally prescribing, administering, or ordering a lower cost clinically appropriate alternative.

(9) Nothing in this subsection shall be construed to limit access to

the most up-to-date insured-specific eligibility or insured-specific prescription cost and benefit data by the insurer or pharmacy benefit manager.

(10) Nothing in this subsection shall interfere with insured choice and a health care provider's ability to convey the full range of prescription drug cost options to an insured. Insurers and pharmacy benefit managers shall not restrict a health care provider from communicating to the insured prescription cost options.

§ 3217-b. Prohibitions. (a) No insurer subject to this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from disclosing to any insured, designated representative or, where appropriate, prospective insured, (hereinafter collectively referred to as insured) any information that such provider deems appropriate regarding:

(1) a condition or a course of treatment with an insured including the availability of other therapies, consultations, or tests; or

(2) the provisions, terms, or requirements of the insurer's products as they relate to the insured.

(b) No insurer subject to this article shall by contract, written policy, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such insurer which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall an insurer subject to this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such insurer which may violate this chapter including paragraphs thirty, as added by chapter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-five of subsection (i) of section thirty-two hundred sixteen and paragraphs five, six, seven, seven-a and seven-b of subsection (l) of section thirty-two hundred twenty-one of this article.

(c) No insurer subject to this article shall by contract, written

policy or written procedure prohibit or restrict any health care provider from advocating to the insurer on behalf of the insured for approval or coverage of a particular course of treatment or for the provision of health care services.

(d) No contract or agreement between an insurer subject to this article and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the insurer as opposed to the health care provider.

(e) Contracts entered into between an insurer and a health care provider shall include terms which prescribe:

(1) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(2) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(3) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(4) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and

(5) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contracts through a proceeding under article seventy-five of the civil practice law and rules.

(f) No contract entered into between an insurer and a health care provider shall be enforceable if it includes terms which transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of section forty-four

hundred three of the public health law, or penalize providers for unfavorable case mix so as to jeopardize the quality of or insureds' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(g)(1) No insurer shall implement an adverse reimbursement change to a contract with a health care professional that is otherwise permitted by the contract, unless, prior to the effective date of the change, the insurer gives the health care professional with whom the insurer has directly contracted and who is impacted by the adverse reimbursement change, at least ninety days written notice of the change. If the contracting health care professional objects to the change that is the subject of the notice by the insurer, the health care professional may, within thirty days of the date of the notice, give written notice to the insurer to terminate his or her contract with the insurer effective upon the implementation date of the adverse reimbursement change. For the purposes of this subsection, the term "adverse reimbursement change" shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional, and the term "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law. The notice provisions required by this subsection shall not apply where: (A) such change is otherwise required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or (B) such change is expressly provided for under the terms of the contract by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

(2) Nothing in this subsection shall create a private right of action on behalf of a health care professional against an insurer for violations of this subsection.

(h) Any contract provision, written policy or written procedure in violation of this section shall be deemed to be void and unenforceable.

* (i) If a contract between an insurer and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of such contract, including reimbursement terms, for a period of two months from the effective date of termination or, in the case of a non-renewal, from the end of the contract period. Notice shall be provided to all insureds potentially affected by such termination or non-renewal within fifteen days after commencement of the two-month period. The commissioner of health shall have the authority to waive the two-month period upon the request of either party to a contract that is being terminated for cause. This subsection shall not apply where both parties mutually agree in writing to the termination or non-renewal and the insurer provides notice to the insured at least thirty days in advance of the date of contract termination.

* NB Repealed June 30, 2027

(j) (1) No insurer shall by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services, observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not comply with certain administrative requirements of such insurer with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and an insurer from agreeing to certain administrative requirements relating to payment for inpatient services, observation services, or emergency department services, including but not limited to timely notification that medically necessary inpatient services have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely notification; provided, however that: (A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for services provided on weekends or federal holidays, (B) any agreed to reduction in payment for failure to meet administrative requirements, including timely notification shall not exceed seven and one-half percent of the payment amount otherwise due for the services provided, and (C) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's

insurance coverage could not be determined by the hospital after reasonable efforts at the time the services were provided.

(3) The provisions of this subsection shall not apply to the denial of a claim: (A) based on a reasonable belief by an insurer of fraud or intentional misconduct resulting in misrepresentation of patient diagnosis or the services provided, or abusive billing; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; (C) that is a duplicate claim, that is a claim submitted late pursuant to subsection (g) of section thirty-two hundred twenty-four-a of this article, or is for services for a benefit that is not covered under the insured's policy or for a patient determined to be ineligible for coverage; (D) except in the case of medically necessary inpatient services resulting from an emergency admission, where there is not an existing participating provider agreement between an insurer and a general hospital; or (E) where the hospital has repeatedly and systematically, over the previous twelve month period, failed to seek prior authorization for services for which prior authorization was required.

(4) For purposes of this subsection, an "administrative requirement" shall not include requirements: (A) imposed on an insurer or provider pursuant to federal or state laws, regulations or guidance; or (B) established by the state or federal government applicable to insurers offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not apply to claims for services for which a request for preauthorization was denied by the insurer prior to delivery of the service.

(k) An insurer shall not require a prior authorization determination for services provided in a neonatal intensive care unit of a general hospital certified pursuant to article twenty-eight of the public health law. Nothing in this subsection shall prohibit an insurer from denying a claim for such services if the services are subsequently determined not medically necessary.

(l) At least sixty days prior to the termination of a contract between a hospital and an insurer, the parties shall utilize a mutually agreed upon mediator to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

* (m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective until January 1, 2027

* (m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance-related and addictive disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the

individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective January 1, 2027

(n) A contract between an insurer and a health care provider shall include a provision that states that the provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the insurer in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the insurer provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the insurer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Nothing in this subsection shall prohibit a health care provider from requiring in the terms of a contract with an insurer that the insurer remove, at the time of termination of such contract, the provider from the insurer's provider directory or that the insurer bear financial responsibility for providing inaccurate network status information to an insured.

(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 two thousand 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 health plan, an entity that contracts with a health plan 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 insured, 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 the insurance law 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.

(p)(1) An insurer may pay a claim for reimbursement made by a provider using a credit card, virtual credit card, or electronic funds transfer payment method that imposes on the provider a specifically identified fee or similar dedicated charge to process the payment if in advance of using such reimbursement method:

(A) The insurer notifies the provider of the potential fees or other charges associated with the use of the credit card, virtual credit card, or electronic funds transfer payment;

(B) The insurer offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(C) The provider or a designee of the provider elects to accept payment of the claim using the credit card, virtual credit card, or electronic funds transfer payment method. Such payment type election shall be made by the provider within thirty days of receipt of the notice from the insurer. If the provider fails to make any payment type election within thirty days, the insurer shall pay the provider using the alternative payment method offered in the notice unless the insurer is unable to pay the provider using that alternative method due to the insurer lacking information necessary to make the alternative payment. In that instance, the insurer may use another fee-free method of payment in order to meet the timeframes established in section three thousand two hundred twenty-four-a of this article.

(2) A decision pursuant to paragraph one of this subsection shall remain in effect until the provider notifies the insurer, in writing, of a change in the designated payment type.

(3) If an insurer contracts with a vendor to process payments of providers' claims, the insurer shall require the vendor to comply with

the provisions of paragraph one of this subsection. This paragraph shall not apply to a vendor used by the provider in order to receive payments from an insurer.

(4) No contract between an insurer and provider issued, renewed, modified, altered or amended after the effective date of this subsection shall contain provisions allowing for waiver of the notice requirements contained in this subsection.

(5) For any contract that is in effect on or before the effective date of this subsection or that is entered into, amended or renewed on or after the effective date of this subsection, an insurer that initiates a payment to a provider using, or changes the payment method to, a health care electronic funds transfers and remittance advice transaction shall not charge a fee solely to transmit the payment to the provider unless the provider elects to accept payment in accordance with subparagraph (C) of paragraph one of this subsection.

(6) For purposes of this subsection, the following terms shall have the following meanings:

(A) "Provider" shall mean a health care professional or a group of health care professionals licensed pursuant to title eight of the education law that has a participating provider contract with an insurer to provide health care services to an insured.

(B) "Virtual credit card" shall mean a single-use series of numbers linked to a fixed dollar amount and provided by an insurer to a provider for the purpose of paying a claim for health care services performed by the provider.

§ 3217-c. Primary and preventive obstetric and gynecologic care. (a) No insurer subject to this article shall by contract, written policy or procedure limit a female insured's direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy, provided that: (1) such qualified provider discusses such services and treatment plan with the insured's primary care practitioner in accordance with the requirements of the insurer; and (2)

such qualified provider agrees to adhere to the insurer's policies and procedures, including any applicable procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan (if any) approved by the insurer.

(b) An insurer shall treat the provision of obstetric and gynecologic care, and the ordering of related obstetric and gynecologic items and services, pursuant to the direct access described in subsection (a) of this section by a participating qualified provider of such services, as the authorization of the primary care provider.

(c) It shall be the duty of the administrative officer or other person in charge of each insurer subject to the provisions of this article to advise each female insured, in writing, of the provisions of this section.

§ 3217-d. Grievance procedure and access to specialty care. (a) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter.

(b) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter and requires that specialty care be provided pursuant to a referral from a primary care provider shall provide access to such specialty care consistent with the requirements of subsections (b), (c) and (d) of section four thousand eight hundred four of this chapter; provided, however, that nothing in this section shall be construed to require that an insurer, or a primary care provider on behalf of the insurer, make a referral to a provider that is not in the insurer's network.

(c) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract

as defined in subsection (c) of section four thousand eight hundred one of this chapter shall provide access to transitional care consistent with the requirements of subsections (e) and (f) of section four thousand eight hundred four of this chapter.

(d) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall provide access to out-of-network services consistent with the requirements of subsection (a) of section four thousand eight hundred four of this chapter, subsections (g-6) and (g-7) of section four thousand nine hundred of this chapter, subsections (a-1) and (a-2) of section four thousand nine hundred four of this chapter, paragraphs three and four of subsection (b) of section four thousand nine hundred ten of this chapter, and subparagraphs (C) and (D) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter.

(e) An insurer that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract, as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall establish and maintain procedures for health care professional applications and terminations consistent with the requirements of section four thousand eight hundred three of this chapter and procedures for health care facility applications consistent with section four thousand eight hundred six of this chapter.

§ 3217-e. Choice of health care provider. An insurer that is subject to this article and requires or provides for designation by an insured of a participating primary care provider shall permit the insured to designate any participating primary care provider who is available to accept such individual, and in the case of a child, shall permit the insured to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the insurer.

§ 3217-f. Prohibition on lifetime and annual limits. (a) An insurer

shall not establish a lifetime limit on the dollar amount of essential health benefits in an individual, group or blanket policy of hospital, medical, surgical or prescription drug expense insurance.

(b) An insurer shall not establish an annual limit on the dollar amount of essential health benefits in an individual, group or blanket policy of hospital, medical, surgical or prescription drug expense insurance for policy years beginning on and after January one, two thousand fourteen.

(c) For policy years beginning prior to January one, two thousand fourteen, an insurer may establish restricted annual limits on the dollar amount of essential health benefits in an individual, group, or blanket policy of hospital, medical, surgical or prescription drug expense insurance consistent with section 2711 of the Public Health Service Act, 42 U.S.C. § 300gg-11 or any regulations thereunder.

(d) The requirements of subsections (b) and (c) of this section shall not be applicable to an individual policy that is a grandfathered health plan. For purposes of this section, "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).

(e) For purposes of this section, "essential health benefits" shall have the meaning ascribed by section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b).

§ 3217-g. Maternal depression screenings. To the extent a policy provides coverage for maternal depression screening, no insurer subject to this article shall by contract, written policy or procedure limit a patient insured's direct access to screening and referral for maternal depression, as defined in subdivision one of section twenty-five hundred-k of the public health law, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the patient insured's access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the policy under which the patient insured is covered.

§ 3217-h. Telehealth delivery of services. * (a) (1) An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. An insurer may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. An insurer may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) An insurer that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor distant site occur within the clinic or other facility.

(3) An insurer that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

* NB Effective until April 1, 2028

* (a) An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise

covered under the policy. An insurer may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. An insurer may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

* NB Effective April 1, 2028

(b) For purposes of this section, "telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.

§ 3217-i. Essential health benefits package and limit on cost-sharing. (a) (1) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(A) ambulatory patient services;

(B) emergency services;

(C) hospitalization;

(D) maternity and newborn care;

(E) mental health and substance use disorder services, including behavioral health treatment;

(F) prescription drugs;

(G) rehabilitative and habilitative services and devices;

(H) laboratory services;

(I) preventive and wellness services and chronic disease management; and

(J) pediatric services, including oral and vision care.

(2) An insurer shall not be required to provide coverage for pediatric oral services as an essential health benefit if:

(A) for coverage offered through the exchange established by this state, the exchange has determined sufficient coverage of the pediatric oral benefit is available through stand-alone dental plans certified by the exchange; or

(B) for coverage offered outside the exchange, the insurer obtains reasonable written assurance that the individual or group has obtained a stand-alone dental plan that has been approved by the superintendent as meeting exchange certification standards.

(b) (1) Every individual and small group accident and health insurance policy that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan shall provide coverage that meets the actuarial requirements of one of the following levels of coverage:

(A) Bronze Level. A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan;

(B) Silver Level. A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan;

(C) Gold Level. A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan; or

(D) Platinum Level. A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(2) The superintendent may provide for a variation in the actuarial values used in determining the level of coverage of a plan to account for the differences in actuarial estimates.

(3) Every student accident and health insurance policy shall provide coverage that meets at least sixty percent of the full actuarial value of the benefits provided under the policy. The policy's schedule of benefits shall include the level as described in paragraph one of this subsection nearest to, but below the actual actuarial value.

(c) Every individual or group accident and health insurance policy that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan, and every student accident and health insurance policy shall limit the insured's cost-sharing for in-network services in a policy year to not more than the maximum out-of-pocket

amount determined by the superintendent for all policies subject to this section. Such amount shall not exceed any annual out-of-pocket limit on cost-sharing set by the United States secretary of health and human services, if available.

(d) The superintendent may require the use of model language describing the coverage requirements for any accident and health insurance policy form that is subject to the superintendent's approval pursuant to section three thousand two hundred one of this article.

(e) For purposes of this section:

(1) "actuarial value" means the percentage of the total expected payments by the insurer for benefits provided to a standard population, without regard to the population to whom the insurer actually provides benefits;

(2) "cost-sharing" means annual deductibles, coinsurance, copayments, or similar charges, for covered services;

(3) "essential health benefits package" means coverage that:

(A) provides for essential health benefits;

(B) limits cost-sharing for such coverage in accordance with subsection (c) of this section; and

(C) provides one of the levels of coverage described in subsection (b) of this section;

(4) "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);

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

(6) "student accident and health insurance" shall have the meaning set forth in subsection (a) of section three thousand two hundred forty of this article.

§ 3217-j. Utilization review determinations for medically fragile children. (a) Notwithstanding any inconsistent provision of the insurer's clinical standards, the insurer, and any utilization review agent under contract with such insurer, shall administer and apply the

clinical standards (and make determinations of medical necessity) regarding medically fragile children in accordance with the requirements of this section and any regulations with special considerations and processes for utilization review related to medically fragile children.

(b) Insurers shall undertake the following with respect to medically fragile children, and as applicable, shall ensure that their contracted utilization review agents undertake the following with respect to medically fragile children:

(1) Consider as medically necessary all covered services that assist medically fragile children in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age.

(2) Shall not base determinations solely upon review standards applicable to (or designed for) adults to medically fragile children. Determinations shall take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

(3) Accommodate unusual stabilization and prolonged discharge plans for medically fragile children, as appropriate. Insurers, and as applicable their contracted utilization review agents, shall consider when developing and approving discharge plans issues including sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults.

(4) It is the insurer's network management responsibility under a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility.

(5) This section does not limit any other rights a medically fragile child may have, including the right to appeal the denial of out of network coverage at in-network cost sharing levels where an appropriate in-network provider is not available pursuant to subsection a-two of section four thousand nine hundred four of this chapter.

(6) Insurers shall contract with providers with demonstrated expertise in caring for the medically fragile children. Network providers shall refer to appropriate network community and facility providers for covered services to meet the needs of the child or seek authorization

from the insurer for out-of-network providers when participating providers cannot meet the child's needs.

(c) In the event an insurer enters into a participation agreement with a specialty care center for medically fragile children in this state, the requirements of this section shall apply to that participation agreement and to all claims submitted to, or payments made by, any other insurers, health maintenance organizations or payors making payment to the specialty care center pursuant to the provisions of that participation agreement.

§ 3218. Medicare supplemental insurance policies. (a) In this section:

(1) "Medicare" means the coverage of health care costs provided under subchapter XVIII of the federal Social Security Act, 42 U.S.C. §§ 1395 et seq.

(2) "Medicare supplemental insurance" means any individual or group accident and health policy issued for delivery in this state on or after June tenth, nineteen hundred eighty, providing for the payment or reimbursement for health care services not provided by medicare, except that such terms shall not include a contract issued pursuant to subsections (c) and (d) of section four thousand two hundred thirty-five or section four thousand three hundred five of this chapter which covers employees of firms doing business in more than one state or the benefit structure of which was the subject of collective bargaining affecting employees of firms doing business in more than one state.

(b) The superintendent shall promulgate rules and regulations which:

(1) Establish as a separate classification, medicare supplemental insurance.

(2) Provide for minimum standards for medicare supplemental insurance policies.

(3) Require the ratio of benefits to premiums to be not less than an appropriate percentage determined by the superintendent and requiring the annual filing of data that will demonstrate the insurer's compliance.

(4) Provide a uniform system of designation for said policies which indicates the type and scope of coverage afforded.

(5) Provide for full disclosure of coverage in a clear and coherent

manner using words with common everyday language.

(6) Prohibit the advertisement, sale, or solicitation of any accident or health insurance policy as being supplemental to medicare coverage unless it conforms to minimum standards for medicare supplemental insurance policies provided by this section.

(7) Provide for the publication and dissemination of a consumer's shopping guide for medicare supplemental insurance.

(c) No authorized insurer shall issue or deliver in this state any medicare supplemental insurance policy other than a medicare supplemental insurance policy which includes the minimum standards as approved by the superintendent.

(d) (1) Every authorized insurer engaged in issuing for delivery in this state, policies for medicare supplemental insurance as set forth in this section shall file with the superintendent a report of all claims experience for such coverage for each twelve month period preceding the dates fixed by the superintendent for the filing of such reports. Such reports shall be made in writing and on a form prescribed by the superintendent not less than annually on dates determined by the superintendent.

(2) The provisions of this subsection shall remain in force until December thirty-first, nineteen hundred eighty-three.

§ 3219. Annuity and pure endowment contracts and certain group annuity certificates; standard provisions as to contractual rights and responsibilities of contract holders, certificate holders and insurers. (a) Except as provided in section four thousand two hundred forty of this chapter, every annuity or pure endowment contract except a group annuity contract, and every group annuity certificate to which section four thousand two hundred twenty-three of this chapter applies by reason of subsection (b) thereof, or to which section four thousand two hundred twenty-three of this chapter would apply if such certificate were not a variable annuity, delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to the holders of such contracts or certificates:

(1) In any such contract or certificate requiring payments to be made

to the insurer, that, after the first payment, there shall be a grace period of thirty-one days following the due date of any subsequent payment within which the payment to the insurer may be made. During such grace period, the contract or certificate shall continue in full force. If a claim arises under the contract or certificate on account of death during the grace period, the insurer may deduct from the death benefit, or, in the case of a reversionary annuity, otherwise called a survivorship annuity, may, at its option, reduce annuity payments to take into account the portion of any unpaid payment applicable to the period ending with the last day of the month in which such death occurred;

(2) That, with respect to any statements, other than those relating to age, sex, and identity, required as a condition of issuing the contract or certificate, the contract or certificate shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two years from its date of issue, except where payments required by the contract or certificate to be made to the insurer have not been made, and except for violation of the conditions, if any, of the contract or certificate relating to service in the armed forces; and at the option of the insurer, such contract or certificate may also except provisions relating to benefits for total and permanent disability and benefits for accidental death;

(3) That the contract, together with the application therefor if a copy of such application is attached to the contract when issued, shall constitute the entire contract between the parties;

(4) That nothing in the group annuity contract invalidates or impairs any right granted to the certificate holder by this section or the certificate;

(5) That if the age or sex of the person or persons upon whose life or lives the contract or certificate is made or of any of them has been misstated, the amount payable or benefit accruing under the contract or certificate shall be such as the payments to the insurer would have purchased according to the correct age or sex; and that if the insurer makes any underpayment or overpayment on account of any such misstatement, the amount thereof, with interest at a rate to be specified in the contract or certificate but not exceeding six per

centum per annum, shall be credited to, or charged against, the current or next succeeding payment or payments to be made by the insurer under the contract or certificate;

(6) That the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract;

(7) Specifying the options available upon cessation of payment of considerations under a contract or certificate. Such options, except for those under a reversionary annuity or pure endowment contract, shall be in accordance with section four thousand two hundred twenty-three of this chapter;

(8) In any such contract or certificate requiring payments to be made to the insurer that at any time within three years from the date of default in making payments to the insurer unless the cash surrender value has been paid, the contract or certificate shall be reinstated if the person entitled thereto pursuant to the provisions of the contract or certificate

(A) applies to the insurer therefor,

(B) pays to the insurer all overdue payments and all indebtedness on the contract or certificate with interest on such overdue payments at a rate specified in the contract or certificate but not to exceed six per cent per annum, compounded annually, and interest on any such indebtedness at a rate or rates not exceeding the applicable loan rate or rates determined in accordance with the contract's or certificate's provisions, and

(C) where required by the insurer as a condition of reinstatement, provides evidence of insurability including good health reasonably satisfactory to the insurer;

(9) That upon surrender of the contract or certificate, together with a written request for cancellation, to the insurer during a period of not less than ten days nor more than thirty days from the date the contract or certificate was delivered to the holder thereof, the insurer refund either (i) any consideration paid for the contract or certificate, including any fees or other charges or, if the contract or certificate, or notice attached thereto, so provides, and the contract or certificate is subject to the provisions of section four thousand two hundred twenty-three of this chapter and provides for the determination of any cash surrender benefits in accordance with a market-value

adjustment formula, (ii) the amount of the cash surrender benefits provided under the contract or certificate plus the amount of all fees and other charges deducted from gross considerations or imposed under the contract or certificate. This provision shall appear in the contract or certificate or in a notice attached to it; provided, however, that the contract or certificate sold by mail order must contain a provision permitting the contract or certificate holder a thirty day period for such surrender.

(b) Any of the provisions of subsection (a) hereof or portions not applicable to non-participating contracts or certificates or not applicable to contracts or certificates for which a single payment to the insurer is made shall, to that extent, not be incorporated in such contract or certificate. Paragraphs one and eight of subsection (a) of this section shall not apply to contracts or certificates that do not require payments to be made to the insurer. An insurer shall issue a certificate for delivery to a person covered under a group annuity contract if such certificate, when issued, would be subject to subsection (a) of this section.

(c) Annuity contracts subject to this section may permit an adjustable maximum rate of interest on loans. Any such contract shall provide that loans shall bear interest at a rate not in excess of an adjustable maximum interest rate established from time to time by the insurer as permitted by law, and shall specify the regular intervals at which the interest rate is to be determined which shall be at least once every twelve months, but not more frequently than once in any three month period.

(d) This section shall not apply to contracts for deferred annuities or reversionary annuities upon the lives of beneficiaries under life insurance policies, nor, except to the extent expressly provided herein, to group annuity contracts.

§ 3220. Group life insurance policies; standard provisions. (a) No policy of group life insurance shall 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 certificate holders or not less favorable to certificate

holders and more favorable to policyholders:

(1) That the policy is incontestable after two years from its date of issue, except for nonpayment of premiums by the policyholder; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime and in no event unless it is in a written instrument signed by him, a copy of which is or has been furnished to such person or to his beneficiary.

(2) That the rights of the policyholder or of any insured or beneficiary thereunder shall not be affected by any provision other than one contained in the policy or the riders or endorsements thereon or in the amendments thereto signed by the policyholder and the insurer, or in the copy of the policyholder's application attached to the policy or in the individual statements, if any, submitted in connection therewith.

(3) For the equitable adjustment of the premium or if the amount of insurance depends upon the age of the insured, for the equitable adjustment of the amount of insurance and the premium in the event of a misstatement of the age of the person insured.

(4) That the insurer will issue to the policyholder for delivery to the person whose life is insured under such policy a certificate containing a statement of the insurance protection to which he is entitled including any changes in such protection depending on the age of the person whose life is insured and the rights to which he is entitled in accordance with paragraphs six and seven hereof.

(5) That the benefits payable under any such policy shall be payable to the beneficiary or beneficiaries designated by the insured except, where the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, but if there is no such designated or specified beneficiary as to all or any part of the insurance payable at the death of the insured, then the amount of insurance so payable for which there is no such designated or specified beneficiary shall be payable to the estate of the insured, except that the policy may provide that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives: wife, husband, mother, father, child or children,

brothers or sisters; and except that the policy may provide that the insurer may, in any case, deduct from the aggregate sum payable under such policy on account of the death of the insured, an amount not to exceed five hundred dollars to be paid to any person or persons appearing to the insurer to be equitably entitled to same by reason of having incurred expenses on behalf of the insured or for his or her burial. Payment in accordance with any of the foregoing provisions shall completely discharge the insurer's liability with respect to the amount of insurance so paid.

(6) That if the insurance on an employee or member covered under the policy, other than one issued in accordance with paragraph three or eight of subsection (b) of section four thousand two hundred sixteen of this chapter, (A) 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, or (B) is reduced (i) in the case of a policy covering an employee or union member under a plan arranged by the insured person's employer or union, on or after the employee's or union member's attainment of age sixty in any increment or series of increments aggregating twenty percent or more of the amount of coverage in force before the first reduction on account of such age, (ii) in the case of a policy covering any member other than as described in item (i) of this subparagraph, at the time of the first reduction of insurance, (iii) due to change in class or (iv) due to an amendment of the policy to take effect immediately or at any subsequent date, such employee or such member shall be entitled to have issued to him by the insurer, without evidence of insurability, upon application made to the insurer within thirty-one days after such termination or reduction of insurance and payment of the premium applicable to the class of risk to which he belongs and to the form and amount of the policy at his then attained age, a policy of life insurance only, in any one of the forms customarily issued by such insurer, except term insurance, in an amount equal to the amount of his protection under such group insurance policy at the time of such termination or reduction, less any amount of life insurance remaining in force, except however, in the case of a reduction in accordance with item (ii) of subparagraph (B) of this paragraph, in an amount equal to eighty percent of his insurance coverage under such group policy immediately prior to such reduction. Under a group policy

issued pursuant to paragraph twelve, thirteen or fourteen of subsection (b) of section four thousand two hundred sixteen of this chapter, an insured shall be entitled to convert, just as if he had terminated membership in the class or classes eligible for coverage, within thirty-one days after notice from the insurer that, in order to continue his coverage under the group policy, he must contribute more than one hundred thirty-three percent of the net premiums computed according to the Commissioners 1960 Standard Group Mortality Table at three percent interest. The group policy may contain a provision that if the policyholder or insurer shall terminate the policy, the amount of life insurance that may be converted shall in no event exceed the amount of such employee's or member's life insurance protection less any amount of life insurance for which he may be or may become eligible under any group policy issued or reinstated by the same or another insurer within forty-five days after the date of such cessation. However, at the option of such employee or member, he shall be entitled to have issued to him in accordance with the conditions prescribed above, a policy of life insurance only, in any one of such forms, preceded by term insurance for a period of one year with the premium payable, at the option of the employee or member, in any mode customarily offered by the insurer. In addition, the group policy shall contain a provision that if the coverage of an employee or member ceases because of termination of employment due to the employee's total and permanent disability or termination of membership due to the member's total and permanent disability, the employee or member, at the option of such employee or member, shall be entitled to have issued to him, a policy of life insurance only, in any one of such forms, preceded by term insurance for a period of one year with the premium payable, at the option of the employee or member, in any mode customarily offered by the insurer, in the amount of such employee's or member's life insurance protection in effect immediately before termination, less the amount of any life insurance which is replaced with the same or another insurer within forty-five days after cessation of the group life insurance protection. Each such group policy shall contain a further provision to the effect that upon the death of any such employee or member during such thirty-one day period and before any such individual policy has become effective, the amount of insurance for which such employee or member was

entitled to make application shall be payable as a death benefit by the insurer; provided, however, each such policy may contain a provision obligating the policyholder to pay a premium to the insurer for coverage extended during such thirty-one day period in the event the extension of coverage is a direct result of the policyholder's voluntary termination of the policy and the policyholder replaces coverage under the policy within six months of its termination either with the insurer or with another insurer. The individual conversion policy may provide that any statement made by the person insured under the group policy relating to his insurability under such group policy may be used in contesting the validity of the insurance under the individual conversion policy to the same extent that such statement could have been used in contesting the validity of his insurance under the group policy if his insurance under the group policy had not ceased. An individual conversion policy shall not exclude or restrict liability in the event of suicide of the insured after two years from the date that the insured became covered under the group policy. 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 paragraph three of subsection (b) of section four thousand two hundred sixteen of this chapter.

(7) At the option of the employee or member, any converted policy or policies shall provide coverage for the dependents or class of dependents of such employee or member who were insured under the group policy. The effective date of the converted policy or policies shall be the date of termination of the employee's or member's insurance under the group policy. The conversion privilege shall be available (A) upon termination or reduction of insurance as described in paragraph six of this subsection, (B) upon the death of the employee or member to the surviving spouse with respect to such spouse and children as are then insured by the group policy, (C) to a child upon his attaining the limiting age of coverage under the group policy while insured as a dependent thereunder, and (D) upon the divorce or annulment of the marriage of the employee or member to the spouse or former spouse of such employee or member.

(8) That in the event a group life insurance policy issued for delivery in this state permits a certificate holder to convert to

another type of life insurance within a specified time after the happening of an event, such certificate holder shall be notified of such privilege and its duration within fifteen days before or after the happening of the event, provided that if such notice be given more than fifteen days, but less than ninety days after the happening of such event, 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 happening of the event, the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days. Written notice by the policyholder given to the certificate holder or mailed to the certificate holder at his last known address, or written notice by the insurer mailed 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 paragraph for the giving of notice.

(9) That all new employees of the employer or all new members of the labor union or other association or group as defined in this chapter, or all new debtors of the vendor or creditor, as the case may be, in the groups or classes eligible for such insurance must be added to such groups or classes for which they are respectively eligible.

(10) In the case of a policy covering members of a labor union, or other association or group as defined in this chapter (other than a group as defined in paragraph one or three of subsection (b) of section four thousand two hundred sixteen of this chapter, a notice in such policy to the effect that the premium for the renewable term as therein provided depends upon the attained ages of the members in the group and increases with advancing ages.

(11) If the policy is in whole or in part on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the superintendent is or are equitable to the insured persons and to the policyholder, but this paragraph does not require that such policy contain the same nonforfeiture provisions required for individual life insurance policies.

(12) In every group plan issued in accordance with paragraph three of subsection (b) of section four thousand two hundred sixteen of this chapter insuring loans made by production credit associations organized

pursuant to an Act of Congress of the United States, entitled the "Farm Credit Act of 1933", approved June sixteenth, nineteen hundred thirty-three as amended, or insuring loans made by a bank, trust company or industrial bank to a borrower engaged in the business of farming, crop production or the raising, breeding, fattening or marketing of livestock for the purpose of such business and other requirements of the borrower, a provision that, upon renewal of the loan commitment each year prior to the attainment of age fifty by the certificate-holder, coverage may be renewed by the certificate-holder without additional requirements each year in an amount equal to the loan commitment or the previous year's coverage, whichever is less, unless coverage has been previously terminated by action of the certificate-holder, and further provided that the group policy is in full force and effect on the date of renewal.

(b) None of the provisions of subsection (a) hereof relating to a certificate issued under any group life insurance policy shall be deemed applicable to any such policy which is issued to a vendor or creditor, as defined in section four thousand two hundred sixteen of this chapter and under the provisions of which no individual certificates are issued or are issuable.

(c) (1) Notwithstanding any provision of law, a person whose life is insured under any policy of group life insurance, whether or not such policy is otherwise subject to this section, is permitted to make an assignment of all or any part of his incidents of ownership in such insurance, including, without limitation, any right to designate a beneficiary or beneficiaries thereunder and any right to have an individual policy issued upon termination either of employment or of said policy of group life insurance, provided that the insurer and the group policyholder may prohibit or restrict such assignment by appropriate policy provisions except as otherwise provided in paragraph three of this subsection.

(2) Paragraph one of this subsection shall be construed as declaring the law as it existed prior to its enactment and not as modifying it.

(3) A group policy that permits assignment of an insured person's rights by gift shall also allow assignment for value to the same extent that it allows assignment by gift.

(d) The provisions of paragraphs four, five, six, seven, eight, nine

and ten of subsection (a) of this section and paragraph one of subsection (c) of this section shall not apply to policies issued under the authority of subsection (d) or subparagraph (B) of paragraph (1) of subsection (a) of section three thousand two hundred five of this article.

§ 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 one hundred twenty days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

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

character and extent of the loss for which claim is made.

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

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

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

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

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

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

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

(17) Every policy delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall provide space on any enrollment, renewal or initial online portal process setup forms required of an insured or applicant for insurance so that the insured or applicant for insurance shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment, renewal or initial online portal process setup forms and that the following is stated on the form in clear and conspicuous type:

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

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

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

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

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

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

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

a group insurance policy, delivered in this state, in lieu of the issuance of a converted individual policy of insurance. Such individual policy, or group policy, as the case may be is hereafter referred to as the converted policy. The benefits provided under the converted policy shall be those required by subsection (f) and (g) of this section, in the event of termination of the converted group policy of insurance, each insured thereunder shall have a right of conversion to a converted individual policy of insurance.

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

(3) The converted policy shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group policy. Provided, however, that if the employee or member chooses the option of dependent coverage then dependents acquired after the permitted time to convert stated in paragraph one of this subsection shall be added to the converted family policy in accordance with the provisions of subsection (c) of section thirty-two hundred sixteen of this article and any regulations promulgated or guidelines issued by the superintendent. The effective date of the individual's coverage under the converted policy shall be the date of the termination of the individual's insurance under the group policy as to those persons covered under the group policy.

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

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

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

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

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

(7) In addition to the right of conversion herein, the employee or member insured under the policy shall at his option, as an alternative to conversion, be entitled to have his coverage continued under the group policy in accordance with the conditions and limitations contained in subsection (m) of this section, and have issued at the end of the period of continuation an individual conversion policy subject to the terms of this subsection. The effective date for the conversion policy shall be the day following the termination of insurance under the group policy, or if there is a continuation of coverage, on the day following

the end of the period of continuation. Notwithstanding the foregoing, the superintendent may require conversion or continuation of insurance under conditions as set forth in a regulation for insureds under a policy issued in accordance with subparagraph (E) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter.

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

(f) If the group insurance policy insures the employee or member for hospital, medical or surgical expense insurance, or if the group insurance policy insures the employee or member for major medical or similar comprehensive-type coverage, then the conversion privilege shall entitle the employee or member to obtain coverage under a converted policy providing, at the insured's option, coverage under any one of the plans described in subsection (g) of this section on an expense incurred basis.

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

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

(1) "essential health benefits package" shall have the meaning set forth in paragraph three of subsection (e) of section three thousand two

hundred seventeen-i of this article;

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

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

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

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

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

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

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

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

(B) Such coverage may be subject to an annual deductible of not more

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

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

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

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

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

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

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

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

(2) (A) Every insurer issuing a group policy delivered or issued for delivery in this state which provides coverage for in-patient hospital care shall include coverage for preadmission tests performed in hospital

facilities prior to scheduled surgery, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state.

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

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

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

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

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

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

(i) The WHO Model Lists of Essential Medicines;

(ii) The WHO Abortion Care Guidance; or

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

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

(4) (A) Every group policy delivered or issued for delivery in this state that provides coverage for inpatient hospital care shall include coverage for services to treat an emergency condition provided in hospital facilities, except that this provision shall not apply to a policy which covers persons employed in more than one state or the

benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state unless the policy otherwise provides coverage for services to treat an emergency condition provided in hospital facilities:

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

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

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

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

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

(C) In this paragraph, an "emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(D) In this paragraph, "emergency services" means, with respect to an emergency condition: (i) a medical screening examination as required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency

department to evaluate such emergency medical condition: and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, to stabilize the patient.

(E) In this paragraph, "to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).

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

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

(iii) The mother shall have the option to be discharged earlier than the time periods established in item (i) of this subparagraph. In such case, the inpatient hospital coverage must include at least one home care visit which shall be in addition to, rather than in lieu of, any home health care coverage available under the policy. The policy must cover the home care visit, which may be requested at any time within forty-eight hours of the time of delivery (ninety-six hours in the case

of caesarean section), and shall be delivered within twenty-four hours, (I) after discharge, or (II) of the time of the mother's request, whichever is later. Such home care coverage shall be pursuant to the policy and subject to the provisions of this subparagraph, and not subject to deductibles, coinsurance or copayments.

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

* (D) Coverage provided under this paragraph for care and treatment during pregnancy shall include medically necessary transvaginal ultrasounds when recommended by nationally recognized clinical practice guidelines. For the purposes of this subparagraph, "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

* NB Effective January 1, 2027

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

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

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

(ii) provided, further however, that subject to the provisions of subparagraph (C) of this paragraph, in no case shall such coverage exclude diagnostic tests and procedures provided as part of such

hospital care that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage provided pursuant to this paragraph, including such diagnostic tests and procedures as hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound; and

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

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

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

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

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

(C) Coverage of diagnostic and treatment procedures, including

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7)(A) Every group or blanket accident and health insurance policy issued or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be

coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

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

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

(8) (A) Every group or blanket policy delivered or issued for delivery in this state which provides coverage for inpatient hospital care shall provide such coverage for such period as is determined by the attending physician in consultation with the patient to be medically appropriate

for such covered person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy. Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such policy and annually thereafter.

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

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

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

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

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

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

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

(9)(A) Every policy which provides medical, major medical, or similar comprehensive-type coverage must provide coverage for a second medical

opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer, subject to the following:

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

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

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

Nothing in this paragraph shall eliminate or diminish an insurer's

obligation to comply with the provisions of section four thousand eight hundred four of this chapter where applicable. Written notice of the availability of such coverage shall be delivered to the policyholder prior to the inception of such policy and annually thereafter.

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

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

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

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

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

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

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

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

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

in the manner determined by the attending physician and the patient to

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

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

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

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

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

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

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

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

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

* (11) Every policy that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein, contain modified protein, or are amino acid based that are medically necessary.

* NB There are 2 par (11)'s

* (11)(A) Every policy which is a "managed care product" as defined in subparagraph (D) of this paragraph that includes coverage for physician services in a physician's office, and every policy which is a "managed care product" that provides major medical or similar comprehensive-type coverage shall include coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law,

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

(C) Every policy which includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive-type coverage, other than a "managed care product" as defined in subparagraph (D) of this paragraph, shall provide coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any

such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive that those applicable under the same policy to care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments, even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. Nothing herein contained shall be construed as impeding or preventing either the provision or coverage of chiropractic care and services by duly licensed doctors of chiropractic, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

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

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

* NB There are 2 par (11)'s

(12) No policy of group or blanket accident and health insurance delivered or issued for delivery in this state shall exclude coverage of a health care service, as defined in paragraph two of such subdivision (e) of section four thousand nine hundred of this chapter, rendered or proposed to be rendered to an insured on the basis that such service is experimental or investigational, is rendered as part of a clinical trial as defined in subsection (b-2) of section forty-nine hundred of this chapter, or a prescribed pharmaceutical product referenced in

subparagraph (B) of paragraph two of subsection (e) of section forty-nine hundred of this chapter provided that coverage of the patient costs of such service has been recommended for the insured by an external appeal agent upon an appeal conducted pursuant to subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter. The determination of the external appeal agent shall be binding on the parties. For purposes of this paragraph, patient costs shall have the same meaning as such term has for purposes of subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter; provided, however, that coverage for the services required under this paragraph shall be provided subject to the terms and conditions generally applicable to other benefits provided under the policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provided, however, that reimbursement under such policy for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

(15)(A) No group or blanket managed care health insurance policy that provides coverage for hospital, medical or surgical care shall provide that services of a participating hospital will be covered as out-of-network services solely on the basis that the health care provider admitting or rendering services to the insured is not a participating provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

coverage with regard to any previously or subsequently approved prescription for eye drop medication and shall be subject to the terms and conditions of the policy otherwise applicable to this coverage. Provided, further, that a pharmacist may contact the prescribing physician or health care provider to verity the prescription.

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

(19) Every group or blanket accident and health insurance policy delivered or issued for delivery in this state that provides medical coverage that includes coverage for physician services in a physician's office and every policy that provides major medical or similar comprehensive-type coverage shall include coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. The coverage required by this paragraph shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits as defined in subsection (a) of section three thousand two hundred seventeen-i of this article.

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

are to be provided through a network of participating providers who meet certain requirements for participation, including provider credentialing.

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

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

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

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

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

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

abortion, and shall provide the insurer's contact information for questions; and

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

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

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

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

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

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

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

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

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

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

(iii) further hospitalization would otherwise be necessary.

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

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

(3) (A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, which provides coverage for in-patient hospital care must make available and if requested by the

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

(B) In this paragraph:

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

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

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

annual anniversary date subject to evidence of insurability.

(4) (A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, that provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law and mental health counselors, marriage and family therapists, and psychoanalysts licensed pursuant to article one hundred sixty-three of the education law, within the lawful scope of his or her practice. Nothing herein shall be construed to modify or expand the scope of practice of a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Further, nothing herein shall be construed to create a new mandated health benefit.

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

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

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

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

* (i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article

thirty-one of the mental hygiene law, or in a facility operated by the office of mental health or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

(ii) where the policy provides coverage for physician services, it shall include benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, or a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law, or a

licensed clinical social worker within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof. Nothing herein shall be construed to modify or expand the scope of practice of a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Further, nothing herein shall be construed to create a new mandated health benefit.

(B) Coverage required by this paragraph may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the policy.

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

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

(E) For purposes of this paragraph:

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

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

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

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

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

* (iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another

generally recognized independent standard of current medical practice such as the international classification of diseases;

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

(G) This subparagraph shall apply to hospitals and crisis residence facilities in this state that are licensed or operated by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten

of section 1.03 of the mental hygiene law and benefits for sub-acute care in a crisis residence facility licensed or operated by the office of mental health shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review for individuals who have not attained the age of eighteen during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured to ensure that the inpatient care is medically necessary for the insured. For individuals who have attained age eighteen, coverage provided under this subparagraph shall also not be subject to concurrent review during the first thirty days of the inpatient or residential admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured, to ensure that the inpatient or residential care is medically necessary for the insured. However, concurrent review may be performed during the first thirty days if an insured meets clinical criteria designated by the office of mental health or where the insured is admitted to a hospital or facility which has been designated by the office of mental health for concurrent review, in consultation with the commissioner of health and the superintendent. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(H) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental

hygiene law and participate in the insurer's provider network. Benefits for care by a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

* (I) This subparagraph shall apply to mobile crisis intervention services providers licensed, certified, or designated by the office of mental health or the office of addiction services and supports. For purposes of this subparagraph, "mobile crisis intervention services" means mental health and substance use disorder services, consisting of: (1) telephonic crisis triage and response; (2) mobile crisis response to provide intervention and facilitate access to other behavioral health services; and (3) mobile and telephonic follow-up services after the initial crisis response until the insured is stabilized provided to an insured who is experiencing, or is at imminent risk of experiencing, a behavioral health crisis, which includes instances in which an insured cannot manage their primarily psychiatric or substance use related symptoms without de-escalation or intervention. Mobile crisis intervention services do not include services provided to an insured after the insured has been stabilized.

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

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

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

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

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

(K) (i) This clause shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health,

or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this clause, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(ii) The office of mental health shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of mental health. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

(6) * (A) Every policy that provides hospital, major medical or similar comprehensive coverage shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. Further, such inpatient coverage shall not apply financial requirements or

treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

* NB Effective until January 1, 2027

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

* NB Effective January 1, 2027

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

* NB Effective until January 1, 2027

* (B) Coverage provided under this paragraph may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of addiction services and supports and, in other states, to those which are accredited by the joint commission as alcoholism, addiction, substance abuse or chemical dependence treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

* NB Effective January 1, 2027

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent

and that are consistent with those imposed on other benefits within a given policy.

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

or deductible otherwise required under the policy.

* NB Effective until January 1, 2027

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

under the policy.

* NB Effective January 1, 2027

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

* NB Effective until January 1, 2027

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

* NB Effective January 1, 2027

* (F) For purposes of this paragraph:

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

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

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

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

* NB Effective until January 1, 2027

* (F) For purposes of this paragraph:

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

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

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

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

* NB Effective January 1, 2027

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

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

predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

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

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

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

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

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism

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

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

(G) For purposes of this paragraph:

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

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

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

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

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

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

(J) (i) This clause shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction

services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this clause, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(ii) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective until January 1, 2027

* (7) (A) Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide outpatient coverage for the diagnosis and treatment of substance-related and addictive disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance-related and addictive disorder benefits that are

more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

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

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

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

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

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of addiction services and supports and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(G) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance

and out-of-pocket expenses;

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

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

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

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

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

(J) (i) This clause shall apply to facilities in this state that are

licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this clause, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(ii) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this clause shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in clause (i) of this subparagraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective January 1, 2027

(7-a) * (A) No policy that provides medical, major medical or similar comprehensive-type small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a

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

* NB Effective until January 1, 2027

* (A) No policy that provides medical, major medical or similar comprehensive-type small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance-related and addictive disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance-related and addictive disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every policy that provides medical, major medical or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance-related and addictive disorder and shall not require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance-related and

addictive disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

* NB Effective January 1, 2027

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

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

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

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

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

of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services;

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

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

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

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

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

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

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved, or that are recommended by the commissioner of health to the superintendent utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the

American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians and/or other similar nationally or internationally recognized scientific organizations;

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

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

(F) The requirements of this paragraph shall also be applicable to a blanket policy of hospital, medical or surgical expense insurance covering students pursuant to subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter.

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

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

eliminate existing coverage provided by the policy. Coverage for the services of a duly licensed registered professional nurse need be provided only if the nature of the patient's illness or condition requires nursing care which can appropriately be provided by a person with the education and professional skill of a registered professional nurse and the nursing care is necessary in the treatment of the patient's illness or condition. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

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

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

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

(D) Such coverage shall be made available at the inception of all new policies and, with respect to policies issued before the effective date

of this provision, at the first annual anniversary date thereafter, without evidence of insurability and at any subsequent annual anniversary date subject to evidence of insurability.

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

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

(i) upon the recommendation of a physician, a mammogram, which may be provided by breast tomosynthesis, at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

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

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

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

(v) upon the recommendation of a physician, screening and diagnostic imaging, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging, recommended by nationally recognized clinical practice guidelines for the detection of breast cancer. For the purposes of this item, "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

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

coinsurance. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

* NB Effective until January 1, 2027

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

* NB Effective January 1, 2027

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

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

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

(ii) with respect to women, such additional preventive care and

screenings for mammography not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

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

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

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

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

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

(11-b) (A) Every large group policy delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every large group policy which provides major medical or similar comprehensive-type coverage shall provide, upon the prescription of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, coverage for colorectal cancer preventive screenings in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals. The coverage required by this paragraph shall also include coverage for all additional colorectal cancer examinations and laboratory tests recommended in accordance with the American Cancer Society Guidelines for colorectal cancer screening

of average risk individuals, including an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test. A large group policy shall cover colorectal cancer screenings, examinations, and laboratory tests described in this paragraph upon any policy issuance or renewal that occurs six months after the date the guideline described in this paragraph is issued.

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

(11-c) (A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker precision medical testing for the purposes of diagnosis, treatment, or appropriate management of, or ongoing monitoring to guide treatment decisions for, an insured's disease or condition when one or more of the following recognizes the efficacy and appropriateness of biomarker precision medical testing for diagnosis, treatment, appropriate management, or guiding treatment decisions for an insured's disease or condition:

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

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

(iii) nationally recognized clinical practice guidelines; or

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

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

biospecimen samples.

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

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

(ii) "Biomarker precision medical testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests and multi-plex panel tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration.

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

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

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

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

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health

and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

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

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

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

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

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

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

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

inconsistent with this paragraph; or

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

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

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

(13) Consistent with federal law every insurer delivering a group policy or issuing a group policy for delivery in this state which provides coverage supplementing part A and part B of subchapter XVIII of the federal Social Security Act, 42 USC §§ 1395 et seq., shall make available and, if requested by the policyholder, provide coverage for at least ninety days of care in a nursing home as defined in section twenty-eight hundred one of the public health law, except where such coverage would duplicate coverage that is available under the aforementioned subchapter XVIII. Such coverage shall be made available at the inception of all new policies and, with respect to all other policies at each anniversary date of the policy.

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

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

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

superintendent.

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

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

(B) For purposes of subparagraphs (A) and (C) of this paragraph, cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

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

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

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

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

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

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

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

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

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

(E) As used in this paragraph:

(i) "Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement shall be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (I) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (II) serious impairment to such person's bodily

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

(ii) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (II) serious impairment to such person's bodily functions; ((III) serious dysfunction of any bodily organ or part of such person; (IV) serious disfigurement of such person; or (V) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

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

(a) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, a group or blanket policy is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this paragraph;

(b) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a group or blanket policy shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. If the attending health care provider, in his or her reasonable professional

judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final. The superintendent shall promulgate regulations establishing a process, including timeframes, for an insured, an insured's designee or an insured's health care provider to request coverage of a non-covered contraceptive drug, device, or product. Such regulations shall include a requirement that insurers use an exception form that shall meet criteria established by the superintendent;

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

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

(2) Voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and identified in the comprehensive guidelines supported by the health resources and services administration and thereby incorporated in the essential health benefits benchmark plan;

(3) Patient education and counseling on contraception; and

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

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

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

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

(E) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for federal food and drug administration approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested,

such contract shall be provided without coverage for contraceptive methods. This paragraph shall not be construed to deny an enrollee coverage of, and timely access to, contraceptive methods.

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

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

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

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

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

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

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

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

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

(H) For the purposes of this paragraph, "over-the-counter

contraceptive products" shall mean those products provided for in comprehensive guidelines supported by the health resources and services administration as of January twenty-first, two thousand nineteen.

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

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

(C) For purposes of this paragraph:

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

(ii) "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human

behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

(ix) "treatment of autism spectrum disorder" shall include the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:

(1) behavioral health treatment;

(2) psychiatric care;

(3) psychological care;

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

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

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

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

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

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

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

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

(J) For purposes of this paragraph:

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

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

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

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

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

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

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

(B) Any insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for prescription drugs shall permit each insured to fill any covered prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the

network participating non-mail order retail pharmacy agrees to the same reimbursement amount that the insurer has established for the network participating mail order or other non-retail pharmacy. In such a case, the policy shall not impose a co-payment fee or other condition on any insured who elects to purchase drugs from a network participating non-mail order retail pharmacy which is not also imposed on insureds electing to purchase drugs from a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a policy that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

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

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

* NB There are 2 par (20)'s

* (20) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of

necrotizing enterocolitis.

* NB There are 2 par (20)'s

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

* NB There are 2 par (21)'s

* (21) Every group or blanket policy delivered or issued for delivery in this state that provides coverage for a prescription drug shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied. This paragraph only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C)

a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective until January 1, 2027

* (21) Every group or blanket policy delivered or issued for delivery in this state that provides coverage for a prescription drug shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the plan deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the plan deductible has been satisfied. This paragraph only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective January 1, 2027

* NB There are 2 par (21)'s

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

* (23) (A) Every group or blanket accident and health insurance policy

issued or issued for delivery in this state which provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs shall include coverage for inhalers for the treatment of asthma if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

(B) Coverage shall be provided for one form of rescue and one form of maintenance inhaler that shall not be subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.

(C) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 par (23)'s

* (23) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for follow-up screening or diagnostic services for lung cancer upon the recommendation of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, and as recommended by nationally recognized clinical practice guidelines for the detection of lung cancer.

(B) Notwithstanding any other provision of law, any policy that provides coverage required by this paragraph shall not impose patient cost sharing for follow-up screening or diagnostic services for lung cancer.

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

(D) Nothing in this paragraph shall be construed to prevent medical management or utilization review of the services, including preauthorization, to ensure that such services are consistent with nationally recognized clinical practice guidelines for the detection of

lung cancer.

(E) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 par (23)'s

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

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

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

(B) An employee or member who wishes continuation of coverage under subparagraph (D) of paragraph four of this subsection must give notice to the employer or group policyholder within sixty days of the determination under title II or title XVI of the United States Social

Security Act that such employee or member was disabled at the time of termination of employment or membership or at any time during the first sixty days of continuation of coverage.

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

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

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

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

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

(i) the death of the employee or member;

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

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

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

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

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

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

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

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

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

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

involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this paragraph within sixty days of the date of enactment of the American Recovery and Reinvestment act of 2009.

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

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

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

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

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

continuation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

subsection, and except that the group insurance policy conversion option of this section shall not be considered as such an arrangement under which an employee, member or dependent could become covered.

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

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

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

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

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

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

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

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

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

(p)(1) Except as provided in this section, if an insurer delivers or issues for delivery in this state a group or blanket policy which

provides hospital, surgical or medical expense coverage for other than accident only, the insurer must renew or continue in force such coverage at the option of the policyholder.

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

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

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

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

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

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

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

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

(3)(A) In any case in which an insurer decides to discontinue offering a particular class of group or blanket policy of hospital, surgical or medical expense insurance offered in the small or large group market,

the policy of such class may be discontinued by the insurer in accordance with this chapter in such market only if:

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

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

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

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

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

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

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

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

(C) (i) If, within forty-five days after the insurer mails or delivers the written notice of discontinuance required by item (i) of subparagraph (A) of this paragraph, the superintendent is notified by a policyholder or covered employee or member insured that a covered

employee, member insured or dependent has a serious medical condition and that a benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition may not be covered by the replacement coverage offered to the policyholder as a result of the discontinuance, then the superintendent shall, within twenty days of the notification, ask the insurer to confirm that the covered employee, member insured or dependent utilize a benefit within the previous twelve months to treat the medical condition that the covered employee, member insured or dependent asserts is a serious medical condition, and that the benefit is not covered by the replacement coverage. The superintendent may request such additional information as the superintendent may require. The insurer shall provide all requested information to the superintendent within five days of receipt of the request.

(ii) If, within twenty days of the superintendent's receipt of all additional information requested from the insurer, the superintendent determines that (I) the covered employee, member insured or dependent has a serious medical condition; and (II) the benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition is not covered by the replacement coverage offered to the policyholder as a result of the discontinuance, then the superintendent shall require the insurer to offer to the policyholder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the policy that the insurer discontinued. If the replacement coverage is not available, at the time that the policy would otherwise be discontinued, then the insurer shall keep the existing policy in force for the affected policyholder until the replacement coverage with the substantially similar benefit is available.

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

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

(i) the insurer provides written notice to the superintendent and to

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

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

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

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

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

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

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

(7) Notwithstanding paragraph three of this subsection, an insurer may discontinue offering a particular class of group or blanket policy of hospital, surgical or medical expense insurance offered in the small or large group market, and instead offer a group or blanket policy of hospital, surgical or medical expense insurance that complies with the requirements of section 2707 of the public health service act, § 42

U.S.C. 300gg-6 that become applicable to such policy as of January first, two thousand fourteen, provided that the insurer:

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

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

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

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

(E) at least one hundred twenty days prior to the date of the discontinuance of such coverage, provides written notice to the superintendent of the discontinuance, including certification by an officer or director of the insurer that the reason for the discontinuance is to replace the coverage with new coverage that complies with the requirements of section 2707 of the public health service act, § 42 U.S.C. 300gg-6 that become effective January first, two thousand fourteen. The written notice shall be in such form and contain such information the superintendent requires.

(q)(1) No insurer delivering or issuing for delivery in this state a

group or blanket policy which provides hospital, surgical or medical expense coverage shall establish rules for eligibility (including continued eligibility) of any individual or dependent of the individual to enroll under the policy based on any of the following health status-related factors:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

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

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

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

following reasons:

(I) termination of employment;

(II) termination of the other plan or policy;

(III) death of the spouse;

(IV) legal separation, divorce, or annulment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Coverage for a child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the policy for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any child;

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

(i) the date the child no longer meets the requirements of paragraph

one of this subsection;

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

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

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

(i) in each certificate of coverage; and

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

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

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

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

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

(2) The requirements of paragraph one of this subsection shall apply

with respect to an employer that applies for coverage either directly from the insurer or through an association or trust to which the insurer has issued coverage and in which the employer participates.

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

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

* (v) With respect to high deductible health plans offered in conjunction with a health savings account, if application of any cost sharing requirements would result in health savings account ineligibility under section two hundred twenty-three of the internal revenue code, such coverage may be subject to the plan's annual deductible.

* NB Effective January 1, 2027

§ 3222. Funding agreements. (a) Any insurer authorized to deliver or issue for delivery annuity contracts in the state may deliver or issue for delivery one or more funding agreements. The issuance or delivery of such funding agreements shall not be deemed to be doing a kind of business specifically authorized by section one thousand one hundred thirteen of this chapter or engaging in any business authorized by section one thousand seven hundred fourteen of this chapter. Notwithstanding the definition of "insurance contract" in paragraph one of subsection (a) of section one thousand one hundred one of this chapter, the issuance or delivery of a funding agreement by an insurer in this state shall constitute doing an insurance business herein.

(b) Such funding agreements may be issued to persons authorized by a

state or foreign country to engage in an insurance business or subsidiaries of such persons. Such funding agreements may also be issued to entities other than persons authorized to engage in an insurance business (and subsidiaries of such persons) and to individuals for the following purposes: (i) to fund benefits under any employee benefit plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq, maintained in the United States or in a foreign country, (ii) to fund the activities of any organization exempt from taxation under section five hundred one (c) of the Internal Revenue Code or of any similar organization in any foreign country, (iii) to fund any program of the government of the United States, the government of any state, foreign country or political subdivision thereof, or any agency or instrumentality thereof, (iv) to fund any agreement providing for periodic payments in satisfaction of a claim or (v) to fund any program of an institution which has assets in excess of twenty-five million dollars.

(c) No amounts shall be guaranteed or credited under any such funding agreement except upon reasonable assumptions as to investment income and expenses and on a basis equitable to all holders of funding agreements of a given class. Such funding agreements shall not provide for payments to or by the insurer based on mortality or morbidity contingencies.

(d) Amounts paid to the insurer, and proceeds applied under optional modes of settlement, under such funding agreements may be allocated by the insurer to one or more separate accounts pursuant to section four thousand two hundred forty of this chapter.

(e) (1) The superintendent may promulgate reasonable regulations relating to (i) the standards to be followed in the approval of forms of such funding agreements, (ii) the reserves to be maintained by insurers issuing such funding agreements, (iii) the accounting and reporting of funds credited under such funding agreements, (iv) the disclosure of information to be given to holders and prospective holders of such funding agreements, and (v) the qualification and compensation of persons selling such funding agreements on behalf of insurers.

(2) Notwithstanding any other provision of law, the superintendent shall have sole authority to regulate the issuance and sale of such funding agreements, including the persons selling such funding agreements on behalf of insurers.

§ 3223. Group annuity contracts; standard provisions as to contractual rights and responsibilities of contract holders, certificate holders and annuitants, and insurers. Except as otherwise provided in section four thousand two hundred forty of this chapter, every group annuity contract delivered or issued for delivery in this state and every certificate used in connection therewith, other than a certificate to which subsection (a) of section three thousand two hundred nineteen of this article applies, shall contain in substance the following provisions to the extent that such provisions are applicable or provisions which the superintendent deems to be more favorable to annuitants, or not less favorable to annuitants and more favorable to the contract holders:

(a) in any such contract requiring payments to be made to the insurer, that, after the first payment, there shall be a grace period of thirty-one days following the due date of any subsequent payment within which the payment to be remitted to the insurer may be made. During such grace period, the contract shall continue in full force;

(b) specifying the document or documents, which shall include the contract and, if a copy is attached thereto, the application of the contract holder, constituting the entire contract between the parties;

(c) that if the age or sex of any person, or any other fact affecting the amount or date of any payment by or to the insurer, has been misstated, there will be an equitable adjustment, as provided in the contract, of the benefits payable thereunder or of the payments to be made to the insurer. Each certificate issued under the contract shall contain an appropriate reference to such provision for equitable adjustment;

(d) in any such contract providing for the maintenance by the insurer of one or more accounts for each annuitant and providing that withdrawals may be made from such accounts only with the annuitant's consent or upon termination of the annuitant's employment, that the insurer shall issue a certificate for delivery to each annuitant who contributes to the contract, specifying the nature and basis of ascertainment of benefits, which are deemed by the superintendent to be equitable to the annuitant and the contract holder, in the event of either the termination of the annuitant's employment, except by death,

or the discontinuance of payments under the contract. The contract and certificate shall provide that if the annuitant dies before the commencement date of the annuity, the insurer shall pay a death benefit at least equal to the accumulated amount in the annuitant's accounts arising from the annuitant's contributions. Nothing herein shall be construed to require that the contract or certificate contain the same provisions required for contracts or certificates subject to section four thousand two hundred twenty-three of this chapter;

(e) that the insurer shall issue for delivery to each person to whom annuity benefits are being paid thereunder a certificate setting forth a statement in substance of the benefits to which such person is entitled under such contract.

§ 3224. Standard claim forms; accident and health insurance. (a) The superintendent shall establish standard claim forms for the services of hospitals, physicians and other health care providers to be used for all accident and health insurance claims. All insurers providing such insurance shall accept said standard claim forms when submitted by a hospital, physician or other health care provider covering services rendered to an individual covered by the policy or when submitted by an insured covering these same services. Corporations operating under article forty-three of this chapter shall be required to use standard claim forms as established by the superintendent pursuant to this section.

(b) The adoption of any uniform claim forms by the superintendent pursuant hereto shall not preclude an insurer from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage.

(c) The superintendent is authorized and empowered to take such action as he deems appropriate for the proper implementation hereof and to provide by rule and regulation that any form which does not comply with the provisions of this section shall not be issued or reissued. The rules and regulations so adopted shall specify an effective date, which shall not be less than one hundred eighty days after the date of adoption or promulgation, after which no insurer may require any hospital, physician, other health care provider or insured to complete

forms differing from those prescribed by the superintendent pursuant hereto, other than additional requests for information pursuant to subsection (b) hereof.

§ 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to this article and articles forty-two, forty-three and forty-seven of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall adhere to the following standards:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer

or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing, and through the internet or other electronic means for claims submitted in that manner, within thirty calendar days of the receipt of the claim:

(1) whether the claim or bill has been denied or partially approved;

(2) which claim or medical payment that it is not obligated to pay stating the specific reasons why it is not liable; and

(3) to request all additional information needed to determine liability to pay the claim or make the health care payment; and

(4) of the specific type of plan or product the policyholder or covered person is enrolled in; provided that nothing in this section shall authorize discrimination based on the source of payment.

Upon receipt of the information requested in paragraph three of this subsection or an appeal of a claim or bill for health care services denied pursuant to this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section; provided, that if the insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law determines that payment or additional payment is due on the claim, such payment shall be made to the policyholder or covered person or health care provider within fifteen days of the determination. Any denial or partial approval of claim or payment and the specific reasons for such denial or partial approval pursuant to this subsection shall be prominently displayed on a written notice with at least twelve-point type. A partial approval of claim or payment shall state at the top of such written notice with at least fourteen-point type bold: "NOTICE OF PARTIAL APPROVAL OF MEDICAL COVERAGE". A denial of claim or payment shall state at the top of such written notice with at least fourteen-point type bold: "NOTICE OF DENIAL OF MEDICAL COVERAGE". Any additional terms or conditions included on

such notice of partial approval or such notice of denial, such as but not limited to time restraints to file an appeal, shall be included with at least twelve-point type.

(c) (1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

(2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not be subject to a civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders.

(d) For the purposes of this section:

(1) "policyholder" shall mean a person covered under such policy or a representative designated by such person;

(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen or thirty-one of the mental hygiene law, a fiscal intermediary operating under section three hundred sixty-five of the social services law, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person;

(3) "plan or product" shall mean:

(i) Medicaid coverage provided pursuant to section three hundred sixty-four-j of the social services law;

(ii) a child health insurance plan certified pursuant to section twenty-five hundred eleven of the public health law;

(iii) basic health program coverage certified pursuant to section three hundred sixty-nine-gg of the social services law, including the specific rating group the policyholder or covered person is enrolled in;

(iv) coverage purchased on the New York insurance exchange established pursuant to section two hundred sixty-eight-b of the public health law; and

(v) any other comprehensive health insurance coverage subject to article thirty-two, forty-three, or forty-seven of this chapter, or article forty-four of the public health law; and

(4) "emergency services" shall have the meaning set forth in subparagraph (D) of paragraph nine of subsection (i) of section three thousand two hundred sixteen of this article, subparagraph (D) of paragraph four of subsection (k) of section three thousand two hundred twenty-one of this article and subparagraph (D) of paragraph two of subsection (a) of section four thousand three hundred three of this chapter.

(e) Nothing in this section shall in any way be deemed to impair any right available to the state to adjust the timing of its payments for medical assistance pursuant to title eleven of article five of the social services law, or for child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law

or otherwise be deemed to require adjustment of payments by the state for such medical assistance or child health insurance.

(f) In any action brought by the superintendent pursuant to this section or article twenty-four of this chapter relating to this section regarding payments for medical assistance pursuant to title eleven of article five of the social services law, child health insurance plan benefits pursuant to title one-a of article twenty-five of the public health law, benefits under the voucher insurance program pursuant to section one thousand one hundred twenty-one of this chapter, and benefits under the New York state small business health insurance partnership program pursuant to article nine-A of the public health law, it shall be a mitigating factor that the insurer, corporation or organization is owed any premium amounts, premium adjustments, stop-loss recoveries or other payments from the state or one of its fiscal intermediaries under any such program.

(g) Time period for submission of claims. (1) Except as otherwise provided by law, health care claims must be initially submitted by health care providers within one hundred twenty days after the date of service to be valid and enforceable against an insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law. Provided, however, that nothing in this subsection shall preclude the parties from agreeing to a time period or other terms which are more favorable to the health care provider. Provided further that, in connection with contracts between organizations or corporations licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law and health care providers for the provision of services pursuant to section three hundred sixty-four-j or three hundred sixty-nine-ee of the social services law or title I-A of article twenty-five of the public health law, nothing herein shall be deemed: (i) to preclude the parties from agreeing to a different time period but in no event less than ninety days; or (ii) to supersede contract provisions in existence at the time this subsection takes effect except to the extent that such contracts impose a time period of less than ninety days.

(2) This subsection shall not abrogate any right or reduce or limit any additional time period for claim submission provided by law or

regulation specifically applicable to coordination of benefits in effect prior to the effective date of this subsection.

(h) (1) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law shall permit a participating health care provider to request reconsideration of a claim that is denied exclusively because it was untimely submitted pursuant to subsection (g) of this section. The insurer or organization or corporation shall pay such claim pursuant to the provisions of paragraph two of this subsection if the health care provider can demonstrate both that: (i) the health care provider's non-compliance was a result of an unusual occurrence; and (ii) the health care provider has a pattern or practice of timely submitting claims in compliance with subdivision (g) of this section.

(2) An insurer or organization or corporation licensed or certified pursuant to article forty-three or article forty-seven of this chapter or article forty-four of the public health law may reduce the reimbursement due to a health care provider for an untimely claim that otherwise meets the requirements of paragraph one of this subsection by an amount not to exceed twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing in this subsection shall preclude a health care provider and an insurer or organization or corporation from agreeing to a lesser reduction. The provisions of this subsection shall not apply to any claim submitted three hundred sixty-five days after the date of service, in which case the insurer or organization or corporation may deny the claim in full.

(i) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a general hospital certified pursuant to article twenty-eight of the public health law shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty days of receipt of payment. Upon receipt of such medical records, an insurer or an

organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall review such information to ascertain the correct coding for payment based on national coding guidelines accepted by the centers for Medicare and Medicaid services or the American medical association, to the extent there are codes for such services, including ICD-10 guidelines to the extent available, and process the claim, including the correct coding, in accordance with the timeframes set forth in subsection (a) of this section. In the event the insurer, organization, or corporation processes the claim consistent with its initial determination, such decision shall be accompanied by a statement of the insurer, organization or corporation setting forth the specific reasons why the initial adjustment was appropriate. An insurer, organization, or corporation that increases the payment based on the information submitted by the general hospital, shall pay to the general hospital interest on the amount of such increase at the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law, to be computed from the date thirty days after initial receipt of the claim if transmitted electronically or forty-five days after initial receipt of the claim if transmitted by paper or facsimile. Provided, however, a failure to remit timely payment shall not constitute a violation of this section. Neither the initial or subsequent processing of the claim by the insurer, organization, or corporation shall be deemed an adverse determination as defined in section four thousand nine hundred of this chapter if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse or when an insurer, organization, or corporation engages in reasonable fraud, waste and abuse detection efforts; provided, however, to the extent any subsequent payment adjustments are made as a result of the fraud, waste and abuse detection processes or efforts, such payment adjustments shall be consistent on the coding guidelines required by this subsection.

(j) An insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law or a student health plan

established or maintained pursuant to section one thousand one hundred twenty-four of this chapter shall accept claims submitted by a policyholder or covered person, in writing, including through the internet, by electronic mail or by facsimile.

(k) The superintendent, in conjunction with the commissioner of health, shall convene a health care administrative simplification workgroup. The workgroup shall consist of stakeholders, including but not limited to, insurers, hospitals, physicians and consumers or their representatives, to study and evaluate mechanisms to reduce health care administrative costs and complexities through standardization, simplification and technology. Areas to be examined by the workgroup shall include claims submission and payment, claims attachments, preauthorization practices, provider credentialing, insurance eligibility verification, and access to electronic medical records. The workgroup shall report on its findings and recommendations to the superintendent, the commissioner of health, the speaker of the assembly and the temporary president of the senate within eighteen months of the effective date of this subsection.

(l) Payments to nonparticipating or nonpreferred providers of ambulance services licensed under article thirty of the public health law. (1) Whenever an insurer or an organization, or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law provides that any health care claims submitted under contracts or agreements issued or entered into pursuant to this article or article forty-two, forty-three or forty-seven of this chapter and article forty-four of the public health law are payable to a participating or preferred provider of ambulance services for services rendered, the insurer, organization, or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider at the usual and customary charge, which shall not be excessive or unreasonable, when the provider has rendered such services, has on file a duly executed assignment of benefits, and has caused notice of such assignment to be given to the insurer, organization, or corporation licensed or certified pursuant to article forty-three or forty-seven of

this chapter or article forty-four of the public health law or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the insurer, organization, or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall be required to send such benefit payments directly to the provider who has the assignment on file. When payment is made directly to a provider of ambulance services as authorized by this section, the insurer, organization, or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall give written notice of such payment to the insured, subscriber, or other covered person.

(2) 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.

(3) Nothing contained in this section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by participating or preferred providers and nonparticipating or nonpreferred providers.

The provisions of this section shall not apply to policies that do not include coverage for ambulance services.

§ 3224-b. Rules relating to the processing of health claims and overpayments to physicians. (a) Processing of health care claims. This subsection is intended to provide uniformity and consistency in the reporting of medical services and procedures as they relate to the processing of health care claims and is not intended to dictate reimbursement policy.

(1) For purposes of this section, a "health plan" shall be defined as an insurer that is licensed to write accident and health insurance, or that is licensed pursuant to article forty-three of this chapter or is

certified pursuant to article forty-four of the public health law.

(2) Subject to the provisions of paragraph three of this subsection, a health plan shall accept and initiate the processing of all health care claims submitted by a physician pursuant to and consistent with the current version of the American medical association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the centers for medicare and medicaid services healthcare common procedure coding system (HCPCS).

(3) Nothing in this section shall preclude a health plan from determining that any such claim is not eligible for payment, in full or in part, based on a determination that: (i) the claim is not complete as defined by 11 NYCRR 217; (ii) the service provided is not a covered benefit under the contract or agreement, including but not limited to, a determination that such service is not medically necessary or is experimental or investigational; (iii) the insured did not obtain a referral, pre-certification or satisfy any other condition precedent to receive covered benefits from the physician; (iv) the covered benefit exceeds the benefit limits of the contract or agreement; (v) the person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her contract; (vi) another insurer, corporation or organization is liable for all or part of the claim; or (vii) the plan has a reasonable suspicion of fraud or abuse. In addition, nothing in this section shall be deemed to require a health plan to pay or reimburse a claim, in full or in part, or dictate the amount of a claim to be paid by a health plan to a physician.

(4) Every health plan shall publish on its provider website and in its provider newsletter the name of the commercially available claims editing software product that the health plan utilizes and any significant edits, as determined by the health plan, added to the claims software product after the effective date of this section, which are made at the request of the health plan. The health plan shall also provide such information upon the written request of a physician who is a participating physician in the health plan's provider network.

(b) Overpayments to health care providers. (1) Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to health care providers before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of

claims to such health care providers. Such notice shall state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

(2) A health plan shall provide a health care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for health care providers to follow to challenge an overpayment recovery. Such challenge shall set forth the specific grounds on which the provider is challenging the overpayment recovery.

(3) A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members. Notwithstanding the aforementioned time limitations, in the event that a health care provider asserts that a health plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For purposes of this paragraph, "abusive billing" shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.

(4) For the purposes of this subsection the term "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen, thirty-one or thirty-two of the mental hygiene law, or a health care professional licensed, registered or certified pursuant to title eight of the education law.

(5) Nothing in this section shall be deemed to limit a health plan's right to pursue recovery of overpayments that occurred prior to the effective date of this section where the health plan has provided the health care provider with notice of such recovery efforts prior to the

effective date of this section.

§ 3224-c. Coordination of benefits. An insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not deny a claim, either in whole or in part, on the basis that it is coordinating benefits and another insurer or organization or corporation or other entity is liable for the payment of the claim, unless it has a reasonable basis to believe that the insured has other health insurance coverage which is primary for that benefit. If an insurer or organization or corporation does not have current information from the insured regarding other coverage, and requests such information in accordance with subsection (b) of section three thousand two hundred twenty-four-a of this article, and no information is received within forty-five days, the claim shall be adjudicated provided, however, the claim shall not be denied based on the insurer, or organization or corporation not having received such information.

§ 3224-d. Prescription synchronization. (a) Every individual or group health insurance policy providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily pro-rated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

(i) The medications are covered by the policy or plan.

(ii) The medications are used for treatment and management of chronic conditions that are subject to refills.

(iii) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(iv) The medications meet all prior authorization criteria specific to medications at the time of the synchronization request.

(v) The medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(vi) The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) No individual or group health insurance policy providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every individual or group health insurance policy must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this paragraph shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(i) The prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(ii) The prescriber prescribes a different drug.

§ 3225. Eligibility for health insurance in cases of exposure to DES. No policy of accident or health insurance, or group or blanket accident or health insurance or renewals thereof shall be denied or cancelled by the insurer, solely because the insured person has been exposed to diethylstilbestrol, commonly referred to as DES.

§ 3226. Reinsurance contracts excepted. The provisions of this article shall not apply to contracts of reinsurance, except as otherwise provided by law.

§ 3227. Interest upon surrenders, policy loans and other funds. (a) Interest, at the rate provided for in section three thousand two hundred fourteen of this article, shall be payable by life insurers, fraternal benefit societies, and life insurance departments of savings banks upon: (1) the value of policies surrendered by policyholders for cash values, including the rollover of annuity funds to other entities, and (2) the funds disbursed as policy loans. Such interest payment shall be added to and be a part of the total sum paid or be paid separately at the option of the insurer.

(b) The interest calculated on amounts described in paragraphs one and two of subsection (a) hereof shall be calculated from the date the documentation necessary to complete the transaction is received by the insurer and shall be payable if the funds are not mailed or delivered by the insurer within ten working days of said receipt.

(c) No interest need be payable pursuant to this section unless the amount of such interest is at least twenty-five dollars or if the payment of benefits by the insurer has been deferred pursuant to other provisions of this chapter.

(d) Irrespective of the payment of interest in accordance with the above provisions, such life insurers, fraternal benefit societies and life insurance departments of savings banks shall make disbursements under paragraphs one and two of subsection (a) hereof as expeditiously as possible.

§ 3228. Individual accident and health insurance policies; premium refund at death of insured. If the death of the insured or a covered dependent occurs during a period for which the premium under an individual accident and health insurance policy has been paid, the insurer shall refund the premium or the portion of the premium actually paid by the insured for that person for any period beyond the end of the policy month in which such death occurred.

§ 3229. Minimum benefit standards for certain long term care plans. (a) The minimum standards for an insurance plan, which may qualify under

the partnership for long term care program pursuant to section three hundred sixty-seven-f of the social services law, shall be established by regulations of the superintendent, in consultation with the commissioner of health and the director of the state office for the aging, as approved by the director of the budget, which shall require at a minimum (1) a residential health care facility benefit in an amount to be determined by the regulations of the superintendent; (2) a home care benefit with personal care, nursing care, adult day health care and respite care services, which shall provide total benefits in an amount determined by regulations of the superintendent; (3) a duration of benefits not less than twelve months; and (4) arrangements through the insurance plan for managed care including preauthorized assessment and referral programs, utilization controls and use of approved providers.

(b) In establishing minimum benefit standards for insurance plans pursuant to this section, the superintendent shall seek to ensure the cost effectiveness of the partnership for long term care program established pursuant to section three hundred sixty-seven-f of the social services law, and may establish minimum permissible payments under such insurance plans. The superintendent shall not approve an insurance plan which includes an exclusion for pre-existing conditions that exceeds six months, or which does not comply with paragraph six of subsection (b) of section one thousand one hundred seventeen of this chapter.

§ 3230. Accelerated payment of the death benefit or special surrender value under a life insurance policy. (a) The application for a life insurance policy or policy rider which provides for accelerated payment of death benefits or a special surrender value shall:

(1) contain a notice, prominently displayed, to read as follows: "Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable."; and

(2) include the amount of any additional premium associated with the accelerated payment or, if there is no separately identifiable premium, whether a discount is associated with acceleration.

(b) The application to accelerate benefits shall:

(1) be dated by the insurer upon transmittal and shall be completed

and signed by the policy owner not more than thirty days thereafter; and

(2) contain a notice, prominently displayed, to read as follows: "Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (medicaid), family assistance and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents."

(3) contain a notice, prominently displayed, to read as follows: "Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policy owners should seek assistance from a qualified tax adviser."; and

(4) contain a statement by the policy owner that such application is voluntary and without coercion on the part of any third party; and

(5) contain a statement of the remaining death benefit available to the beneficiary.

(c) Insurers are prohibited from paying accelerated death benefits or special surrender values to the policy owner or certificate holder for a period of five days from the date on which the information specified in subdivision (d) of this section is transmitted in writing to the policy owner or certificate holder. The policy owner or certificate holder shall have the right to rescind the request for such payments at any time during the process of application for said benefits.

(d) Within five day of receipt of an application to accelerate benefits an insurer must provide the policy owner with the following:

(1) an illustration demonstrating the effect of the accelerated benefit on the policy's cash value and policy loans;

(2) a numerical computation of the amount of the death benefit which would be payable upon death;

(3) a numerical computation of the amount of the death benefit that would be payable upon acceleration; and

(4) a notice that other means may be available to achieve the intended goal, including a policy loan.

(e) A group life insurance policy which provides for accelerated payment of death benefits or a special surrender value must provide that only the certificateholder has the right to accelerate the benefits.

(f) This section shall apply to all life insurance policies or policy riders or provisions thereof that provide for accelerated payment of death benefits or a special surrender value pursuant to subparagraph (A), (B), (C), (D), (E) or (F) of paragraph one of subsection (a) of section one thousand one hundred thirteen of this chapter.

*** § 3231. Rating of individual and small group health insurance policies; approval of superintendent.** (a) (1) No individual health insurance policy and no group health insurance policy covering between one and fifty employees or members of the group or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual health insurance coverage, including medicare supplemental coverage, or small group health insurance coverage, including medicare supplemental insurance, but not including coverage issued on or after January first, two thousand fourteen, specified in subsection (l) of section three thousand two hundred sixteen, of this article must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (g) of section three thousand two hundred sixteen or subsection (p) of section three thousand two hundred twenty-one of this article. Group hospital

and/or medical coverage, including medicare supplemental insurance, obtained through an out-of-state trust covering a group of fifty or fewer employees, or between one and one hundred employees for policies issued or renewed on or after January first, two thousand sixteen, or participating persons who are residents of this state must be community rated regardless of the situs of delivery of the policy. Notwithstanding any other provisions of law, the underwriting of such policy may involve no more than the imposition of a pre-existing condition limitation if permitted by this article, and once accepted for coverage, an individual or small group cannot be terminated due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (p) of section three thousand two hundred twenty-one of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy form is the same based on the experience of the entire pool of risks of all individuals or small groups covered by the insurer without regard to age, sex, health status, tobacco usage or occupation, excluding those individuals or small groups covered by medicare supplemental insurance. For medicare supplemental insurance coverage, "community rated" means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, tobacco usage or occupation.

(b) (1) The superintendent may set standard premium tiers and standard rating relativities between tiers applicable to all policies subject to this section. The superintendent may set a standard relativity applicable to child-only policies issued pursuant to section 1302(f) of the affordable care act, 42 U.S.C. § 18022(f). The relativity for child-only policies shall be actuarially justifiable using the aggregate experience of insurers to prevent the charging of unjustified premiums. The superintendent may adjust such premium tiers and relativities periodically based upon the aggregate experience of insurers. (2) An insurer shall establish separate community rates for individuals as opposed to small groups. (3) If an insurer is required to issue a policy to individual proprietors pursuant to subsection (i) of this section, such policy shall be subject to subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the insurer in its rate filing so long as the insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the insurer's community rates. (2) Beginning on January first, two thousand fourteen, for every policy subject to this section that provides physician services, medical, major medical or similar comprehensive-type coverage, except for medicare supplement plans, insurers shall use standardized regions established by the superintendent.

(d) (1) Notwithstanding any other provision of this chapter to the contrary, no policy form subject to this section shall be issued or delivered, nor any insurance contract entered into, unless and until the insurer has filed with the superintendent a schedule of premiums, not to exceed twelve months in duration, to be paid under the policy forms and obtained the superintendent's approval thereof. The superintendent may refuse such approval if he or she finds that such premiums are excessive, inadequate, or unfairly discriminatory. The superintendent may consider the financial condition of such insurer in approving or disapproving any premium. In determining whether to approve the schedule of premiums filed, the superintendent shall, subject to the provisions of section three thousand two hundred thirty-three of this article, consider the prior experience of the insurer's community pool and the insurer's projections relating to claim costs, utilization and administrative expenses and shall not adjust the insurer's rates based upon the rates approved for other insurers.

(2) An insurer shall provide specific claims experience to a municipal corporation, as defined in subsection (f) of section four thousand seven hundred two of this chapter, covered by the insurer under a community rated policy when the municipal corporation requests its claims experience for purposes of forming or joining a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter. Notwithstanding the forgoing provisions, no insurer shall be

required to provide more than three years' claims experience to a municipal corporation making this request.

(e) (1) (A) An insurer desiring to increase or decrease premiums for any policy form subject to this section shall submit a rate filing or application to the superintendent.

An insurer shall send written notice of the proposed rate adjustment, including the specific change requested, to each policy holder and certificate holder affected by the adjustment on or before the date the rate filing or application is submitted to the superintendent. The notice shall prominently include mailing and website addresses for both the department of financial services and the insurer through which a person may, within thirty days from the date the rate filing or application is submitted to the superintendent, contact the department of financial services or insurer to receive additional information or to submit written comments to the department of financial services on the rate filing or application. The superintendent shall establish a process to post on the department's website, in a timely manner, all relevant written comments received pertaining to rate filings or applications. The insurer shall provide a copy of the notice to the superintendent with the rate filing or application. The superintendent shall immediately cause the notice to be posted on the department of financial services' website. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. The superintendent may modify or disapprove the rate filing or application if the superintendent finds that the premiums are unreasonable, excessive, inadequate, or unfairly discriminatory, and may consider the financial condition of the insurer when approving, modifying or disapproving any premium adjustment. The determination of the superintendent shall be supported by sound actuarial assumptions and methods, and shall be rendered in writing between thirty and sixty days from the date the rate filing or application is submitted to the superintendent. Should the superintendent require additional information from the insurer in order to make a determination, the superintendent shall require the insurer to furnish such information, and in such event, the sixty days shall be tolled and shall resume as of the date the insurer furnishes the

information to the superintendent. If the superintendent requests additional information less than ten days from the expiration of the sixty days (exclusive of tolling), the superintendent may extend the sixty day period an additional twenty days to make a determination. The application or rate filing will be deemed approved if a determination is not rendered within the time allotted under this section. An insurer shall not implement a rate adjustment unless the insurer provides at least sixty days advance written notice of the premium rate adjustment approved by the superintendent to each policy holder and certificate holder affected by the rate adjustment.

(B) The expected minimum loss ratio for a policy form subject to this section, for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance policy, or, with the approval of the superintendent, an aggregation of policy forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than July thirty-first of each year, every insurer subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the insurer to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

(2) (A) Until September thirtieth, two thousand ten, as an alternate procedure to the requirements of paragraph one of this subsection, an insurer desiring to increase or decrease premiums for any policy form subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that: (i) the anticipated minimum loss ratio for a policy form shall not be less than eighty-two percent of the premium; and (ii) the insurer submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual

acceptable to the superintendent that the insurer is in compliance with the provisions of this paragraph, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the insurer in establishing premium rates for policy forms subject to this section. An insurer shall not utilize the alternate procedure pursuant to this paragraph to implement a change in rates to be effective on or after October first, two thousand ten.

(B) Each calendar year, an insurer shall return, in the form of aggregate benefits for each policy form filed pursuant to the alternate procedure set forth in this paragraph at least eighty-two percent of the aggregate premiums collected for the policy form during that calendar year. Insurers shall annually report, no later than June thirtieth of each year, the loss ratio calculated pursuant to this paragraph for each such policy form for the previous calendar year. In each case where the loss ratio for a policy form fails to comply with the eighty-two percent loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal eighty-two percent of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy holder who had a policy which was in effect at any time during the applicable year. The dividend or credit shall be prorated based on the direct premiums earned for the applicable year among all policy holders eligible to receive such dividend or credit. An insurer shall make a reasonable effort to identify the current address of, and issue dividends or credits to, former policy holders entitled to the dividend or credit. An insurer shall, with respect to dividends or credits to which former policy holders that the insurer is unable to identify after a reasonable effort would otherwise be entitled, have the option, as deemed acceptable by the superintendent, of prospectively adjusting premium rates by the amount of such dividends or credits, issuing the amount of such dividends or credits to existing policy holders, depositing the amount of such dividends or credits in the fund established pursuant to section four thousand three hundred twenty-two-a of this chapter, or utilizing any

other method which offsets the amount of such dividends or credits. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include an insurer's calculation of the dividends and credits, as well as an explanation of the insurer's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policy holder.

(3) All policy forms subject to this subsection, other than medicare supplemental insurance policy forms, issued or in effect during calendar year two thousand ten shall be subject to a minimum loss ratio requirement of eighty-two percent. Insurers may use the alternate filing procedure set forth in paragraph two of this subsection to adjust premium rates in order to meet the required minimum loss ratio for calendar year two thousand ten. The rate filing or application shall be submitted no later than September thirtieth, two thousand ten.

(f) (1) In the case of disapproval or modification of a requested rate change by more than twenty percent for any policy to which prior approval applies, the insurer shall have the right to request a hearing before the superintendent, or his or her representative, in order for the insurer to present any evidence, arguments or other information as to why the insurer believes the superintendent's disapproval or modification is not appropriate. Such hearing shall not be a required condition prior to any challenge to the disapproval or modification pursuant to the civil practice law and rules, but if an insurer challenges the superintendent's disapproval or modification pursuant to the civil practice law and rules, the insurer shall not be entitled to such hearing. An insurer entitled to such hearing must make a written request for such hearing no later than thirty days after the date of the superintendent's decision. The hearing shall be held as soon as practicable thereafter, but not sooner than twenty days from receipt of the request for the hearing. A stenographic record of all hearings shall be made. The superintendent shall provide the insurer with a written response to the insurer's presentation at the hearing no later than

forty-five days after the date of the hearing. The superintendent's written response pursuant to this subsection shall be subject to challenge as provided for in article seventy-eight of the civil practice law and rules.

(2) Such hearing shall not be required in any case where the superintendent returns the initial filing within thirty days on the basis that the premium increase or decrease requested by the insurer is unreasonable.

(g) * (1) (A) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups having one hundred or fewer employees or members exclusive of spouses and dependents. For a policy issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection. (B) Subparagraph A of this paragraph shall not apply to either the renewal of a policy issued to a group or the issuance, between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of a policy, and any renewal thereof, to a group, provided that the following three requirements are met: (I) the group had been issued a policy that was in effect on July first, two thousand fifteen; (II) the group had member employers, who, on or after July first, two thousand fifteen, have between fifty-one and one hundred employees, exclusive of spouses and dependents; and (III) the group is either: (i) comprised entirely of one or more municipal corporations or districts (as such terms are defined in section one hundred nineteen-n of the general municipal law); or (ii) comprised entirely of nonpublic schools providing education in any grade from pre-kindergarten through twelfth grade.

* NB Effective until December 28, 2028

* (1) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five, including but not limited to an association or trust of

employers, if the group includes one or more member employers or other member groups which have one hundred or fewer employees or members exclusive of spouses and dependents. For policies issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection.

* NB Effective December 28, 2028

(2) If a policy is issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including an association group, that includes one or more individual or individual proprietor members, for rating purposes the insurer shall include such members in its individual pool of risks in establishing premium rates for such members.

(h) * (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. Provided, however, the provisions of this paragraph shall not apply to: (A) the renewal of stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen to small groups covering between fifty-one and one hundred employees or members of the group; and (B) the issuance between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of stop loss, catastrophic or reinsurance coverage, and any renewal thereof, to a small group covering between fifty-one and one hundred employees or members of the group, provided that such group had stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen.

* NB Effective until December 28, 2028

* (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company

system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section.

* NB Effective December 28, 2028

(2) This subsection shall not apply to coverage insuring a plan which was in effect on or before December thirty-first, nineteen hundred ninety-one and was issued to a group which includes member small employers or other member small groups, including but not limited to association groups, provided that (A) acceptance of additional small member employers (or other member groups comprised of fifty or fewer employees or members, exclusive of spouses and dependents) into the group on or after June first, nineteen hundred ninety-two and before April first, nineteen hundred ninety-four does not exceed an amount equal to ten percent per year of the total number of persons covered under the group as of June first, nineteen hundred ninety-two, but nothing in this subparagraph shall limit the addition of larger member employers; (B) (i) after April first, nineteen hundred ninety-four, the group thereafter accepts member small employers and member small groups without underwriting by any more than the imposition of a pre-existing condition limitation as permitted by this article and the cost for participation in the group for all persons covered shall be the same based on the experience of the entire pool of risks covered under the entire group, without regard to age, sex, health status or occupation; and (ii) once accepted for coverage, an individual or small group cannot be terminated due to claims experience; (C) the insurer has registered the names of such groups, including the total number of persons covered as of June first, nineteen hundred ninety-two, with the superintendent, in a form prescribed by the superintendent, on or before April first, nineteen hundred ninety-three and shall report annually thereafter until such groups comply with the provisions of subparagraph (B) of this paragraph; and (D) the types or categories of employers or groups eligible to join the association are not altered or expanded after June first, nineteen hundred ninety-two.

(3) An insurer may apply to the superintendent for an extension or

extensions of time beyond April first, nineteen hundred ninety-four in which to implement the provisions of this subsection as they relate to groups registered with the superintendent pursuant to subparagraph (C) of paragraph two of this subsection; any such extension or extensions may not exceed two years in aggregate duration, and the ten percent per year limitation of subparagraph (A) of paragraph two of this subsection shall be reduced to five percent per year during the period of any such extension or extensions. Any application for an extension shall demonstrate that a significant financial hardship to such group would result from such implementation.

(i)(1) If an insurer issues coverage to an association group (including chambers of commerce), as defined in subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, the insurer must issue the same coverage to individual proprietors which purchase coverage through the association group as the insurer issues to groups which purchase coverage through the association group; provided, however, that an insurer which, on the effective date of this subsection, is issuing coverage to individual proprietors not connected with an association group, may continue to issue such coverage provided that the coverage is otherwise in accordance with this subsection and all other applicable provisions of law.

(2) For coverage purchased pursuant to this subsection, through December thirty-first, two thousand thirteen, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand thirteen, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. Coverage purchased or renewed pursuant to this subsection on or after January first, two thousand fourteen shall be classified in the individual rating category.

(3) An insurer may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and

obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance policy, and (C) present a copy of the following documentation to the insurer or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an incorporated business, the prior year's federal income tax Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for the purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations.

* NB There are 2 § 3231's

*** § 3231. Health insurance policies and subscriber contracts; prohibited claims.** (a) For the purposes of this section the terms health care provider, practitioner, clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services shall have the same meanings as are set forth in section two hundred thirty-eight of the public health law.

(b) No health care provider or practitioner may demand or request any payment for clinical laboratory services, pharmacy services, radiation

therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by subdivision one of section two hundred thirty-eight-a of the public health law.

(c) No insurer shall be required to pay any claim, bill or other demand or request for payment by a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by subdivision one of section two hundred thirty-eight-a of the public health law.

(d) Every policy of accident or health insurance issued by a commercial insurer and every subscriber contract issued by a hospital service corporation, health service corporation or medical expense indemnity corporation which provides coverage for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services shall include a provision excluding payment of any claim, bill or other demand or request for payment for such services furnished pursuant to a referral prohibited by subdivision one of section two hundred thirty-eight-a of the public health law.

(e) Every insurer subject to the provisions of this section shall report to the commissioner of health any pattern of submission of claims, bills or other demands or requests for payment submitted in violation of subsection (b) of this section, within thirty days after such insurer has knowledge of such pattern.

(f) Notwithstanding the requirements of subsections (c), (d) and (e) of this section, an insurer reimbursing for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services is not required to audit or investigate any claim, bill or other demand or request for payment for such items or services furnished pursuant to a referral.

* NB There are 2 § 3231's

§ 3232. Pre-existing condition provisions in health policies. Every individual health insurance policy and every group or blanket accident and health insurance policy issued or issued for delivery in this state which includes a pre-existing condition provision shall contain in

substance the following provision or provisions which in the opinion of the superintendent are more favorable to the individuals, members of the group and their eligible dependents:

(a) In determining whether a pre-existing condition provision applies to a covered person, the group or blanket accident and health insurance policy or individual health insurance policy shall credit the time the covered person was previously covered under creditable coverage, if the previous creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of the new coverage. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective shall also be credited pursuant to this subsection.

(b) No pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the enrollment date of coverage for the covered person and may only relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. For purposes of this section "enrollment date" means the first day of coverage of the individual under the policy or, if earlier, the first day of the waiting period that must pass with respect to an individual before such individual is eligible to be covered for benefits. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period. For purposes of this section genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information. No pre-existing condition limitation provision shall exclude coverage in the case of:

(1) an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage as defined in subsection (c) of this section;

(2) a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage as defined in subsection (c) of this section;

(3) pregnancy (except in an individual health insurance policy or a student blanket accident and health insurance policy in which an insurer may exclude coverage, subject to a credit for previous creditable coverage, for a period not to exceed ten months for a pregnancy existing on the enrollment date); or

(4) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage.

Paragraphs one and two of this subsection shall no longer apply to an individual after the end of the first sixty-three day period during all of which the individual was not covered under any creditable coverage.

(c) For purposes of this section "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or B of title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of title 10, United States Code;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under chapter 89 of title 5, United States Code;

(9) A public health plan (as defined in regulations);

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(d)(1) For purposes of applying the credit of such creditable coverage an insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(2) Alternatively, an insurer may elect to count the period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits as specified in regulations. Such election shall be made on a uniform basis for all insureds, participants

and beneficiaries. Pursuant to such election an insurer shall count the period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category. An insurer making such election shall prominently state in any disclosure statement, and shall set forth in any policy or certificate issued in connection with the coverage, that the insurer has made such election. Such disclosure statement shall include a description of the effect of the election with regard to the application of creditable coverage.

(3) Notwithstanding the foregoing paragraph, for purposes of determining the extent to which a pre-existing condition limitation has been satisfied in a policy issued pursuant to subsection (l) of section three thousand two hundred sixteen of this article within thirty days of discontinuance of a class of health maintenance organization direct payment contract for enrollees whose contract was discontinued, an insurer shall credit the time that the enrollee was covered under a health maintenance organization direct payment contract issued prior to January first, nineteen hundred ninety-six, without regard to the specific benefits covered under the health maintenance organization contract.

(4) With respect to an "eligible individual", as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. § 300 gg-41(b), an insurer may not impose any pre-existing condition exclusion in an individual health insurance policy. For all other covered persons, the pre-existing condition crediting requirement of subsection (a) of this section shall be applicable.

(e) For the purposes of this section the term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(f) An insurer shall not impose any pre-existing condition exclusion in an individual or group policy of hospital, medical, surgical or prescription drug expense insurance.

§ 3232-a. Certification of creditable coverage. (a) Every insurer who delivers or issues for delivery individual health insurance policies or group or blanket accident and health insurance policies shall provide to covered individuals written certification, in a form as the superintendent may approve, of:

(1) the period of creditable coverage, as defined in section three thousand two hundred thirty-two of this article, of the individual under such policy and any continuation coverage of the individual pursuant to state or federal law; and

(2) any waiting period or affiliation period (if applicable) imposed with respect to the individual for any coverage under the policy.

(b) The insurer shall provide such written certification:

(1) at the time an individual ceases to be covered under the policy, including any period of time such individual was covered pursuant to any right of continuation under such policy; and

(2) on the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in paragraph one of this subsection.

(c) In the event of an election by an insurer or a group health plan to count the period of creditable coverage based on coverage of benefits within classes or categories of benefits as provided in state or federal law, if that insurer or group health plan enrolls an individual for coverage under its policy or plan and such individual provides written certification of coverage of the individual pursuant to subsection (a) of this section, then upon request of such insurer or group health plan, the insurer that issued the certification of coverage so provided by the individual shall promptly disclose to such requesting insurer or group health plan information on coverage of classes and categories of health benefits available under its policy. An insurer disclosing such information may charge the requesting plan or insurer for the reasonable cost of such disclosure.

(d) An insurer who delivers or issues for delivery group or blanket accident and health insurance policies is deemed to have satisfied the requirements of subsection (a) of this section if the policyholder by written agreement with the insurer actually provides the written certification in accordance with this section.

§ 3233. Stabilization of health insurance markets and premium rates. (a) Notwithstanding any provision of this chapter or any other chapter, on or before October first, nineteen hundred ninety-two the superintendent shall promulgate regulations to assure an orderly implementation and ongoing operation of the open enrollment and community rating required by sections thirty-two hundred thirty-one and forty-three hundred seventeen of this chapter, including provisions designed to encourage insurers to remain in or enter the small group or individual health insurance markets. The regulations shall apply to all insurers and health maintenance organizations subject to community rating. The regulations shall be designed to promote an insurance marketplace where premiums do not unduly fluctuate, insurers and health maintenance organizations are reasonably protected against unexpected significant shifts in the number of persons insured, and other market stability features deemed appropriate by the superintendent. Such regulations shall not require any insurer or health maintenance organization subject to this section, or any subsidiary or controlled person of a holding company of such insurer or health maintenance organization, to enter, continue to conduct, or withdraw from any line of business as a condition of entering, continuing in, or withdrawing from any other line of business.

(b) Prior to adopting such regulations the superintendent shall convene a technical advisory committee to provide advice and recommendations to the superintendent on issues including, but not limited to, voluntary reinsurance, pooling, risk sharing, the moderation of initial community rates as compared to prior rates, or premium stabilization methods. The technical advisory committee shall be comprised of nine members, one of whom shall be the superintendent or his or her designee. The superintendent or his or her designee shall chair the committee and shall appoint two other members to the committee. The temporary president of the senate and the speaker of the assembly shall each appoint three members to the committee. The appointees shall be representatives of commercial health insurers, not-for-profit health insurers, health maintenance organizations and purchasers of insurance and shall be named no later than July fifteenth,

nineteen hundred ninety-two. In addition, the superintendent may obtain the services of an actuary with experience relating to premium rates and market stabilization for small group health insurance.

(c) (1) Such regulations shall include reinsurance or a pooling process involving insurer contributions to, or receipts from, a fund which shall be designed to share the risk of or equalize high cost claims, claims of high cost persons, cost variations among insurers and health maintenance organizations based upon demographic factors of the persons insured which correlate with such cost variations designed to protect insurers from disproportionate adverse risks of offering coverage to all applicants; provided that such regulations shall relate only to risk sharing among insurers and health maintenance organizations and shall not create differences in community rates charged by a single insurer because an individual's or small group's coverage has been reinsured or pooled, and neither the small employer nor the employee shall have reason to know that their coverage has been reinsured or pooled pursuant to such regulations. Such regulations may also include other mechanisms designed to share risks or prevent undue variations in insurer claim costs which are not related to expected differences in insurer costs based upon competition, innovation and efficiency of operation. The regulations may segregate any reinsurance, pooling or other process among various geographic regions of the state.

(2) Effective on and after January first, nineteen hundred ninety-six, health maintenance organizations and insurers shall be required to contribute only ninety percent of the amounts calculated pursuant to regulations based upon demographic factors. The required contribution will be further reduced by an additional twenty-two and one-half percent on each succeeding January first. The aggregate total contributions by health maintenance organizations and insurers required pursuant to regulations based upon specified medical conditions shall be increased by the aggregate total amount of savings resulting from decreased contributions calculated pursuant to regulations based upon demographic factors, provided, however, that the funds received by an insurer or health maintenance organization pursuant to such regulations be applied to reduce the premiums of the particular class of contracts issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this chapter whose subscribers

caused the payments to be received.

(3) On and after January first, two thousand, such regulations shall include only reinsurance or a pooling process involving insurer and health maintenance organization contributions to, or receipts from, a fund which shall be designed to share the risk of or equalize high cost claims or the claims of high cost persons; provided that such regulations shall relate only to risk sharing among insurers and health maintenance organizations and shall not create differences in community rates charged by a single insurer or health maintenance organization because an individual's or small group's coverage has been reinsured or pooled, and neither the small employer nor the employee shall have reason to know that their coverage has been reinsured or pooled pursuant to such regulations. Such regulations may also include other mechanisms designed to share risks or prevent undue variations in insurer and health maintenance organization claim costs which are not related to expected differences in insurer and health maintenance organization costs based upon competition, innovation and efficiency of operation. The regulations may segregate any reinsurance, pooling or other process among various geographic regions of the state. Prior to adopting such regulations the superintendent shall convene a technical advisory committee to provide advice and recommendations to the superintendent on issues including, but not limited to, voluntary reinsurance, pooling, risk sharing, the moderation of initial community rates as compared to prior rates, or premium stabilization methods. The technical advisory committee shall be comprised of nine members, one of whom shall be the superintendent or his or her designee. The superintendent or his or her designee shall chair the committee and shall appoint two other members to the committee. The temporary president of the senate and the speaker of the assembly shall each appoint three members to the committee. The appointees shall be representatives of not-for-profit and commercial health insurers, health maintenance organizations, consumers and other purchasers of insurance and shall be named no later than September first, nineteen hundred ninety-five.

The superintendent shall also convene the technical advisory committee periodically to evaluate the impact of the standardized direct payment enrollee contracts offered pursuant to sections four thousand three

hundred twenty-one and four thousand three hundred twenty-two of this chapter on the individual health insurance market. In the course of such evaluation, the superintendent and the technical advisory committee shall consider: the adequacy of the benefits provided under the contracts and their effect on the affordability of the contracts; enrollment levels in the contracts in various regions of the state; utilization and claims experience of the contract holders; the impact of non-standardized direct payment enrollee contracts on the individual market; whether there is a need for an additional standardized direct payment enrollee contract and recommendations on whether other or different standardized benefit packages should be offered in the individual market; other options to enhance the affordability of the contracts; and such other areas as the technical advisory committee deems appropriate. After completing such evaluation, but in no event later than October first, nineteen hundred ninety-six, the technical advisory committee shall deliver a report to the governor, the speaker of the assembly and the temporary president of the senate which contains the results of its evaluation and any findings or recommendations on enhancing access to and affordability of individual health insurance products.

(d) Notwithstanding any provision of this chapter or any other chapter, the superintendent may suspend or terminate, by regulation, the operation, in whole or in part, of any mechanism established and operating pursuant to the authority of this section provided that the superintendent determines that the objectives stated in subsection (a) of this section are met by the operation of a mechanism or mechanisms established by the federal government pursuant to section 1343 of the affordable care act, 42 U.S.C. § 18063. Notwithstanding subsection (b) of this section, the superintendent may exercise this authority without convening a technical advisory committee.

*** § 3234. Pre-existing condition provisions in group and blanket disability policies.** (a) Every group or blanket policy issued or issued for delivery in this state which provides benefits by reason of the disability of the insured and which includes a pre-existing condition provision shall contain in substance the following provision or

provisions which in the opinion of the superintendent are more favorable to the members of the group:

(1) In determining whether a pre-existing condition provision applies to an eligible person, the group or blanket disability policy shall credit the time the person was previously covered under a previous group or blanket disability insurance plan or policy or employer-provided disability benefit arrangement, if the previous coverage was continuous to a date not more than sixty days prior to the effective date of the new coverage. The credit shall apply to the extent that the previous coverage or level of benefits was substantially similar to the new coverage or level of benefits; and

(2) No pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the effective date of coverage for the covered person.

(b) Nothing herein shall be construed to prohibit or restrict an insurer from utilizing other forms of underwriting for the members of the group in lieu of, or in addition to, the pre-existing condition provision described in subsection (a) of this section.

* NB There are 2 § 3234's

*** § 3234. Limitations on administrative services and stop-loss coverage.** No insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of a group which denies or limits benefits for a specific disease or condition or for a procedure or treatment unique to a specific disease or condition in a manner which would be inconsistent with this chapter or regulations promulgated by the superintendent had the group purchased insurance. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to groups which deny or limit benefits for a specific disease or condition or for a procedure or treatment unique to a specific disease or condition in a manner which would be inconsistent with this chapter or regulations promulgated by the superintendent had the group purchased insurance. A limit, maximum, or other mechanism that controls total coverage without regard to a specific disease or condition shall not be deemed one that

denies or limits benefits for a specific disease or condition, or for a procedure or treatment unique to a specific disease or condition. Nothing herein shall be construed to mandate the inclusion of specified benefits in an employer group plan, if such plan is not subject to the provisions of this chapter.

* NB There are 2 § 3234's

§ 3235. Explanation of benefits forms relating to claims under medicare supplemental insurance policies and limited benefits health insurance policies or certificates designed primarily to supplement medicare benefits. (a) Every insurer issuing medicare supplement insurance policies or certificates and limited benefits health insurance policies or certificates designed primarily to supplement medicare benefits, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under such policy or certificate.

(b) The explanation of benefits form must include at least the following:

(1) the name of the provider of service and the admission or financial control number, to the extent that they are included in the information received on the medicare claim from the medicare carrier or intermediary or from the beneficiary;

(2) a statement that the name and address of the provider of service, an identification of the service, the amount charged for the service, and the medicare approved amount are specified on the medicare explanation of benefits form to which the claim corresponds;

(3) the date of service;

(4) the amount of the benefit payable under the policy or certificate, including, if applicable, any amount exceeding medicare's approved charge;

(5) when payment under the policy or certificate is based upon the medicare approved charge and does not include any part of a charge which exceeds the medicare approved charge, a statement that the policy or

certificate only provides reimbursement for the difference between the medicare approved charge and the medicare payment, that charges in excess of the medicare approved charge may be subject to limitations pursuant to section nineteen of the public health law, that the insured or subscriber has a right to appeal the medicare approved charge by writing to medicare's carrier or fiscal intermediary, and that the insured or subscriber may be responsible for the amount by which the charge exceeds the medicare approved charge; and

(6) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

(c) Except on demand by the insured or subscriber, insurers, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, issuing medicare supplement insurance policies or limited benefits health insurance policies or certificates designed primarily to supplement medicare benefits shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider on an assignment basis and the insurer's reimbursement is paid directly to the facility or provider.

§ 3236. Public health law assessments. Any insurer licensed pursuant to this chapter and any health maintenance organization certified pursuant to article forty-four of the public health law or licensed pursuant to this chapter shall reflect the methodology for financing the costs of graduate medical education in general hospitals and affiliated sites, uncompensated care in general hospitals and diagnostic and treatment centers, and other publicly financed programs established pursuant to sections twenty-eight hundred seven-j, twenty-eight hundred seven-k, twenty-eight hundred seven-l, twenty-eight hundred seven-m,

twenty-eight hundred seven-p, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law for hospital and other health care services provided on and after January first, nineteen hundred ninety-seven in policies and contracts which provide reimbursement for, and in arrangements reflecting anticipated claims costs for, any of the following services:

(a) inpatient hospital services provided by a general hospital issued an operating certificate pursuant to article twenty-eight of the public health law;

(b) outpatient hospital services provided by a general hospital issued an operating certificate pursuant to article twenty-eight of the public health law;

(c) emergency services provided by a general hospital issued an operating certificate pursuant to article twenty-eight of the public health law;

(d) ambulatory surgical services provided by a general hospital issued an operating certificate pursuant to article twenty-eight of the public health law;

(e) ambulatory surgical services provided by a diagnostic and treatment center issued an operating certificate pursuant to article twenty-eight of the public health law;

(f) health care services provided by a diagnostic and treatment center issued an operating certificate pursuant to article twenty-eight of the public health law;

(g) clinical laboratory services provided by a clinical laboratory issued a permit pursuant to title five of article five of the public health law.

§ 3237. Health insurance coverage for full-time students on medical leaves of absence. (a) Every individual health insurance policy and every group or blanket accident and health insurance policy that provides coverage for dependent children who are full-time students to a higher age than other dependent children shall continue the coverage of a covered dependent student who takes a leave of absence from school due to illness for a period of twelve months from the last day of attendance in school, provided, however, that nothing in this section shall require

coverage of a dependent student beyond the age at which coverage would otherwise terminate.

(b) In order to qualify under this section, the medical necessity of a leave of absence from school must be certified to by the student's attending physician who is licensed to practice in the state of New York. Written documentation of the illness must be submitted to the insurer.

(c) The rate charged for such extended coverage shall be the same as that charged while the dependent is enrolled as a full-time student.

§ 3238. Pre-authorization of health care services. (a) An insurer, corporation organized pursuant to article forty-three of this chapter, municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, or health maintenance organization and other organizations certified pursuant to article forty-four of the public health law ("health plan") shall pay claims for a health care service for which a pre-authorization was required by, and received from, the health plan prior to the rendering of such health care service, unless:

(1) (i) the insured, subscriber, or enrollee was not a covered person at the time the health care service was rendered.

(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, a health plan shall not deny a claim on this basis if the insured's, subscriber's or enrollee's coverage was retroactively terminated more than one hundred twenty days after the date of the health care service, provided that the claim is submitted within ninety days after the date of the health care service. If the claim is submitted more than ninety days after the date of the health care service, the health plan shall have thirty days after the claim is received to deny the claim on the basis that the insured, subscriber or enrollee was not a covered person on the date of the health care service.

(2) the submission of the claim with respect to an insured, subscriber or enrollee was not timely under the terms of the applicable provider contract, if the claim is submitted by a provider, or the policy or contract, if the claim is submitted by the insured, subscriber or

enrollee;

(3) at the time the pre-authorization was issued, the insured, subscriber or enrollee had not exhausted contract or policy benefit limitations based on information available to the health plan at such time, but subsequently exhausted contract or policy benefit limitations after authorization was issued; provided, however, that the health plan shall include in the notice of determination required pursuant to subsection (b) of section four thousand nine hundred three of this chapter and subdivision two of section forty-nine hundred three of the public health law that the visits authorized might exceed the limits of the contract or policy and accordingly would not be covered under the contract or policy;

(4) the pre-authorization was based on materially inaccurate or incomplete information provided by the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider such that if the correct or complete information had been provided, such pre-authorization would not have been granted;

(5) the pre-authorized service was related to a pre-existing condition that was excluded from coverage; or

(6) there is a reasonable basis supported by specific information available for review by the superintendent that the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider has engaged in fraud or abuse.

(b) Nothing in this section shall be construed to prohibit a health plan from denying continued or extended coverage as part of a concurrent review of a health care service.

(c)(1) If a health care provider, while providing a service or procedure to treat a patient, determines that providing an additional or related service or procedure, such as a service or procedure to address a co-morbid condition, is immediately necessary as part of such treatment, and in the clinical judgment of the health care provider it is a medically timely service and it would not be medically advisable to interrupt the provision of care to the patient in order to obtain pre-authorization from a health plan for the additional or related service or procedure, a denial of payment for the additional or related service or procedure due to lack of pre-authorization shall be upheld on appeal only if it is determined that:

(i) the additional or related service or procedure is not a covered benefit;

(ii) the additional or related service or procedure was not medically necessary pursuant to section four thousand nine hundred four of this chapter or section forty-nine hundred four of the public health law;

(iii) the additional or related service or procedure was experimental or investigational pursuant to section four thousand nine hundred four of this chapter or section forty-nine hundred four of the public health law; or

(iv) one of the conditions set forth in paragraphs one through six of subsection (a) of this section is met.

(2) The provisions of this subsection shall apply to situations in which pre-authorization was required and received for the initial service or procedure.

(3) The provisions of this subsection shall apply without regard to whether the current procedural terminology (CPT) code for the additional or related service or procedure is different than the CPT code for the initial service or procedure.

(d) Payment for such health care services shall be subject to a health plan's provider contracts or claims payment policies that are consistent with applicable law, rule or regulation.

(e) Nothing in this section shall be deemed to limit the right of a health plan to deny a claim if the health plan determines that it is not primarily obligated to pay the claim because other insurance coverage exists that is primary, including but not limited to workers' compensation and no-fault coverage.

(f) Notification that a health care service is being provided shall not constitute a request for pre-authorization of that health care service for purposes of this section; provided, however, that if a health plan provides a written acknowledgement of the notification to the health care provider, such acknowledgment shall clearly state that the acknowledgment does not constitute a pre-authorization of the services to be rendered.

(g) Nothing in this section shall preclude a health care provider and a health plan from agreeing to provisions different from those in this section; provided, however, that any agreement that purports to waive, limit, disclaim, or in any way diminish the rights of a health care

provider set forth in this section shall be void as contrary to public policy.

§ 3239. Wellness programs. (a) An insurer licensed to write life insurance may establish a wellness program in conjunction with its issuance of life insurance policies and an insurer licensed to write accident and health insurance, a corporation organized pursuant to article forty-three of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law and a municipal cooperative health benefits plan may establish a wellness program in conjunction with its issuance of a group accident and health insurance policy or group subscriber contract. A "wellness program" is a program designed to promote health, longevity or prevent disease that may contain rewards and incentives for participation. A "wellness program" shall not include limited benefits health insurance. Participation in the wellness program shall be available to similarly-situated members of the group or with regard to life insurance, to all insureds within the same class and equal expectation of life and shall be voluntary on the part of the member or insured. With regard to life insurance, an insurer is prohibited from increasing premiums or charges stated in the policy as a result of participation or non-participation in the program. The terms of the wellness program shall be set forth in the policy or contract. With regard to a wellness program established in connection with life insurance, an insurer shall provide a prominent disclosure to an applicant at or prior to the time of application that the program is not health insurance and participants should not view the program as a substitute for the purchase of health insurance.

(b) A wellness program may include, but is not limited to, the following programs or services:

(1) the use of a health risk assessment tool;

(2) a smoking cessation program;

(3) a weight management program;

(4) a stress and/or hypertension management program;

(5) a worker injury prevention program;

(6) a nutrition education program;

(7) health or fitness incentive programs;

(8) a coordinated weight management, nutrition, stress management and physical fitness program to combat the high incidence of adult and childhood obesity, asthma and other chronic respiratory conditions;

(9) a substance or alcohol abuse cessation program;

(10) a program to manage and cope with chronic pain;

(11) a preventive care program, screenings (including biometric screenings), or chronic disease management program; and

(12) a stress management program, including participation in a meditation or sleep improvement program.

(c)(1) A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium.

(2) Permissible rewards and incentives may include:

(A) full or partial reimbursement of the cost of participating in smoking cessation, weight management, stress and/or hypertension, worker injury prevention, nutrition education, substance or alcohol abuse cessation, preventive care programs, screenings, chronic disease management programs, or chronic pain management and coping programs;

(B) full or partial reimbursement of the cost of membership in a health club or fitness center;

(C) (1) the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group health insurance policy or subscriber contract;

(2) a premium refund, discount, or policy value credit, or other increase in benefits or decrease in charges under a life insurance policy;

(D) monetary rewards in the form of gift cards, gift certificates, vouchers or discounts on products or services in return for engaging in healthy behaviors;

(E) full or partial reimbursement of the cost of participating in a stress management program or activity, including participation in a meditation or sleep improvement program, provided that such program or activity shall be based on data and research that the program or service can be reasonably expected to result in overall good health, well being,

or improved mortality risk;

(F) full or partial reimbursement of the cost of participating in a health or fitness program; and

(G) full or partial reimbursement of the cost of a wearable device and any associated subscription membership to track physical activity or biometric data, and which incents behavioral changes to improve health or mortality risk.

(3) Where the reward involves a group member's meeting a specified standard based on a health condition, the wellness program under a health insurance policy shall meet the requirements of 45 CFR Part 146.

(4) A reward or incentive that involves a discounted premium rate or a rebate or refund of premium under accident and health insurance policies shall be based on actuarial demonstration that the wellness program can reasonably be expected to result in the overall good health and well being of the group. A premium refund, discount, or policy value credit, or other increase in benefits or decrease in charges under life insurance policies in connection with a wellness program shall be based on sound actuarial principles related to actual or reasonably anticipated experience.

(d) Fair collection and use of personal information. (1) Nonpublic personal information, including health data, an insurer collects and shares in connection with a wellness program shall be subject to all state and federal privacy and security laws and regulations promulgated thereunder, including 11 NYCRR 420.

(2) Wellness program participants shall have the right to obtain a copy of their wellness program information and an opportunity to correct any inaccuracies.

(3) An insurer may contract with a third party for purposes of administering or operating a wellness program on such insurer's behalf provided that the insurer maintains a system of supervision to ensure compliance with this section, including procedures to take appropriate corrective action for any participant harmed by a violation of this section by the insurer directly or by any third party with whom the insurer contracts.

*** § 3240. Unclaimed benefits.** (a) Definitions. For the purposes of

this section:

(1) "Account" means: (A) any mechanism, whether denoted as a retained asset account or otherwise, whereby the settlement of proceeds payable to a beneficiary under a policy is accomplished by the insurer or an entity acting on behalf of the insurer placing the proceeds into an account where the insurer retains those proceeds and the beneficiary has check or draft writing privileges; or (B) any other settlement option relating to the manner of distribution of the proceeds payable under a policy.

(2) "Death index" means the death master file maintained by the United States social security administration or any other database or service that is at least as comprehensive as the death master file maintained by the United States social security administration and that is acceptable to the superintendent.

(3) "Insured" means an individual covered by a policy or an annuitant when the annuity contract provides for benefits to be paid or other monies to be distributed upon the death of the annuitant.

(4) "Insurer" means a life insurance company or fraternal benefit society.

(5) "Lost policy finder" means a service made available by the department on its website or otherwise developed by the superintendent either on his or her own or in conjunction with other state regulators, to assist consumers with locating unclaimed life insurance benefits.

(6) "Policy" means a life insurance policy; an annuity contract; a certificate under a life insurance policy or annuity contract; or a certificate issued by a fraternal benefit society; under which benefits are to be paid upon the death of the insured, including a policy that has lapsed or been terminated.

(b) Applicability. (1) This section shall apply to a policy:

(A) issued by a domestic insurer and any account established under or as a result of such policy; or

(B) delivered or issued for delivery in this state by an authorized foreign insurer and any account established under or as a result of such policy.

(2) Notwithstanding paragraph one of this subsection:

(A) with respect to a policy delivered or issued for delivery outside this state, a domestic insurer may, in lieu of the requirements of this

section, implement procedures that meet the minimum requirements of the state in which the insurer delivered or issued the policy, provided that the superintendent determines that such other requirements are no less favorable to the policy owner and beneficiary than those required by this section; and

(B) this section shall not apply to a lapsed or terminated policy with no benefits payable that was searched within the eighteen months preceding the effective date of this section or that was searched more than eighteen months prior to the most recent search conducted by the insurer.

(c) Identifying information. (1) Except as set forth in paragraph two of this subsection, at no later than policy delivery or the establishment of an account and upon any change of insured, owner, account holder, or beneficiary, an insurer shall request information sufficient to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured or account holder, including, at a minimum, the name, address, social security number, date of birth, and telephone number of every owner, account holder, insured, and beneficiary of such policy or account, as applicable.

(2) Where an insurer issues a policy or provides for an account based on data received directly from an insured's employer, the insurer may obtain the beneficiary information described in paragraph one of this subsection by communicating with the insured after receiving the data from the insured's employer.

(d) Standards for cross-checking policies. (1) An insurer shall use the death index to cross-check every policy and account subject to this section no less frequently than quarterly, except as specified in subsection (g) of this section. An insurer may perform the cross-check using the updates made to the death index since the date of the last cross-check performed by the insurer, provided that the insurer performs the cross-check using the entire death index at least once a year. The superintendent may promulgate rules and regulations that allow an insurer to perform the cross-checks less frequently than quarterly but not less frequently than semi-annually.

(2) The cross-checks shall be performed using: (A) the insured or account holder's social security number; or (B) where the insurer does

not know the insured or account holder's social security number, the name and date of birth of the insured or account holder.

(3) If an insurer only has a partial name, social security number, date of birth, or a combination thereof, of the insured or account holder under a policy or account, then the insurer shall use the available information to perform the cross-check.

(4) An insurer shall implement reasonable procedures to account for common variations in data that would otherwise preclude an exact match with a death index.

(e) Multiple policy search procedures. (1) Upon receiving notification of the death of an insured or account holder or in the event of a match made by a death index cross-check pursuant to subsection (d) of this section, an insurer shall search every policy or account subject to this section to determine whether the insurer has any other policies or accounts for the insured or account holder.

(2) An insurer that receives a notification of the death of an insured or account holder, or identifies a death index match, shall notify each United States affiliate, parent, or subsidiary, and any entity with which the insurer contracts that may maintain or control records relating to policies or accounts covered by this section, of the notification or verified death index match. An insurer shall take all steps necessary to have each affiliate, parent, subsidiary, or other entity perform the search required by paragraph one of this subsection.

(f) Standards for locating claimants. (1) An insurer shall establish procedures to reasonably confirm the death of an insured or account holder and begin to locate beneficiaries within ninety days after the identification of a potential match made by a death index cross-check or by a search conducted by the insurer pursuant to subsection (e) of this section. If the insurer cannot locate beneficiaries within ninety days after the identification of a potential match, then the insurer shall continue to search for beneficiaries until the benefits escheat in accordance with applicable state law.

(2) Once the beneficiary or beneficiaries under the policy or account have been located, the insurer shall provide to the beneficiary or beneficiaries the information necessary to make a claim pursuant to the terms of the policy or account. The insurer shall process all claims and make prompt payments and distributions in accordance with all applicable

laws, rules, and regulations.

(3) Nothing herein shall prevent an insurer from requiring satisfactory proof of loss, such as a death certificate, for the purpose of verifying the death of the insured, provided that if a beneficiary cannot obtain a death certificate, then an insurer shall accept an alternate form of satisfactory proof of loss.

(g) This section shall not apply to:

(1) a group policy administered by the group policyholder where the insurer does not maintain or control the records containing the information necessary to comply with the requirements of this section; or

(2) any other circumstance as determined to be appropriate by the superintendent in a regulation.

(h) Lost policy finder. (1) The superintendent shall develop and implement a lost policy finder to assist requestors with locating unclaimed life insurance benefits. The lost policy finder shall be available online and via other means, including but not limited to the department's toll free telephone number. The superintendent shall assist a requestor with using the lost policy finder, including informing the requestor of the information an insurer may need to facilitate responding to the request.

(2) As soon as practicable, but no later than thirty days after receiving a request from a requestor via the lost policy finder, the superintendent shall:

(A) forward the request to all insurers deemed necessary by the superintendent in order to successfully respond to the request; and

(B) inform the requestor in writing that the superintendent received the request and forwarded the request to all insurers deemed necessary by the superintendent in order to successfully respond to the request.

(3) Upon receiving a request forwarded by the superintendent through a lost policy finder, an insurer shall search for policies and any accounts subject to this section that insure the life of, or are owned by, an individual named as the decedent in the request forwarded by the superintendent.

(4) Within sixty days of receiving the request referenced in paragraph two of this subsection the insurer shall:

(A) report to the superintendent through the lost policy finder the

findings of the search conducted pursuant to paragraph three of this subsection;

(B) for each identified policy and account insuring the life of, or owned by, the individual named as the decedent in the request, provide to a requestor who is:

(i) also the beneficiary of record on the identified policy or account the information necessary to make a claim pursuant to the terms of the policy or account; and

(ii) not the beneficiary of record on the identified policy or account the requested information to the extent permissible to be disclosed in accordance with any applicable law, rule, or regulation and take such other steps necessary to facilitate the payment of any benefit that may be due under the identified policy or account.

(5) The superintendent shall, within thirty days of receiving from all insurers the information required in subparagraph (A) of paragraph four of this subsection, inform the requestor of the results of the search.

(6) When a beneficiary identified in paragraph four of this subsection submits a claim or claims to an insurer, the insurer shall process such claim or claims and make prompt payments and distributions in accordance with all applicable laws, rules, and regulations.

(7) Within thirty days of the final disposition of the request, an insurer shall report to the superintendent through the lost policy finder any benefits paid and any other information requested by the superintendent.

(8) An insurer shall establish procedures to electronically receive the lost policy finder request from, and make reports to, the superintendent as provided for in this section. When transmitted electronically, the date that the superintendent forwards the request shall be deemed to be the date of receipt by the insurer; provided, however, that if the date is a Saturday, Sunday, or a public holiday, as defined in section twenty-four of the general construction law, then the date of receipt shall be as provided in section twenty-five-a of the general construction law. The superintendent may promulgate rules and regulations that allow an insurer to apply for an exemption from the requirement that it electronically receive the lost policy finder request and report any benefits paid or other information the superintendent requests pursuant to section three hundred sixteen of

this chapter.

(i) Reports. An insurer subject to this section shall include in the report required under section seven hundred three of the abandoned property law any information on unclaimed benefits due pursuant to this section and the number of policies and accounts that the insurer has identified pursuant to this section for the prior calendar year under which any outstanding monies have not been paid or distributed by December thirty-first of such year, except potential matches still being investigated pursuant to paragraph one of subsection (f) of this section. A copy of the report also shall be filed with the superintendent.

(j) The superintendent is authorized to promulgate any rules and regulations necessary to implement the provisions of this section in accordance with the provisions of the state administrative procedure act.

* NB There are 2 § 3240's

*** § 3240. Student accident and health insurance.** (a) In this section:

(1)(A) "Student accident and health insurance" means a policy or contract of hospital, medical, or surgical expense insurance delivered or issued for delivery in this state on or after January first, two thousand fourteen, by an insurer or a corporation, to an institution of higher education covering students enrolled in the institution and the students' dependents.

(B) "Student accident and health insurance" shall not include:

(i) a policy or contract that provides limited scope dental or vision benefits meeting the definition of "excepted benefits" set forth in section 2791 of the public health service act, 42 U.S.C. § 300gg-91(c);

(ii) an accident policy or contract that provides benefits meeting the definition of "excepted benefits" set forth in section 2791 of the public health service act, 42 U.S.C. § 300gg-91(c), if the policy or contract:

(I) is limited to coverage for intercollegiate sports injuries only;

(II) provides benefits to diagnose and treat any intercollegiate sports injury and does not include a benefit dollar maximum amount per injury that is less than the overall benefit dollar maximum amount per

student under the intercollegiate sports injury policy or contract;

(III) provides benefits on an expense incurred basis;

(IV) provides that premiums are paid in full by the institution of higher education;

(V) includes prominent disclosure to the student that the accident policy is not a substitute for comprehensive hospital and medical coverage;

(VI) provides coverage for intercollegiate sports injuries primary to any student accident and health insurance policy or contract or any student health plan issued pursuant to section one thousand one hundred twenty-four of this chapter; except that a policy or contract meeting the requirements of this item may be excess or secondary to any other policy or contract of accident and health insurance; and

(VII) includes a maximum benefit amount that is no less than the deductible under the separate athletic association policy or contract if designed to coordinate with a separate policy or contract issued to an athletic association that extends coverage for intercollegiate sports injuries;

(iii) an accident policy or contract that provides benefits meeting the definition of "excepted benefits" set forth in section 2791 of the public health service act, 42 U.S.C. § 300gg-91(c)(1)(A), if the policy or contract:

(I) is limited to transportation expenses in the event an insured student incurs a covered sickness or accident, including transportation expenses for a medical escort to travel with the student and transportation expenses for returning the student to the student's domicile;

(II) provides that premiums are paid in full by the institution of higher education;

(III) covers students enrolled in the institution of higher education;

(IV) includes prominent disclosure to the student that the accident policy is not a substitute for comprehensive hospital and medical coverage; and

(V) provides coverage for a period of twelve months; or

(iv) an insurance policy, contract, or certificate that provides hospital, medical, or surgical expense coverage for a student while studying outside the United States for a period of twelve months or less

that is issued to a student, provided that the student is also covered by comprehensive hospital and medical coverage within the United States and the insurance policy, contract, or certificate:

(I) is subject to the requirements of subsections (b), (c), (d), (e), (h), and (i) of this section;

(II) meets the definition of "expatriate health plan" set forth in 42 U.S.C. § 18014(d)(2);

(III) excludes coverage within the United States;

(IV) may offer coverage for global evacuation and repatriation in the event of the insured student's sickness or accident; and

(V) may offer coverage for trip cancellation, trip interruption, baggage, personal effects, or global evacuation and repatriation, including evacuation in the event of a natural or man-made disaster, such as an epidemic, political event, war, terrorist act, riot, or civil insurrection, pursuant to section three thousand four hundred fifty-two of this chapter.

(2) "Institution of higher education" or "institution" shall have the meaning set forth in the higher education act of 1965, 20 U.S.C. § 1001.

(3) "Insurer" means an insurer licensed to write accident and health insurance pursuant to this chapter.

(4) "Corporation" means a corporation organized in accordance with article forty-three of this chapter.

(5) "Intercollegiate sport" means a sport that has been designated as an intercollegiate sport by the institution of higher education in which a student is enrolled and that is organized or sponsored by an institution of higher education.

(6) "Intercollegiate sports injury" means an injury sustained by a student member of an athletics team during participation in an intercollegiate sport.

(b) An insurer or corporation shall not impose any pre-existing condition exclusion in a student accident and health insurance policy or contract. An insurer or corporation shall not condition eligibility, including continued eligibility, for a student accident and health insurance policy or contract on health status, medical condition, including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic

violence, or disability.

(c) An insurer or corporation shall condition eligibility including continuing eligibility, on the covered individual being enrolled as a student in an institution of higher education to which the student accident and health insurance policy or contract is issued.

(d) A student accident and health insurance policy or contract shall provide coverage for essential health benefits as defined in subsection (a) of section three thousand two hundred seventeen-i or subsection (a) of section four thousand three hundred six-h of this chapter, as applicable.

(e) An insurer or corporation shall not refuse to renew or otherwise terminate a student accident and health insurance policy or contract except for one or more of the reasons set forth in:

(1) subparagraphs (A), (B), (D) or (G) of paragraph two of subsection (p) of section three thousand two hundred twenty-one of this article; or

(2) subparagraphs (A), (B), (D) or (G) of paragraph two of subsection (j) of section four thousand three hundred five of this chapter.

(f) Other than the provisions herein also required by article forty-three of this chapter, this section shall not apply to coverage under a student health plan issued pursuant to section one thousand one hundred twenty-four of this chapter.

(g) The superintendent may promulgate regulations regarding student accident and health insurance, which may include minimum standards for the form, content and sale of the policies and contracts and, notwithstanding the provisions of section three thousand two hundred thirty-one and four thousand three hundred eight of this chapter, the establishment of rating methodology to be applied to the policies and contracts; provided that any such regulations shall be no less favorable to the insured than that which is provided under federal law and state law applicable to individual insurance.

(h) The ratio of benefits to premiums shall be not less than eighty-two percent as calculated in a manner to be determined by the superintendent.

(i) Every insurer or corporation shall report to the superintendent annually, on a date specified by the superintendent in a regulation, claims experience and other data in a manner acceptable to the superintendent that shall demonstrate the insurer's or corporation's

compliance with the applicable rules and regulations, including the minimum loss ratio required by subsection (h) of this section. Failure to comply with subsection (h) of this section is subject to corrective action, which may include the submission, to the superintendent, of an appropriate rate filing or form and rate filing to reduce future premiums, increase benefits, issue dividends, issue premium refunds or credits, or any combination of these such that the minimum loss ratio can reasonably be expected to be achieved.

(j) With respect to benefits for treatment relating to an intercollegiate sports injury, as defined in paragraph six of subsection (a) of this section, a policy or contract of student accident and health insurance or a student health plan issued pursuant to section one thousand one hundred twenty-four of this chapter shall be secondary to a separate accident policy or contract meeting the requirements of clauses (I) through (VII) of item (ii) of subparagraph (B) of paragraph one of subsection (a) of this section.

* NB There are 2 § 3240's

§ 3241. Network coverage. * (a) (1) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The superintendent shall review the network of health care providers for adequacy at the time of the superintendent's initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract in conformance with the standards set forth in subdivision five of section four thousand four hundred three of the public health law. The superintendent shall determine standards for network adequacy for mental health and substance use disorder treatment services, including

sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services, in consultation with the commissioner of the office of mental health and the commissioner of the office of addiction services and supports. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate by the superintendent.

(2) The superintendent, in consultation with the commissioner of health, the commissioner of the office of mental health, and the commissioner of the office of addiction services and supports, shall propose regulations setting forth standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services, by December thirty-first, two thousand twenty-three.

* NB Effective until January 1, 2027

* (a) (1) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the health, substance-related and addictive disorder and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The superintendent shall review the network of health care providers for adequacy at the time of the superintendent's initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract in conformance with the standards set forth in subdivision five of section four thousand four hundred three of the public health law. The superintendent shall determine standards for network adequacy for mental health and substance-related and addictive disorder treatment services,

including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services, in consultation with the commissioner of the office of mental health and the commissioner of the office of addiction services and supports. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate by the superintendent.

(2) The superintendent, in consultation with the commissioner of health, the commissioner of the office of mental health, and the commissioner of the office of addiction services and supports, shall propose regulations setting forth standards for network adequacy for mental health and substance-related and addictive disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services, by December thirty-first, two thousand twenty-three.

* NB Effective January 1, 2027

(b)(1)(A) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a comprehensive group or group remittance health insurance policy or contract that covers out-of-network health care services shall make available and, if requested by the policyholder or contractholder, provide at least one option for coverage for at least eighty percent of the usual and customary cost of each out-of-network health care service after imposition of a deductible or any permissible benefit maximum.

(B) If there is no coverage available pursuant to subparagraph (A) of this paragraph in a rating region, then the superintendent may require an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance

organization certified pursuant to article forty-four of the public health law, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter issuing a comprehensive group or group remittance health insurance policy or contract in the rating region, to make available and, if requested by the policyholder or contractholder, provide at least one option for coverage of eighty percent of the usual and customary cost of each out-of-network health care service after imposition of any permissible deductible or benefit maximum. The superintendent may, after giving consideration to the public interest, permit an insurer, a corporation, or a health maintenance organization to satisfy the requirements of this paragraph on behalf of another insurer, corporation, or health maintenance organization within the same holding company system, as defined in article fifteen of this chapter, including a health maintenance organization operated as a line of business of a health service corporation organized pursuant to article forty-three of this chapter. The superintendent may, upon written request, waive the requirement for coverage of out-of-network health care services to be made available pursuant to this subparagraph if the superintendent determines that it would pose an undue hardship upon an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter.

(2) For the purposes of this subsection, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law or a student health plan established or maintained pursuant

to section one thousand one hundred twenty-four of this chapter.

(3) This subsection shall not apply to emergency care services in hospital facilities or prehospital emergency medical services as defined in clause (i) of subparagraph (E) of paragraph twenty-four of subsection (i) of section three thousand two hundred sixteen of this article, or clause (i) of subparagraph (E) of paragraph fifteen of subsection (l) of section three thousand two hundred twenty-one of this chapter, or subparagraph (A) of paragraph five of subsection (aa) of section four thousand three hundred three of this chapter.

(4) Nothing in this subsection shall limit the superintendent's authority pursuant to section three thousand two hundred seventeen of this article to establish minimum standards for the form, content and sale of accident and health insurance policies and subscriber contracts, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.

(c) When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network of an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter ("health care plan"), the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network. For the purpose of this section, "emergency services" shall have the meaning set forth in subparagraph (D) of paragraph nine of subsection (i) of section three thousand two hundred sixteen of this article, subparagraph (D) of paragraph four of subsection (k) of section three thousand two hundred twenty-one of this article, and subparagraph (D) of paragraph two of subsection (a) of section four thousand three hundred three of this chapter.

§ 3242. Prescription drug coverage. * (a) Every insurer that delivers or issues for delivery in this state a policy that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.

* NB Effective until January 1, 2027

* (a) Every insurer that delivers or issues for delivery in this state a policy that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds, prospective insureds, health care providers, and other interested parties. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments. A formulary drug list shall only be considered easily accessible if:

(1) it can be viewed on the insurer's public website without requiring an individual to create or access an account or enter a password or to be covered under an insurance policy issued by the insurer; and

(2) an individual can easily discern which formulary drug list applies to which plan, if an insurer offers more than one plan.

* NB Effective January 1, 2027

(b) (1) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, an insurer shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health

law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

(2) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on a standard exception request that is not based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than seventy-two hours following receipt of the request.

(C) An insurer that grants a standard exception request that is not based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills.

(D) For the purpose of this subsection, "exigent circumstances" means when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary prescription drug.

(3) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request an expedited review based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on an expedited review request based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than twenty-four hours following receipt of the request.

(C) An insurer that grants an exception based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

(4) An insurer that denies an exception request under paragraph two or three of this subsection shall provide written notice of its determination to the insured or the insured's designee and the insured's prescribing health care provider within three business days of receipt

of the exception request. The written notice shall be considered a final adverse determination under section four thousand nine hundred four of this chapter or section four thousand nine hundred four of the public health law. Written notice shall also include the name or names of clinically appropriate prescription drugs covered by the insurer to treat the insured.

(5) (A) If an insurer denies a request for an exception under paragraph two or three of this subsection, the insured, the insured's designee, or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal agent certified by the superintendent pursuant to section four thousand nine hundred eleven of this chapter in accordance with article forty-nine of this chapter or article forty-nine of the public health law.

(B) An external appeal agent shall make a determination on the external appeal and notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than seventy-two hours following the external appeal agent's receipt of the request, if the original request was a standard exception request under paragraph two of this subsection. The external appeal agent shall notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider in writing of the external appeal determination within two business days of rendering such determination.

(C) An external appeal agent shall make a determination on the external appeal and notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than twenty-four hours following the external appeal agent's receipt of the request, if the original request was an expedited exception request under paragraph three of this subsection and the insured's prescribing health care provider attests that exigent circumstances exist. The external appeal agent shall notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider in writing of the external appeal determination within seventy-two hours of the external appeal agent's receipt of the external appeal.

(D) An external appeal agent shall make a determination in accordance

with subparagraph (A) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter or subparagraph (A) of paragraph (d) of subdivision two of section four thousand nine hundred fourteen of the public health law. When making a determination, the external appeal agent shall consider whether the formulary prescription drug covered by the insurer will be or has been ineffective, would not be as effective as the non-formulary prescription drug, or would have adverse effects.

(E) If an external appeal agent overturns the insurer's denial of a standard exception request under paragraph two of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills. If an external appeal agent overturns the insurer's denial of an expedited exception request under paragraph three of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

* (c)(1) Except as otherwise provided in paragraph three of this subsection, an insurer shall not:

(A) remove a prescription drug from a formulary;

(B) move a prescription drug to a tier with a larger deductible, copayment, or coinsurance if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier; or

(C) add utilization management restrictions to a prescription drug on a formulary, unless such changes occur at the time of enrollment, issuance or renewal of coverage.

(2) Prohibitions provided in paragraph one of this subsection shall apply beginning on the date on which a plan year begins and through the end of such plan year.

(3) (A) An insurer with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deductible, copayment or coinsurance if an AB-rated generic equivalent or interchangeable biological product for such prescription drug is added to the formulary at the same time.

(B) An insurer may remove a prescription drug from a formulary if the federal Food and Drug Administration determines that such prescription

drug should be removed from the market, including new utilization management restrictions issued pursuant to federal Food and Drug Administration safety concerns.

(C) An insurer with a formulary that includes two or more tiers of benefits providing for different copayments applicable to prescription drugs may move a prescription drug to a tier with a larger copayment during the plan year, provided the change is not applicable to an insured who is already receiving such prescription drug or has been diagnosed with or presented with a condition on or prior to the start of the plan year that is treated by such prescription drug or is a prescription drug that is or would be part of the insured's treatment regimen for such condition.

(4) An insurer shall provide notice to insureds of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in the upcoming plan year, ninety days prior to the start of the plan year. Such notice of impending formulary and deductible, copayment or coinsurance changes shall also be posted on the insurer's online formulary and in any prescription drug finder system that the insurer provides to the public.

(5) The provisions of this subsection shall not supersede the terms of a collective bargaining agreement, or the rights of labor representation groups to collectively bargain changes to the formularies.

* NB There are 2 sb (c)'s

* (c) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to immediately obtain, on the insured's behalf, an additional thirty-day supply of any current prescription of the insured, except as provided in section two hundred seventy-eight-a of the public health law, at the same level of coverage as a normal refill of such prescription drug upon the declaration of a state disaster emergency pursuant to section twenty-eight of the executive law.

* NB There are 2 sb (c)'s

§ 3243. Discrimination because of sex or marital status in hospital,

surgical or medical expense insurance. (a) With regard to an accident and health insurance policy that provides hospital, surgical, or medical expense coverage or a policy of student accident and health insurance, as defined in subsection (a) of section three thousand two hundred forty of this article, delivered or issued for delivery in this state, no insurer shall because of sex, marital status or based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions:

(1) make any distinction or discrimination between persons as to the premiums or rates charged for the policy or in any other manner whatever;

(2) demand or require a greater premium from any person than it requires at that time from others in similar cases;

(3) make or require any rebate, discrimination or discount upon the amount to be paid or the service to be rendered on any policy;

(4) insert in the policy any condition, or make any stipulation, whereby the insured binds his or herself, or his or her heirs, executors, administrators or assigns, to accept any sum or service less than the full value or amount of such policy in case of a claim thereon except such conditions and stipulations as are imposed upon others in similar cases; and any such stipulation or condition so made or inserted shall be void;

(5) reject any application for a policy issued or sold by it;

(6) cancel or refuse to issue, renew or sell such policy after appropriate application therefor;

(7) fix any lower rate or discriminate in the fees or commissions of insurance agents or insurance brokers for writing or renewing such a policy; or

(8) engage in sexual stereotyping.

(b) For the purposes of this section, "sex" shall include sexual orientation, gender identity or expression, and transgender status.

§ 3244. Explanation of benefits forms relating to claims under certain accident and health insurance policies. (a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any

other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital, medical or pharmaceutical expenses, including policies and certificates providing nursing home expense or home care expense benefits.

(b) The explanation of benefits form must include at least the following:

(1) the name of the provider of service the admission or financial control number, if applicable;

(2) the date of service;

(3) an identification of the service for which the claim is made;

(4) the provider's charge or rate;

(5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;

(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

(c) Except on demand by the insured or subscriber, insurers, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider.

(d) This section shall not apply to medicare supplemental insurance policies or certificates or limited benefits health insurance policies or certificates designed primarily to supplement medicare benefits.

(e) The provisions of this section requiring an explanation of benefits form for pharmaceutical claims shall be satisfied by either a quarterly written summary of the information prescribed by subsection (b) of this section or by making such information available electronically on the member portal of the insurer's, health maintenance organization's, or article forty-three organization's website, provided that the member consents to receiving the information electronically.

§ 3245. Liability to providers in the event of an insolvency. In the event an insurance company authorized to do an accident and health insurance business in this state is deemed insolvent, as provided in section one thousand three hundred nine of this chapter, no insured covered under a policy delivered or issued for delivery in this state by the insurance company shall be liable to any provider of health care services for any covered services of the insolvent insurance company. No provider of health care services or any representative of such provider shall collect or attempt to collect from the insured sums owed by such insurance company, and no provider or representative of such provider may maintain any action at law against an insured to collect sums owed to such provider by such insurance company.

ARTICLE 34

INSURANCE CONTRACTS-PROPERTY/CASUALTY

Section 3401. Insurable interest in property.

3402. Executory contract not a change in interest, title or possession.

3404. Fire insurance contracts; standard policy provisions; permissible variations.

3405. Fire insurance contract; losses from nuclear reaction or radiation.

3406. Copy of examination of insured to be delivered to insured.

3407. Property insurance; proofs of loss; notice of loss.

3407-a. Property/casualty insurance contract and policy standard provisions.

3408. Fire insurance; appraisal of loss; procedure for selection of umpire on failure to agree.

3409. Distribution of hazardous material report forms.

3410. Fire insurance contract; payment of liens on proceeds; certain cases.

3411. Automobile physical damage insurance covering private passenger automobiles; standard provisions; required inspections; duties of insurers and insureds.

3412. Automobile physical damage insurance covering private passenger automobiles; salvage; total losses; thefts; duties of insurers.

3413. Standard claim forms for fire losses.

3414. Reports by insurers of certain casualty loss on property owned or operated by religious organizations.

3415. Supplemental claim form to be submitted for certain fire loss claims in excess of ten thousand dollars in a city with a population of one million or more persons.

3416. Parametric insurance.

3420. Liability insurance; standard provisions; right of injured person.

3421. Homeowners' liability insurance; dogs.

3422. Hate crimes; coverage refusal.

3425. Certain property/casualty insurance policies; cancellation and renewal provisions; agents' contracts and brokers' accounts.

3426. Commercial lines insurance; cancellation and renewal provisions.

3427. Gap insurance; cancellation, renewal and other provisions.

3428. Cancellation of insurance contracts; return premiums; financed insurance premiums.

3429. Geographical location of risks; fire, fire and extended coverage policies; private passenger automobile insurance policies.

3429-a. Geographical location of risks in area serviced by a volunteer fire department; fire, fire and extended coverage policies.

3430. Right of insured, agent or broker aggrieved on basis of geographical location of property or risks.

3431. Immunity; insurers' reports to insureds, to applicants for insurance and to terminated agents or brokers.

3432. Immunity; reports to certain public officials and to designated organizations.

3433. Termination of contracts or accounts of licensed agents or brokers; prohibition; geographical location.

3434. Motor vehicle insurance policies; disabled persons; prohibitions against cancelling, refusing to issue or renew policies.

3435. Group property/casualty insurance.

3435-a. Motor vehicle insurance policies; New York state licensed drivers; prohibitions against refusing to issue policies or renew policies.

3436. Medical malpractice insurance; type of coverage.

3436*2. Group credit unemployment insurance and individual credit unemployment insurance.

3436-a. Adverse action against legal reproductive health care or gender-affirming care.

3437. Credit insurance for in-vitro fertilization or intrauterine insemination.

3439. Reinsurance contracts excepted.

3440. Insurance covering private passenger motor vehicles; rental vehicle coverage.

3442. Credit card, debit card, or checking account group policies.

3443. Workers' compensation and employers' liability insurance; optional policyholder deductibles.

3444. Flood insurance notice.

3445. Windstorm insurance notice; deductible trigger standards.

3446. Product or system group insurance policies.

3447. Qualification of environmental remediation insurance for

tax credit.
3448. Involuntary unemployment insurance policies.
3449. Wireless communications equipment insurance policies.
3450. Insurance for expenses incurred as a result of an act or threatened act of violence.
3451. Identity theft group insurance policies.
3451*2. Regulations.
3452. Group property travel insurance policies.
3453. Group policy for service providers listed in a commercial directory.
3453*2. Self-service storage company group insurance policies.
3453*3. Employer sponsored group personal excess insurance.
3454. Sponsored group personal insurance.
3455. Transportation network company group insurance policies.
3456. Prohibition against cancellation of policy when motor vehicle is used or operated through a transportation network company program.
3457. Group insurance policies for certain for hire motor vehicles.
3458. Electronic notices and documents.
3458*2. Group insurance for peer-to-peer car sharing programs.
3459. Car share exclusions for personal motor vehicle liability insurance policies.
3460. Prohibition against cancellation of policy when motor vehicle is used or operated through a peer-to-peer car sharing program.
3461. Notice of claim.
3462. Affordable housing underwriting and rating.

§ 3401. Insurable interest in property. No contract or policy of insurance on property made or issued in this state, or made or issued upon any property in this state, shall be enforceable except for the benefit of some person having an insurable interest in the property insured. In this article, "insurable interest" shall include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

§ 3402. Executory contract not a change in interest, title or possession. The making of a contract to sell or to exchange real property shall not constitute a change in the interest, title or possession, within the meaning of the applicable provisions of any contract of fire insurance, including any contract supplemental thereto, covering property located in this state.

§ 3404. Fire insurance contracts; standard policy provisions; permissible variations. (a) The printed form of a policy of fire insurance, as set forth in subsection (e) hereof, shall be known and designated as the "standard fire insurance policy of the state of New York."

(b) (1) No policy or contract of fire insurance shall be made, issued or delivered by any insurer or by any agent or representative thereof, on any property in this state, unless it shall conform as to all provisions, stipulations, agreements and conditions with such form of policy, except policies subject to the provisions of section three thousand one hundred two of this chapter which shall be required to comply with the provisions of paragraph one of subsection (f) of this section.

(2) There shall be printed or typewritten at the head of such policy the name and home office address of the insurer or insurers issuing the policy and a statement whether such insurer or insurers are stock or mutual corporations or are reciprocal insurers or Lloyds underwriters. In lieu of such statement a corporation organized under a special act of the legislature of any state may so indicate upon its policy. The head of the policy may also have such devices as the insurer or insurers issuing it desire.

(3) The standard fire insurance policy need not be used for effecting reinsurance between insurers.

(4) If the policy is issued by a mutual, cooperative or reciprocal insurer having special regulations with respect to the payment by the policyholder of assessments, such regulations shall be printed upon the policy, and any such insurer may print upon the policy such regulations

as may be appropriate to or required by its form of organization.

(c) Two or more insurers authorized to do the business of fire insurance in this state may, with the approval of the superintendent, issue a combination standard form of fire insurance policy which shall contain the following provisions:

(1) A provision substantially to the effect that the insurers executing such policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of such insurance under such policy.

(2) A provision substantially to the effect that service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing such policy, shall be deemed to be service upon all such insurers.

(d) (1) Appropriate forms of a supplemental contract or contracts or extended coverage endorsements insuring against one or more of the perils which the insurer is empowered to insure, in addition to the perils covered by such standard fire insurance policy, may be approved by the superintendent, who may authorize their use in connection with a standard fire insurance policy.

(2) The first page of the policy, in a form approved by the superintendent, may be rearranged to provide space for the listing of amounts of insurance, rates and premiums for the basic coverages insured under the standard form of policy and for additional coverages or perils insured under attached endorsements, and such other data as may be conveniently included for duplication on daily reports for office records.

(e) The form of the standard fire insurance policy of the state of New York (with permission to substitute for the word "company" a more accurate descriptive term for the type of insurer) shall be as follows:

FIRST PAGE OF STANDARD FIRE POLICY

No. .....

[Space for insertion of name of company or companies issuing the

policy and other matter permitted to be stated at the head of the policy.]

[Space for listing amounts of insurance, rates and premiums for the

basic coverages insured under the standard form of policy and for

additional coverages or perils insured under endorsements attached.]

In Consideration of the Provisions and Stipulations herein or added hereto and of ..... Dollars Premium this Company, for the term of ....., from the ..... day of ....., 19.. to the ..... day of ....., 19.. at noon, Standard Time, at location of property involved, does insure ..... and legal representatives, TO THE LESSER AMOUNT OF EITHER:

.1) THE ACTUAL CASH VALUE OF THE PROPERTY AT THE TIME OF THE LOSS, OR

2) THE AMOUNT WHICH IT WOULD COST TO REPAIR OR REPLACE THE PROPERTY WITH MATERIAL OF LIKE KIND AND QUALITY WITHIN A REASONABLE TIME AFTER SUCH LOSS, WITHOUT ALLOWANCE FOR ANY INCREASED COST OF REPAIR OR RECONSTRUCTION BY REASON OF ANY ORDINANCE OR LAW REGULATING CONSTRUCTION OR REPAIR, AND WITHOUT COMPENSATION FOR LOSS RESULTING FROM INTERRUPTION OF BUSINESS OR MANUFACTURE, OR

3) TO AN AMOUNT NOT EXCEEDING ..... DOLLARS, BUT IN ANY EVENT FOR NO MORE THAN THE INTEREST OF THE INSURED, AGAINST ALL DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations

and agreements as may be added hereto, as provided in this policy.
In Witness Whereof, this Company has executed and attested these presents; but this policy shall not be valid unless countersigned by the duly authorized Agent of this Company at .....
.....
.....

Secretary. President.

Countersigned this .... day of ....., 19 ....
Agent.

SECOND PAGE OF STANDARD FIRE POLICY

Concealment, fraud. This entire policy shall be void if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance. Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring
(a) while the hazard is increased by any means within the control or knowledge of the insured; or
(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or
(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be cancelled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be

cancelled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a

proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of

appraisal and umpire shall be paid by the parties equally.

Company's options. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment. There can be no abandonment to this Company of any property.

When loss payable. The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit. No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within twenty-four months next after inception of the loss.

Subrogation. This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

THIRD PAGE OF STANDARD FIRE POLICY

ATTACH FORM BELOW THIS LINE

BACK OF STANDARD FIRE POLICY

(OPTIONAL)

Standard Fire Insurance Policy of the States of

Expires _____

Property _____

Assured _____

No. _____

(COMPANY)

It is important that the written portions of all policies covering the same property read exactly alike. If they do not, they should be made uniform at once.

(f) (1) Subject to the approval of the superintendent, a policy which insures solely against the peril of fire or which insures against the peril of fire in combination with other kinds of insurance either for a divisible or indivisible premium need not comply with the provisions of subsection (e) of this section, provided:

(A) the policy contains, with respect to the peril of fire, terms and provisions no less favorable to the insured than those contained in the standard fire policy;

(B) the provisions in relation to mortgagee interests and obligations in such standard fire policy are incorporated without substantive change; and

(C) the policy or contract is complete as to all of its terms without reference to the standard form fire insurance policy or any other policy.

(2) Policies of automobile or aircraft physical damage insurance or policies of inland marine insurance may be issued as heretofore without reference to the limitations contained in paragraph one of this subsection.

(g) Notwithstanding any other provision of law to the contrary, the provisions of the appraisal clause set out on the second page of the standard fire policy and the provisions of section three thousand four hundred eight of this article, including determinations as to the amount of loss or damage rendered thereunder, shall be binding on all parties to the contract of insurance evidenced by the policy and may be enforced by either the insurer or the insured by application made pursuant to subsection (c) of section three thousand four hundred eight of this article.

(h) As used in this section, "binder" means a written document (1) which includes the name and address of the insured and any additional named insureds, mortgagees, or lienholders; a description of the property insured; a description of the nature and amount of coverage which shall be deemed to include the terms of the standard fire insurance policy except as conspicuously noted on the binder; the

identity of the insurer and of the authorized representative executing the binder; the effective date of coverage; the binder number or the policy number where applicable to a policy extension, and (2) which temporarily obligates the insurer to provide that insurance coverage pending issuance of the insurance policy. The cancellation of such a binder shall be governed at the minimum by the provisions of the standard fire insurance policy and the provisions of this chapter applicable thereto. No exempt organization, as defined in section five hundred ninety of the banking law, or licensed mortgage banker which originates mortgage loans shall, at the time of title closing for a loan secured by a one to four family residential real property, refuse to accept a binder, issued by an insurer, or a duly authorized representative of an insurer, licensed to do business in this state, as evidence that hazard insurance has been procured for the mortgaged premises. Nothing herein is intended to prohibit the mortgage banker or exempt organization from requiring the borrower to also furnish a receipt indicating that the annual or installment premium on such insurance policy has been paid.

§ 3405. Fire insurance contract; losses from nuclear reaction or radiation. (a) Insurers issuing the standard fire insurance policy pursuant to section three thousand four hundred four of this article are authorized to affix or include in the policy a written statement that such policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under such policy.

(b) This section shall not prohibit the attachment to any such policy of an endorsement specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

§ 3406. Copy of examination of insured to be delivered to insured. (a) If any policy or contract of insurance against loss or damage to property located in this state contains any provision requiring the insured to permit any examination by the insurer of the insured, or of a

member of his family, or of any employee of the insured, and if any such examination takes place and is reduced to writing, whether or not signed by the insured or by such person so examined, such insurer shall, within ten days from the time when the insured shall have requested the same in writing, deliver to the insured a copy of such examination so reduced to writing.

(b) If such copy is not delivered to the insured as required, no part of the examination shall be used by the insurer as a part of the proof of loss or damage or as evidence in any action or proceeding based upon or involving such policy or contract.

§ 3407. Property insurance; proofs of loss; notice of loss. (a) The failure of any person insured against loss or damage to property under any contract of insurance, issued or delivered in this state or covering property located in this state, to furnish proofs of loss to the insurer or insurers as specified in such contract shall not invalidate or diminish any claim of such person insured under such contract, unless such insurer or insurers shall, after such loss or damage, give to such insured a written notice that it or they desire proofs of loss to be furnished by such insured to such insurer or insurers on a suitable blank form or forms. If the insured shall furnish proofs of loss within sixty days after the receipt of such notice and such form or forms, or within any longer period of time specified in such notice, such insured shall be deemed to have complied with the provisions of such contract of insurance relating to the time within which proofs of loss are required. Neither the giving of such notice nor the furnishing of such blank form or forms by the insurer shall constitute a waiver of any stipulation or condition of such contract, or an admission of liability thereunder.

(b) If any contract of insurance issued or delivered in this state, covering loss of or damage to property by fire provides that the insured give immediate notice, in writing, to the insurer, of any loss or damage, it shall be sufficient compliance if immediate written notice is given, by or on behalf of the insured, to any licensed agent of the insurer in this state, with particulars sufficient to identify the insured and the property insured under such contract and to notify the insurer of the time and place of such loss or damage.

§ 3407-a. Property/casualty insurance contract and policy standard provisions. No property/casualty insurance policy or contract shall be issued or issued for delivery on a risk located or resident in this state insuring against damage to the insured's real property unless it contains in substance the following provision or a provision which is equal or more favorable to the insured: a provision that in the event of a pending claim for damage to real property, upon request, the insurer shall furnish to the insured's representative, designated in writing, or if none has been designated, to the insured, a copy of any written estimate or estimates of the cost of damages to real property resulting from the loss which the insurer has independently prepared for its own purposes, or had prepared on its behalf for its own purposes, specifying all appropriate deductions, within thirty days after the request or preparation, whichever is later, of such estimate or estimates. An insurer shall not be required to provide an estimate on claims for damages to real property unless it has independently prepared one or had one prepared on its behalf for the insurer's own purposes.

§ 3408. Fire insurance; appraisal of loss; procedure for selection of umpire on failure to agree. (a) Whenever application shall be made for the selection of an umpire pursuant to the provisions relating to appraisals contained in the standard fire insurance policy of the state of New York it shall be made to a justice of the supreme court residing in the county or to a county judge of the county in which the lost or damaged property is or was located. The application shall be on five days' notice in writing to the other party. Any such notice in writing, when served by the insured, may be served upon any local agent of the insurer.

(b) The court shall, on proof by affidavit of the failure or neglect of the appraisers to agree upon and select an umpire within the time provided in such policy, and of the service of notice pursuant to subsection (a) hereof, forthwith appoint a competent and disinterested person to act as such umpire in the ascertainment of the amount of such loss or damage.

(c) In the event of a covered loss, whenever an insured or insurer fails to proceed with an appraisal upon demand of the other, either party may apply to the court in the manner provided in subsection (a) of this section for an order directing the other to comply with such demand. An appraisal shall determine the actual cash value, the replacement cost, the extent of the loss or damage and the amount of the loss or damage which shall be determined as specified in the policy and shall proceed pursuant to the terms of the applicable appraisal clause of the insurance policy and not as an arbitration. Notwithstanding the provisions of this subsection, an appraisal shall not determine whether the policy actually provides coverage for any portion of the claimed loss or damage.

§ 3409. Distribution of hazardous material report forms. The superintendent shall require every insurance company issuing a policy of fire insurance against a risk located in this state to annually issue to each of its fire insurance policyholders engaged in commerce in this state a suitable supply of forms supplied by the office of fire prevention and control for reporting the presence of hazardous materials as required by section two hundred nine-u of the general municipal law.

§ 3410. Fire insurance contract; payment of liens on proceeds; certain cases. (a) Every fire insurance policy insuring the interest of an owner pursuant to this article shall include a statement that, prior to the payment of any proceeds thereunder otherwise payable to the insured for damages resulting to the premises from a loss occasioned by fire, the insurer will deduct and pay the claim of any tax district which renders a certificate of lien pursuant to the provisions of section three hundred thirty-one of this chapter.

(b) Such statement shall further relate that upon the payment of such claim the insurer shall, to the extent of such payment, be released from any obligation to pay the same to the insured and that the payment of any such claim within thirty days of receipt by the insurer of the certificate of lien shall, as between the insured and the insurer, operate as a conclusive presumption that such claim was valid and

properly paid.

§ 3411. * Automobile physical damage insurance covering private passenger automobiles; standard provisions; required inspections; duties of insurers and insureds.

* NB Effective until May 15, 2024

* Automobile physical damage insurance covering private passenger automobiles; standard provisions; inspections; duties of insurers and insureds.

* NB Effective May 15, 2024 until October 1, 2027

* Automobile physical damage insurance covering private passenger automobiles; standard provisions; required inspections; duties of insurers and insureds.

* NB Effective October 1, 2027

(a) The provisions of this section shall be applicable to all automobile physical damage insurance policies covering private passenger automobiles registered in this state, notwithstanding any other provisions of this chapter.

(b) In this article, "renewal" means the issuance and delivery by an insurer, at the end of the policy period, of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. Any policy with a policy period or term of less than one year shall, for the purpose of determining each renewal date in this section, be considered as if written for a policy period or term of one year commencing with the annual anniversary date, and any policy written for a period or term of more than one year or any policy with no fixed expiration date shall, for the purpose of this section, be considered as if written for successive policy periods or terms of one year commencing with the annual anniversary date.

(c) No policy providing automobile physical damage insurance for private passenger automobiles registered in this state shall be issued, delivered, or renewed unless it complies with this section.

* (d) A newly issued policy shall not provide coverage for automobile physical damage perils prior to an inspection of the automobile by the insurer.

* NB Effective until May 15, 2024

* (d) A newly issued policy shall not provide coverage for automobile physical damage perils prior to an inspection of the automobile by the insurer, unless the insurer has waived the right to such inspection pursuant to a statement of operation filed with the superintendent. In its statement of operation, an insurer may waive the right to inspect some or all automobiles. Every statement of operation shall take effect upon its filing with the superintendent and may cover some or all automobiles.

* NB Effective May 15, 2024 until October 1, 2027

* (d) A newly issued policy shall not provide coverage for automobile physical damage perils prior to an inspection of the automobile by the insurer.

* NB Effective October 1, 2027

(e) For a renewal of a policy referred to in subsection (d) of this section, an insurer may require, as a condition of such renewal, that the automobile be made available for inspection.

(f) If an insurer requests an inspection pursuant to subsection (e) of this section, the insured shall make the automobile available for inspection by the insurer, upon reasonable notice. If the insured fails to make the automobile available for inspection, the insurer may refuse to continue such physical damage coverage.

* (g) If an automobile subject to the provisions of this section is acquired by the insured as a replacement for or an addition to an automobile insured for physical damage coverage, and the insured requests physical damage coverage for the replacement or additional automobile, such coverage for physical damage shall not be effective before such inspection is made. If, at the time of the request for such coverage, the automobile is unavailable for inspection because of conditions of purchase or other circumstances and is thereafter made available for inspection, the insurer shall promptly inspect the automobile, and physical damage coverage shall not become effective before the inspection has been made.

* NB Effective until May 15, 2024

* (g) If an automobile subject to the provisions of this section is acquired by the insured as a replacement for or an addition to an automobile insured for physical damage coverage, and the insured

requests physical damage coverage for the replacement or additional automobile, such coverage for physical damage shall not be effective before such inspection is made, unless the insurer has waived the right to such an inspection pursuant to a statement of operation filed with the superintendent. If, at the time of the request for such coverage, the automobile is unavailable for inspection because of conditions of purchase or other circumstances and is thereafter made available for inspection, the insurer shall promptly inspect the automobile, and physical damage coverage shall not become effective before the inspection has been made.

* NB Effective May 15, 2024 until October 1, 2027

* (g) If an automobile subject to the provisions of this section is acquired by the insured as a replacement for or an addition to an automobile insured for physical damage coverage, and the insured requests physical damage coverage for the replacement or additional automobile, such coverage for physical damage shall not be effective before such inspection is made. If, at the time of the request for such coverage, the automobile is unavailable for inspection because of conditions of purchase or other circumstances and is thereafter made available for inspection, the insurer shall promptly inspect the automobile, and physical damage coverage shall not become effective before the inspection has been made.

* NB Effective October 1, 2027

(h) Where an inspection is made pursuant to this section, it shall be conducted by the insurer or its authorized representative and shall be recorded on a form prescribed by the superintendent. Such form shall be retained by the insurer with its policy records for such insured, and a copy of such form shall be made available to the insured upon request.

(i) Payment of a physical damage claim shall not be conditioned upon the repair of the automobile, provided, however, the insured shall replace any inflatable restraint system (airbag), as defined in subparagraph (b) of S 4.1.5.1 of standard 208 of part 571 of title 49 of the code of federal regulations, that inflated and deployed, or that was stolen, which is included in a physical damage or theft claim. The insurer may request that the automobile be made available for inspection whether or not the automobile is repaired. The results of such inspection may form a basis for determining the value of the automobile

in the event of a subsequent loss. If the automobile is repaired the insurer shall request the repair invoice and shall require the insured and the automobile repairer to certify, under penalties of perjury, whether the applicable deductible has been paid to the automobile repairer, whether any repairs have been made and whether the repairs did not include all items allowed by the insurer.

(j) The superintendent may approve policy forms for physical damage coverage, for new and renewable business, which exclude coverage for specified items of personal property located in or upon the automobile.

(k) Each insurer which offers physical damage insurance subject to the provisions of this section shall offer such insurance with a standard deductible of two hundred dollars for each occurrence. The insured shall, however, at the inception of the policy or at the annual anniversary date, or at the time of the replacement or addition of an automobile, have the option of purchasing a policy with a lesser deductible, but in no event may the insurer sell a policy with a deductible of less than fifty dollars for fire, theft or comprehensive insurance coverages (one hundred dollars for assigned risk policies issued pursuant to paragraph two of subsection (a) of section five thousand three hundred three of this chapter) and one hundred dollars for collision insurance coverage except that window glass coverage may be sold without a deductible. Each insurer which offers physical damage insurance subject to the provisions of this section shall also offer physical damage coverages with co-insurance or deductible provisions or combinations thereof as the superintendent may prescribe, including but not limited to deductibles of two hundred fifty dollars, five hundred dollars and one thousand dollars.

(l) Every insurer subject to the provisions of this section shall report to the commissioner of motor vehicles any evidence of overcharges, improper repairs or adjustments or other wrongdoing by motor vehicle repair shops, in order that the department of motor vehicles may properly discharge its responsibilities under the vehicle and traffic law to protect consumers from dishonest, deceptive and fraudulent practices in the repair of automobiles, to protect the public from improper repairs and to eliminate unqualified motor vehicle repair shops.

* (m) (1) The superintendent, in regulations implementing the

provisions of this section, shall also require that insurers take appropriate action to ensure that there is wide public dissemination of the provisions of this section relating to the rights and obligations of insureds and insurers.

(2) The inspections provided for in this section may be dispensed with or deferred under circumstances specified in regulations of the superintendent. Such circumstances may include but are not limited to, the insuring of a new automobile, the insuring of an automobile whose inspection would constitute a serious hardship to the insurer, the insured or an applicant for insurance, and the insuring of an automobile for a limited specified period of time.

(3) Inspections made pursuant to this section shall be made at locations and times reasonably convenient to the insured. The results of any inspection may be considered in determining the value of the automobile.

* NB Effective until May 15, 2024

* (m) (1) The superintendent, in regulations implementing the provisions of this section, shall also require that insurers take appropriate action to ensure that there is wide public dissemination of the provisions of this section relating to the rights and obligations of insureds and insurers.

(2) The inspections provided for in this section may be dispensed with or deferred by an insurer under circumstances specified in their statement of operation filed with the superintendent or in regulations of the superintendent. Such circumstances may include but are not limited to, the insuring of a new automobile, the insuring of an automobile whose inspection would constitute a serious hardship to the insurer, the insured or an applicant for insurance, and the insuring of an automobile for a limited specified period of time.

(3) Inspections made pursuant to this section shall be made at locations and times reasonably convenient to the insured. The results of any inspection may be considered in determining the value of the automobile.

* NB Effective May 15, 2024 until October 1, 2027

* (m) (1) The superintendent, in regulations implementing the provisions of this section, shall also require that insurers take appropriate action to ensure that there is wide public dissemination of

the provisions of this section relating to the rights and obligations of insureds and insurers.

(2) The inspections provided for in this section may be dispensed with or deferred under circumstances specified in regulations of the superintendent. Such circumstances may include but are not limited to, the insuring of a new automobile, the insuring of an automobile whose inspection would constitute a serious hardship to the insurer, the insured or an applicant for insurance, and the insuring of an automobile for a limited specified period of time.

(3) Inspections made pursuant to this section shall be made at locations and times reasonably convenient to the insured. The results of any inspection may be considered in determining the value of the automobile.

* NB Effective October 1, 2027

(n) If the superintendent, after notice and hearing, finds that any insurer or its authorized representative has violated any provision of this section, he shall order the payment of a penalty, not to exceed five hundred dollars for each such offense. Each issuance, procurement or negotiation of a policy of insurance in violation of this section shall be a separate offense.

§ 3412. Automobile physical damage insurance covering private passenger automobiles; salvage; total losses; thefts; duties of insurers. (a) Notwithstanding any other provision of this chapter, the provisions of this section shall be applicable to all physical damage losses incurred on policies covering private passenger automobiles registered in this state for model year nineteen hundred seventy-three or later.

(b) In accordance with regulations of the superintendent insurers shall, except where the insured is permitted to retain the automobile as part of the claim settlement, take possession of any salvage and the certificate of title, properly endorsed to them of private automobiles whenever a loss is determined by the insurer to be a total loss or a constructive total loss. Insurers, in disposing of the salvage, shall fully comply with the requirements of section four hundred twenty-nine of the vehicle and traffic law. An insurer shall also have the right,

where a claim is filed for the replacement of an inflated and deployed or stolen inflatable restraint system (air bag), as defined in subparagraph (b) of S 4.1.5.1 of standard 208 of part 571 of title 49 of the code of federal regulations, to inspect the vehicle for which the claim is being filed to verify that the air bag did inflate and deploy or was stolen. The insurer shall also have the right to take possession of a deployed airbag.

(c) Except with respect to vehicles recovered after a theft loss has been paid and which meet the criteria set forth in subdivision two of section four hundred thirty of the vehicle and traffic law, insurers shall not, directly or indirectly, transfer within or without this state any vehicle for salvage, except to a governmental agency, an automobile dealer, a vehicle dismantler, or a scrap processor licensed, registered or certified in accordance with the provisions of the vehicle and traffic law, or any such person meeting licensing, registration or certification requirements of the state in which such person does business. An insurer or its agents shall not purchase salvage vehicles or used major component parts of motor vehicles except from a registered vehicle dismantler or an automobile dealer.

(d) Insurers shall report private passenger automobiles involved in total losses, including the vehicle identification number and such other information as may be required, to a central organization engaged in automobile loss prevention as designated by the superintendent, in accordance with regulations of the superintendent. The central organization shall also be responsible for recording any special vehicle identification number issued by the commissioner of motor vehicles pursuant to subdivision two of section four hundred thirty-one of the vehicle and traffic law and in accordance with regulations of the superintendent.

(e) Prior to the payment of total losses, insurers shall comply with verification procedures in accordance with regulations of the superintendent.

(f) Police and other law enforcement agencies charged with the investigation of automobile thefts shall promptly report to the owner of the automobile and the central organization designated by the superintendent, all locations of private passenger automobiles reported stolen or found to be abandoned. In accordance with regulations of the

superintendent, the central organization shall be responsible for receiving and recording such reports, and shall promptly transmit such information to the insurer of the automobile physical damage coverage.

(g) All policies providing automobile physical damage coverage shall include a provision authorizing the insurer to take the insured motor vehicle into custody for safekeeping, when notified that the motor vehicle reported stolen or found to be abandoned has been located.

(h) (1) The central organization designated by the superintendent and each insurer authorized to issue automobile comprehensive insurance policies covering losses incurred to private passenger vehicles shall upon request of any appropriate law enforcement agency or insurance organization engaged in automobile loss prevention release information in its possession resulting from an investigation conducted by it pertaining to such comprehensive loss, including information as such agency or organization deems related to its investigation. Should a central organization or the insurer be of the opinion that the loss was caused by any criminal or fraudulent act of any person or organization, or that an improper action occurred in the disposition of automobiles subject to the provisions of this section, it shall notify the appropriate law enforcement agency or insurance organization engaged in automobile loss prevention of that opinion, and it shall notify the department of financial services or department of motor vehicles of any improper action of their respective licensees or registrants.

(2) Any information or evidence furnished pursuant to this subsection shall be held in confidence by the appropriate agency or insurance organization engaged in automobile loss prevention, until such information is required to be released pursuant to a criminal proceeding, or if such agency or organization shall be served a summons or subpoena to testify as to any information or evidence in its possession regarding such automobile comprehensive loss in any civil action where an insured or other person is seeking recovery under a policy against an insurer for such loss.

§ 3413. Standard claim forms for fire losses. (a) (1) On or before April first, nineteen hundred eighty-two, the superintendent shall establish a standard claim form to be used for all fire loss claims

under an insurance policy which is issued or issued for delivery in this state covering such losses for property located in this state.

(2) The superintendent shall investigate and review claim forms which are currently utilized prior to establishing such standard claim form.

(3) All insurers shall require the completion and filing of the standard claim form.

(b) The adoption of such standard claim form by the superintendent shall not preclude an insurer from obtaining any necessary additional information regarding a claim from the claimant or any other source.

(c) (1) The superintendent is authorized and empowered to take such action as he shall deem appropriate for the proper implementation hereof and to provide by regulation that any form which does not comply with this section shall not be issued or reissued.

(2) The regulation so promulgated shall specify an effective date, which shall not be less than one hundred eighty days after the date of promulgation, after which no insurer may require any claimant to complete a form differing from the one prescribed by the superintendent, other than additional requests for information pursuant to subsection (b) of this section.

§ 3414. Reports by insurers of certain casualty loss on property owned or operated by religious organizations. (a) Insurers shall report all claims in excess of two hundred fifty dollars filed for casualty losses resulting from desecration, vandalism and theft of religious articles sustained by a "Religious Corporations Law corporation", "incorporated church" or "unincorporated church", as such terms are defined in section two of the religious corporations law, to the division of criminal justice services for a period of twelve months commencing with the effective date of the rules and regulations required to be promulgated pursuant to subsection (b) of this section.

(b) Such division shall promulgate rules and regulations within ninety days of the effective date of this section detailing the contents of such reports which shall require at least the following information:

(1) name and address of the claimant;

(2) nature, substance and approximate dollar value of the claim;

(3) date and specific place in which the claim arose.

§ 3415. Supplemental claim form to be submitted for certain fire loss claims in excess of ten thousand dollars in a city with a population of one million or more persons. (a) For the purposes of this section, the following terms shall have the following meanings:

(1) "Supplemental claim form" means a form which shall be established by the superintendent and which shall be used as provided in this section for fire loss claims. The superintendent shall, within one hundred twenty days, promulgate regulations for the implementation of the supplemental claim form as provided herein.

(2) "Local fire investigation agency" or "agency" means an officer or agency of a city with a population of one million or more persons designated by the mayor of such city.

(3) "Fire loss claim" means a claim for fire loss in excess of ten thousand dollars under a policy covering real property located in a city with a population of one million or more persons, property permanently affixed to such real property or personal property, except motor vehicles, located on or within such real property against the perils of fire or explosion which is issued or issued for delivery in this state.

(b) Within thirty days after the effective date of this section, the mayor of a city with a population of one million or more persons shall designate a local fire investigation agency. Within sixty days after such designation the local fire investigation agency shall establish and shall thereafter maintain a central registry of those fires and explosions in such city which have been determined to be incendiary.

(c) All fire loss claims filed by an insured or an insured's representative after the effective date of a regulation promulgated by the superintendent establishing a supplemental claim form shall be subject to the provisions of this section.

(d) Within seven days after the receipt of a fire loss claim, the insurer shall contact the central registry maintained by the local fire investigation agency for information as to whether the fire or explosion which is the subject of the claim has been determined to be incendiary.

(e) Within seven days after the receipt of such request the local fire investigation agency shall advise the insurer whether or not the fire or explosion has been determined to be incendiary. If within such seven day

period the agency advises the insurer that the fire or explosion has been determined to be incendiary, unless the insurer is reasonably satisfied that neither the insured nor any of its agents, officers, directors, or persons in control of or controlled by the insured intentionally started the fire or cause the explosion or acted in concert with another individual to start the fire or cause the explosion, the insurer shall require the insured to submit a supplemental claim form and shall withhold payment of the claim until a completed supplemental claim form has been received.

(f) The withholding of any payment pursuant to this section shall not constitute an unfair claim settlement practice within the meaning of section two thousand six hundred one of this chapter or any implementing regulation thereof.

(g) Within twenty days after receiving a completed supplemental claim form from an insured, the insurer shall file a copy with the local fire investigation agency.

(h) Supplemental claim forms shall not be subject to public disclosure under the freedom of information law or any other law which requires public disclosure of records maintained by a governmental agency.

(i) The supplemental claim form shall require the insured to provide the insurer with the following information:

(1) the name and address of the insured and of all persons with an interest of five percent or more in the proceeds of the claim;

(2) the names and addresses of all persons with an ownership interest in the property, any mortgagee, vendee in possession, receiver, executor or trustee;

(3) if any of the persons described in paragraphs one and two of this subsection is a trustee, the names and addresses of the beneficiaries of the trust;

(4) if any of the persons described in paragraphs one and two of this subsection is a partnership, the names and addresses of all the partners, including limited partners;

(5) if any of the persons described in paragraphs one and two of this subsection is a corporation (other than a banking organization as defined in section two of the banking law, a national bank association, a federal savings and loan association, the mortgage facilities corporation, savings bank life insurance fund, the savings bank

retirement system, an authorized insurer as defined in section one hundred seven of this chapter or a trust company or other corporation organized under the laws of this state all the capital stock of which is owned by at least twenty savings banks or by at least twenty savings and loan associations or a subsidiary corporation all of the capital stock of which is owned by such trust company or other corporation or a corporation the shares of which are listed on a national securities exchange or regularly quoted in over-the-counter market by one or more members of a national or affiliated securities association) the names and addresses of all officers, directors and persons having an interest in more than ten percent of the issued and outstanding stock of the corporation.

(j) For the purposes of section 176.05 of the penal law, a supplemental claim form shall be considered to be a part of a claim for payment or benefit pursuant to an insurance policy and the information required in such form shall be considered to be material thereto.

§ 3416. Parametric insurance. (a) Except as provided in subsection (b) of this section, an insurer that issues a parametric insurance policy shall disclose the following information in the application for the insurance policy and in a prominent writing upon policy issuance and renewal:

(1) the policy is not a substitute for property insurance or flood insurance, as relevant, which generally provide more comprehensive coverage in the event of a loss; and

(2) a mortgagee or loss payee may not accept a parametric insurance policy.

(b) An excess line broker who procures a parametric insurance policy pursuant to section two thousand one hundred five of this chapter shall provide the disclosures required by subsection (a) of this section on behalf of the insurer.

§ 3420. Liability insurance; standard provisions; right of injured person. (a) No policy or contract insuring against liability for injury to person, except as provided in subsection (g) of this section, or

against liability for injury to, or destruction of, property shall be issued or delivered in this state, unless it contains in substance the following provisions or provisions that are equally or more favorable to the insured and to judgment creditors so far as such provisions relate to judgment creditors:

(1) A provision that the insolvency or bankruptcy of the person insured, or the insolvency of the insured's estate, shall not release the insurer from the payment of damages for injury sustained or loss occasioned during the life of and within the coverage of such policy or contract.

(2) A provision that in case judgment against the insured or the insured's personal representative in an action brought to recover damages for injury sustained or loss or damage occasioned during the life of the policy or contract shall remain unsatisfied at the expiration of thirty days from the serving of notice of entry of judgment upon the attorney for the insured, or upon the insured, and upon the insurer, then an action may, except during a stay or limited stay of execution against the insured on such judgment, be maintained against the insurer under the terms of the policy or contract for the amount of such judgment not exceeding the amount of the applicable limit of coverage under such policy or contract.

(3) A provision that notice given by or on behalf of the insured, or written notice by or on behalf of the injured person or any other claimant, to any licensed agent of the insurer in this state, with particulars sufficient to identify the insured, shall be deemed notice to the insurer.

(4) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, an injured person or any other claimant if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible thereafter.

(5) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, injured person or any other claimant, unless the failure to provide timely notice has prejudiced the insurer, except as provided in paragraph four of this subsection. With respect to

a claims-made policy, however, the policy may provide that the claim shall be made during the policy period, any renewal thereof, or any extended reporting period, except as provided in paragraph four of this subsection. As used in this paragraph, the terms "claims-made policy" and "extended reporting period" shall have their respective meanings as provided in a regulation promulgated by the superintendent.

(6) A provision that, with respect to a claim arising out of death or personal injury of any person, if the insurer disclaims liability or denies coverage based upon the failure to provide timely notice, then the injured person or other claimant may maintain an action directly against such insurer, in which the sole question is the insurer's disclaimer or denial based on the failure to provide timely notice, unless within sixty days following such disclaimer or denial, the insured or the insurer: (A) initiates an action to declare the rights of the parties under the insurance policy; and (B) names the injured person or other claimant as a party to the action.

(b) Subject to the limitations and conditions of paragraph two of subsection (a) of this section, an action may be maintained by the following persons against the insurer upon any policy or contract of liability insurance that is governed by such paragraph, to recover the amount of a judgment against the insured or his personal representative:

(1) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured's personal representative, for damages for injury sustained or loss or damage occasioned during the life of the policy or contract;

(2) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured's personal representative to enforce a right of contribution or indemnity, or any person subrogated to the judgment creditor's rights under such judgment; and

(3) any assignee of a judgment obtained as specified in paragraph one or paragraph two of this subsection, subject further to the limitation contained in section 13-103 of the general obligations law.

(c) (1) If an action is maintained against an insurer under the provisions of paragraph two of subsection (a) of this section and the insurer alleges in defense that the insured failed or refused to cooperate with the insurer in violation of any provision in the policy

or contract requiring such cooperation, then the burden shall be upon the insurer to prove such alleged failure or refusal to cooperate.

(2)(A) In any action in which an insurer alleges that it was prejudiced as a result of a failure to provide timely notice, the burden of proof shall be on: (i) the insurer to prove that it has been prejudiced, if the notice was provided within two years of the time required under the policy; or (ii) the insured, injured person or other claimant to prove that the insurer has not been prejudiced, if the notice was provided more than two years after the time required under the policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an irrebuttable presumption of prejudice shall apply if, prior to notice, the insured's liability has been determined by a court of competent jurisdiction or by binding arbitration; or if the insured has resolved the claim or suit by settlement or other compromise.

(C) The insurer's rights shall not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim.

(d)(1)(A) This paragraph applies with respect to a liability policy that provides coverage with respect to a claim arising out of the death or bodily injury of any person, where the policy is: (i) subject to section three thousand four hundred twenty-five of this article, other than an excess liability or umbrella policy; or (ii) used to satisfy a financial responsibility requirement imposed by law or regulation.

(B) Upon an insurer's receipt of a written request by an injured person who has filed a claim or by another claimant, an insurer shall, within sixty days of receipt of the written request: (i) confirm to the injured person or other claimant in writing whether the insured had a liability insurance policy of the type specified in subparagraph (A) of this paragraph in effect with the insurer on the date of the alleged occurrence; and (ii) specify the liability insurance limits of the coverage provided under the policy.

(C) If the injured person or other claimant fails to provide sufficient identifying information to allow the insurer, in the exercise of reasonable diligence, to identify a liability insurance policy that may be relevant to the claim, the insurer shall within forty-five days of receipt of the written request, so advise the injured person or other

claimant in writing and identify for the injured person or other claimant the additional information needed. Within forty-five days of receipt of the additional information, the insurer shall provide the information required under subparagraph (B) of this paragraph.

(2) If under a liability policy issued or delivered in this state, an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of a motor vehicle accident or any other type of accident occurring within this state, it shall give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant.

(e) No policy or contract of personal injury liability insurance or of property damage liability insurance, covering liability arising from the ownership, maintenance or operation of any motor vehicle or of any vehicle as defined in section three hundred eighty-eight of the vehicle and traffic law, or an aircraft, or any vessel as defined in section forty-eight of the navigation law, shall be issued or delivered in this state to the owner thereof, or shall be issued or delivered by any authorized insurer upon any such vehicle or aircraft or vessel then principally garaged or principally used in this state, unless it contains a provision insuring the named insured against liability for death or injury sustained, or loss or damage occasioned within the coverage of the policy or contract, as a result of negligence in the operation or use of such vehicle, aircraft or vessel, as the case may be, by any person operating or using the same with the permission, express or implied, of the named insured.

(f) (1) No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any natural person arising out of the ownership, maintenance and use of a motor vehicle or an altered motor vehicle commonly referred to as a "stretch limousine" having a seating capacity of eight or more passengers used in the business of carrying or transporting passengers for hire, by the insured shall be issued or delivered by any authorized insurer upon any motor vehicle or an altered motor vehicle commonly referred to as a "stretch limousine" having a seating capacity of eight or more passengers used in the business of carrying or transporting passengers for hire, then principally garaged or principally used in this state unless it contains a provision whereby the insurer agrees that it will pay to the insured,

as defined in such provision, subject to the terms and conditions set forth therein to be prescribed by the board of directors of the Motor Vehicle Accident Indemnification Corporation and approved by the superintendent, all sums, not exceeding a maximum amount or limit of twenty-five thousand dollars exclusive of interest and costs, on account of injury to and all sums, not exceeding a maximum amount or limit of fifty thousand dollars exclusive of interest and costs, on account of death of one person, in any one accident, and the maximum amount or limit, subject to such limit for any one person so injured of fifty thousand dollars or so killed of one hundred thousand dollars, exclusive of interest and costs, on account of injury to, or death of, more than one person in any one accident, which the insured or his legal representative shall be entitled to recover as damages from an owner or operator of an uninsured motor vehicle, unidentified motor vehicle which leaves the scene of an accident, a motor vehicle registered in this state as to which at the time of the accident there was not in effect a policy of liability insurance, a stolen vehicle, a motor vehicle operated without permission of the owner, an insured motor vehicle where the insurer disclaims liability or denies coverage or an unregistered vehicle because of bodily injury, sickness or disease, including death resulting therefrom, sustained by the insured, caused by accident occurring in this state and arising out of the ownership, maintenance or use of such motor vehicle. No payment for non-economic loss shall be made under such policy provision to a covered person unless such person has incurred a serious injury, as such terms are defined in section five thousand one hundred two of this chapter. Such policy shall not duplicate any element of basic economic loss provided for under article fifty-one of this chapter. No payments of first party benefits for basic economic loss made pursuant to such article shall diminish the obligations of the insurer under this policy provision for the payment of non-economic loss and economic loss in excess of basic economic loss. Notwithstanding any inconsistent provisions of section three thousand four hundred twenty-five of this article, any such policy which does not contain the aforesaid provisions shall be construed as if such provisions were embodied therein.

(2) (A) Any such policy shall, at the option of the insured, also provide supplementary uninsured/underinsured motorists insurance for

bodily injury, in an amount up to the bodily injury liability insurance limits of coverage provided under such policy, subject to a maximum of two hundred fifty thousand dollars because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to five hundred thousand dollars because of bodily injury to or death of two or more persons in any one accident, or a combined single limit policy of five hundred thousand dollars because of bodily injury to or death of one or more persons in any one accident; and any such policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any natural person arising out of the ownership, maintenance, and use of an altered motor vehicle commonly referred to as a "stretch limousine" having a seating capacity of eight or more passengers used in the business of carrying or transporting passengers for hire, shall provide supplementary uninsured/underinsured motorists insurance for bodily injury, in an amount of a combined single limit of one million five hundred thousand dollars because of bodily injury or death of one or more persons in any one accident. Provided however, an insurer issuing any such policy, except a policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any natural person arising out of the ownership, maintenance, and use of an altered motor vehicle commonly referred to as a "stretch limousine" having a seating capacity of eight or more passengers used in the business of carrying or transporting passengers for hire, in lieu of offering to the insured the coverages stated above, may provide supplementary uninsured/underinsured motorists insurance for bodily injury, in an amount up to the bodily injury liability insurance limits of coverage provided under such policy, subject to a maximum of one hundred thousand dollars because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to three hundred thousand dollars because of bodily injury to or death of two or more persons in any one accident, or a combined single limit policy of three hundred thousand dollars because of bodily injury to or death of one or more persons in any one accident, if such insurer also makes available a personal umbrella policy with liability coverage limits up to at least five hundred thousand dollars which also provides coverage for supplementary uninsured/underinsured motorists claims. Supplementary

uninsured/underinsured motorists insurance shall provide coverage, in any state or Canadian province, if the limits of liability under all bodily injury liability bonds and insurance policies of another motor vehicle liable for damages are in a lesser amount than the bodily injury liability insurance limits of coverage provided by such policy. Upon written request by any insured covered by supplemental uninsured/underinsured motorists insurance or his duly authorized representative and upon disclosure by the insured of the insured's bodily injury and supplemental uninsured/underinsured motorists insurance coverage limits, the insurer of any other owner or operator of another motor vehicle against which a claim has been made for damages to the insured shall disclose, within forty-five days of the request, the bodily injury liability insurance limits of its coverage provided under the policy or all bodily injury liability bonds. The time of the insured to make any supplementary uninsured/underinsured motorist claim, shall be tolled during the period the insurer of any other owner or operator of another motor vehicle that may be liable for damages to the insured, fails to so disclose its coverage. As a condition precedent to the obligation of the insurer to pay under the supplementary uninsured/underinsured motorists insurance coverage, the limits of liability of all bodily injury liability bonds or insurance policies applicable at the time of the accident shall be exhausted by payment of judgments or settlements. As used in this subsection, "motor vehicle" shall include fire vehicles, as defined in section one hundred fifteen-a of the vehicle and traffic law, and police vehicles, as defined in section one hundred thirty-two-a of the vehicle and traffic law.

(B) In addition to the notice provided, upon issuance of a policy of motor vehicle liability insurance pursuant to regulations promulgated by the superintendent, insurers shall notify insureds, in writing, of the availability of supplementary uninsured/underinsured motorists coverage. Such notification shall contain an explanation of supplementary uninsured/underinsured motorists coverage and the amounts in which it can be purchased. Subsequently, a notification of availability shall be provided at least once a year and may be simplified pursuant to regulations promulgated by the superintendent, but must include a concise statement that supplementary uninsured/underinsured motorists coverage is available, an explanation of such coverage, and the coverage

limits that can be purchased from the insurer.

* (2-a) (A) Notwithstanding paragraph two of this subsection, this paragraph shall apply to any new insurance policy or contract subject to this subsection entered into after the effective date of this paragraph. This paragraph shall not be deemed to apply to any policies originally entered into prior to the effective date of this paragraph, but renewed after the effective date of this paragraph, or to any policy of commercial risk insurance. Any new insurance policy or contract entered into after the effective date of this paragraph shall, at the option of the first named insured, also provide supplementary uninsured/underinsured motorists insurance for bodily injury, in an amount equal to the bodily injury liability insurance limits of coverage provided under such motor vehicle liability insurance policy; provided, however, that a first named insured may exercise the choice to decline such supplementary uninsured/underinsured motorists insurance or select a lower amount of coverage through a written waiver signed, or electronically signed, by such insured, subject to the requirements of subparagraph (B) of this paragraph. Supplementary uninsured/underinsured motorists insurance shall provide coverage, in any state or Canadian province, if the limits of liability under all bodily injury liability bonds and insurance policies of any other motor vehicle liable for damages are in a lesser amount than the bodily injury liability insurance limits of coverage provided by such policy. Upon written request by any insured covered by supplemental uninsured/underinsured motorists insurance or a duly authorized representative and upon disclosure by the insured of the insured's bodily injury and supplemental uninsured/underinsured motorists insurance coverage limits, the insurer of any other owner or operator of another motor vehicle against which a claim has been made for damages to the insured shall disclose, within forty-five days of the request, the bodily injury liability insurance limits of its coverage provided under the policy or all bodily injury liability bonds. The time of the insured to make any supplementary uninsured/underinsured motorist claim, shall be tolled during the period the insurer of any other owner or operator of another motor vehicle that may be liable for damages to the insured, fails to so disclose its coverage. As a condition precedent to the obligation of the insurer to pay under the supplementary uninsured/underinsured motorists

insurance coverage, the limits of liability of all bodily injury liability bonds or insurance policies applicable at the time of the accident shall be exhausted by payment of judgments or settlements.

(B) In addition to the notice provided, upon issuance of a policy of motor vehicle liability insurance pursuant to regulations promulgated by the superintendent, insurers shall notify insureds, in writing, of the availability of supplementary uninsured/underinsured motorists coverage. Such notification shall contain an explanation of supplementary uninsured/underinsured motorists coverage and the amounts in which it can be purchased. Subsequently, a notification of availability shall be provided at least once a year and may be simplified pursuant to regulations promulgated by the superintendent, but must include a concise statement that supplementary uninsured/underinsured motorists coverage is available, an explanation of such coverage, and the coverage limits that can be purchased from the insurer. If an insured elects to reject supplementary uninsured/underinsured motorist coverage or select a lower amount of supplementary uninsured/underinsured motorist coverage than the bodily injury liability insurance limits of coverage provided under the insured's motor vehicle liability insurance policy, the selection of lower supplementary uninsured/underinsured motorists coverage or rejection of such coverage must be made on a written or electronic form provided to the first named insured. Such form shall also advise that such coverage is equal to the insured's bodily injury liability limits under the motor vehicle liability insurance policy unless lower limits are requested or the coverage is rejected.

(i) The form shall also advise that supplementary uninsured/underinsured motorists coverage (sum coverage) provides insurance protection for any person included as insured under your policy if he or she is injured in an accident involving another motor vehicle whose owner or operator was negligent but who has either no bodily injury or liability insurance, or less than the insurance you carry. Sum coverage shall be equal to the level of the bodily injury liability coverage of your motor vehicle liability insurance policy unless you sign a waiver requesting lower coverage or declining the coverage. You are urged to carefully consider this decision.

(ii) An insured's written waiver shall apply to all subsequent renewals of coverage and to all policies or endorsements which extend,

change, supersede, or replace an existing policy issued to the named insured, unless changed in writing by any named insured.

(iii) The selection of lower supplementary uninsured/underinsured motorists coverage or the rejection of such coverage by any first named insured shall be binding upon all insureds under such policy.

(C) Notwithstanding the provisions of subparagraph (A) of this paragraph, at the insurer's option, the insured's supplementary uninsured/underinsured motorists coverage limit may be required to equal the insured's bodily injury liability insurance limit under the motor vehicle liability insurance policy.

(D) An insurer may provide the coverage described in this paragraph available in an umbrella or excess liability policy if the umbrella or excess liability policy expressly provides such coverage.

* NB Repealed June 30, 2029

(3) The protection provided by this subsection shall not apply to any cause of action by an insured person arising out of a motor vehicle accident occurring in this state against a person whose identity is unascertainable, unless the bodily injury to the insured person arose out of physical contact of the motor vehicle causing the injury with the insured person or with a motor vehicle which the insured person was occupying (meaning in or upon or entering into or alighting from) at the time of the accident.

(4) An insurer shall give notice to the commissioner of motor vehicles of the entry of any judgment upon which a claim is made against such insurer under this subsection and of the payment or settlement of any claim by the insurer.

(5) This paragraph shall apply to a policy that provides supplementary uninsured/underinsured motorist insurance coverage for bodily injury and is a policy: (A) issued or delivered in this state that insures against liability arising out of the ownership, maintenance, and use of a fire vehicle, as defined in section one hundred fifteen-a of the vehicle and traffic law, where the fire vehicle is principally garaged or used in this state, or a police vehicle, as defined in section one hundred thirty-two-a of the vehicle and traffic law, where the police vehicle is principally garaged or used in this state; or (B) as specified in paragraph one of this subsection. Every such policy that insures a fire department, fire company, as defined in section one hundred of the

general municipal law, an ambulance service, a voluntary ambulance service, as defined in section three thousand one of the public health law, or a police agency, as defined in section eight hundred thirty-five of the executive law, shall provide such supplementary uninsured/underinsured motorist insurance coverage to an individual employed by or who is a member of the fire department, fire company, ambulance service, voluntary ambulance service, or police agency and who is injured by an uninsured or underinsured motor vehicle while acting in the scope of the individual's duties for the fire department, fire company, ambulance service, voluntary ambulance service, or police agency covered under the policy, except with respect to the use or operation by such an individual of a motor vehicle not covered under the policy.

* (g) (1) Except as otherwise provided in paragraph two of this subsection, no policy or contract shall be deemed to insure against any liability of an insured because of death of or injuries to the insured's spouse or because of injury to, or destruction of property of the insured's spouse unless express provision relating specifically thereto is included in the policy. This exclusion shall apply only where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

(2) (A) (i) Upon issuance of a motor vehicle liability policy and payment of a reasonable premium established in accordance with article twenty-three of this chapter, an insurer issuing or delivering any policy that satisfies the requirements of article six of the vehicle and traffic law and is subject to section three thousand four hundred twenty-five of this article shall provide coverage in such a policy issued to a first named insured who has indicated that such insured has a spouse on the insurance application, against liability of an insured because of death of or injuries to the insured's spouse up to the liability insurance limits provided under such policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse, unless a first named insured elects, in writing and in such form as the superintendent determines, to decline and refuse such coverage in the first named insured's policy. Such insurance coverage shall be known as "supplemental spousal liability insurance".

(ii) Upon written request of an insured, and upon payment of a reasonable premium established in accordance with article twenty-three of this chapter, an insurer issuing or delivering any policy that satisfies the requirements of article six of the vehicle and traffic law, other than as specified in item (i) of this subparagraph, shall provide coverage in such a policy against liability of an insured because of death of or injuries to the insured's spouse up to the liability insurance limits provided under such policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

(B) (i) Upon issuance of a motor vehicle liability policy that satisfies the requirements of article six of the vehicle and traffic law and is subject to section three thousand four hundred twenty-five of this article, the insurer shall notify a first named insured who has indicated that such insured has a spouse on the insurance application, in writing, that such policy shall include supplemental spousal liability insurance unless a first named insured declines and refuses such insurance, in writing and in such form as shall be determined by the superintendent. Such notification shall be contained on the front of the premium notice in boldface type and include a concise statement that supplemental spousal liability coverage is provided unless declined by a first named insured, an explanation of such coverage, and the insurer's premium for such coverage.

(ii) Upon renewal or amendment of a motor vehicle liability policy that satisfies the requirements of article six of the vehicle and traffic law and has supplemental spousal liability coverage under the policy, the insurer shall provide a notification to a first named insured that includes a concise statement that such policy includes supplemental spousal liability coverage unless declined by a first named insured in writing and in such form as shall be determined by the superintendent, an explanation of such coverage, and the insurer's premium for such coverage. Such notification shall be contained on the front of the premium notice in boldface type.

(iii) A written declination shall apply to subsequent policy renewals unless a first named insured requests supplemental spousal liability insurance.

(C) A notification of the availability of supplemental spousal

liability insurance shall be provided upon policy issuance, other than for the policies to which the notification requirement in item (i) of subparagraph (B) of this paragraph applies, and at least once a year for all motor vehicle liability policies that satisfy the requirements of article six of the vehicle and traffic law, where the policy does not already provide supplemental spousal liability insurance. Such notice shall be contained on the front of the premium notice in boldface type and include a concise statement that supplemental spousal liability coverage is available, an explanation of such coverage, and the insurer's premium for such coverage.

* NB Effective until July 31, 2027

* (g) No policy or contract shall be deemed to insure against any liability of an insured because of death of or injuries to his or her spouse or because of injury to, or destruction of property of his or her spouse unless express provision relating specifically thereto is included in the policy as provided in paragraphs one and two of this subsection. This exclusion shall apply only where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

(1) Upon written request of an insured, and upon payment of a reasonable premium established in accordance with article twenty-three of this chapter, an insurer issuing or delivering any policy that satisfies the requirements of article six of the vehicle and traffic law shall provide coverage against liability of an insured because of death of or injuries to his or her spouse up to the liability insurance limits provided under such policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse. Such insurance coverage shall be known as "supplemental spousal liability insurance".

(2) Upon issuance of a motor vehicle liability policy that satisfies the requirements of article six of the vehicle and traffic law and that becomes effective on or after January first, two thousand three, pursuant to regulations promulgated by the superintendent, the insurer shall notify the insured, in writing, of the availability of supplemental spousal liability insurance. Such notification shall be contained on the front of the premium notice in boldface type and include a concise statement that supplementary spousal coverage is

available, an explanation of such coverage, and the insurer's premium for such coverage. Subsequently, a notification of the availability of supplementary spousal liability coverage shall be provided at least once a year in motor vehicle liability policies issued pursuant to article six of the vehicle and traffic law, including those originally issued prior to January first, two thousand three. Such notice must include a concise statement that supplementary spousal coverage is available, an explanation of such coverage, and the insurer's premium for such coverage.

* NB Effective July 31, 2027

(h) In this section, the term "insurance upon any property or risk located in this state" includes insurance against legal liability arising out of the ownership, operation or maintenance of any vehicle which is principally garaged or principally used in this state, or arising out of the ownership, operation, use or maintenance of any property which is principally kept or principally used in this state, or arising out of any other activity which is principally carried on in this state.

(i) Except as provided in subsection (j) of this section, the provisions of this section shall not apply to any policy or contract of insurance in so far as it covers the liability of an employer for workers' compensation, if such contract is governed by the provisions of section fifty-four of the workers' compensation law, or by any similar law of another state, province or country, nor to the kinds of insurances set forth in paragraph three of subsection (b) of section two thousand one hundred seventeen of this chapter.

(j) (1) Notwithstanding any other provision of this chapter or any other law to the contrary, every policy providing comprehensive personal liability insurance on a one, two, three or four family owner-occupied dwelling, issued or delivered in this state on and after the first of March, nineteen eighty-four, shall provide for coverage against liability for the payment of any obligation, which the policyholder may incur pursuant to the provisions of the workers' compensation law, to an employee arising out of and in the course of employment of less than forty hours per week, in and about such residences of the policyholder in this state. Such coverage shall provide for the benefits in the standard workers' compensation policy issued in this state. No one who

purchases a policy providing comprehensive personal liability insurance shall be deemed to have elected to cover under the workers' compensation law any employee who is not required, under the provisions of such law, to be covered.

(2) The term "policyholder" as used in this subsection shall be limited to an individual or individuals as defined by the terms of the policy, but shall not include corporate or other business entities or an individual who has or individuals who have in effect a workers' compensation policy which covers employees working in and about his or their residence.

(3) Every insurer who is licensed by the superintendent to issue homeowners or other policies providing comprehensive personal liability insurance in this state shall also be deemed to be licensed to transact workers' compensation insurance for the purpose of covering those persons specified in this subsection.

§ 3421. Homeowners' liability insurance; dogs. 1. With respect to homeowners' insurance policies as defined in section two thousand three hundred fifty-one of this chapter, no insurer shall refuse to issue or renew, cancel, or charge or impose an increased premium or rate for such policy or contract, or exclude, limit, restrict, or reduce coverage under such policy or contract based solely upon harboring or owning any dog of a specific breed or mixture of breeds.

2. The provisions of this section shall not prohibit an insurer from refusing to issue or renew or from canceling any such contract or policy, nor from imposing a reasonably increased premium or rate for such a policy or contract based upon the designation of a dog of any breed or mixture of breeds as a dangerous dog pursuant to section one hundred twenty-three of the agriculture and markets law, based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience subject to the applicable provisions of section three thousand four hundred twenty-five of this article.

§ 3422. Hate crimes; coverage refusal. (a) For purposes of this

section, "insured" means a current policyholder or a person or entity that is covered under an insurance policy.

(b) This section shall apply to policies of insurance if the insured or proposed insured is:

(1) an individual;

(2) a business entity that is independently owned and operated and employs one hundred or fewer individuals;

(3) a religious organization;

(4) an educational organization; or

(5) any other nonprofit organization that is organized and operated for religious, charitable or educational purposes.

(c) An insurer that issues or delivers a policy in this state shall not cancel, refuse to issue, refuse to renew, or increase the premium of a policy or exclude, limit, restrict, or reduce coverage under such policy solely on the basis that one or more claims have been made against any policy during the preceding sixty months for a loss that is the result of a hate crime, as defined pursuant to article four hundred eighty-five of the penal law, committed against the person or property insured if the named insured provides evidence to the insurer that the act causing such loss is a result of a hate crime and that an insured was not the perpetrator of the hate crime.

(d) Nothing in this section shall prohibit an insurer from canceling, refusing to renew, increasing the premium of an insurance policy or excluding, limiting, restricting, or reducing coverage under such policy due to other factors that are permitted by any other section of this chapter, including the factors set forth in section two thousand three hundred three of this chapter.

§ 3425. Certain property/casualty insurance policies; cancellation and renewal provisions; agents' contracts and brokers' accounts. (a) This section shall apply to covered policies of insurance as defined in paragraphs one, two and three hereof.

(1) "Covered policy" means a contract of insurance, referred to in this section as "automobile insurance", issued or issued for delivery in this state, on a risk located or resident in this state, insuring against losses or liabilities arising out of the ownership, operation,

or use of a motor vehicle, predominantly used for non-business purposes, when a natural person is the named insured under the policy of automobile insurance; provided, however, that the use or operation of the motor vehicle by a transportation network company driver as a TNC vehicle in accordance with article forty-four-B of the vehicle and traffic law or the use or operation of the motor vehicle through a peer-to-peer car sharing program in accordance with article forty of the general business law, shall not be included in determining whether the motor vehicle is being used predominantly for non-business purposes.

(2) "Covered policy" also means a contract of insurance, referred to in this section as "personal lines insurance", other than a contract of insurance defined in paragraph one hereof, issued or issued for delivery in this state, on a risk located or resident in this state, insuring any of the following contingencies:

(A) loss of or damage to real property used predominantly for residential purposes and that consists of not more than four dwelling units, other than hotels and motels;

(B) loss of or damage to personal property in which natural persons have an insurable interest, except personal property used in the conduct of a business;

(C) other liabilities for loss of, damage to, or injury to persons or property, not arising from the conduct of a business, when a natural person is the named insured under the policy; and

(D) parametric insurance, as defined in paragraph thirty-four of subsection (a) of section one thousand one hundred thirteen of this chapter.

(3) A personal umbrella liability policy shall be considered a "covered policy" under paragraph two, and not paragraph one, of this subsection.

(4) A contract which insures any of the foregoing contingencies described in paragraph one or two hereof as well as other contingencies shall be a covered policy if that portion of the annual premium attributable to such foregoing contingencies exceeds that portion attributable to other contingencies.

(5) A covered policy shall not include a policy issued pursuant to any plan established under article fifty-three or fifty-four of this chapter or legal services insurance.

(6) "Renewal" or "to renew" means the issuance and delivery by an insurer, at the end of the policy period, of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term; provided, however, that any policy with a policy period or term of less than one year shall, for the purpose of this section, be considered as if written for a policy period or term of one year, or any policy with no fixed expiration date, shall, for the purpose of this section, be considered as if written for successive policy periods or terms of one year.

(7) With respect to personal lines insurance, "required policy period" means a period of three years from the date as of which a covered policy is first issued or is voluntarily renewed.

(8) With respect to automobile insurance, "required policy period" means a period of one year from the date as of which a covered policy becomes effective after first issuance or voluntary renewal.

(9) With respect to automobile insurance, "voluntary renewal" means the renewal of a covered policy which has completed the required policy period pursuant to this section.

(10) "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance or any installment of such premium, whether the premium is payable directly to the insurer or its agent, or indirectly under any premium finance plan or extension of credit. Payment to the insurer, or to an agent or broker authorized to receive such payment, shall be timely, if made within fifteen days after the mailing to the insured of a notice of cancellation for nonpayment of premium.

(11) "Administrative suspension" means a temporary suspension of a driver's license pending a hearing, prosecution or investigation or an indefinite suspension of a driver's license because of the failure of the person suspended to perform an act, which suspension will be terminated by the performance of the act by the person suspended.

(b) During the first sixty days a covered policy is in effect, no notice of cancellation shall be issued or be effective unless it states or is accompanied by a statement of the specific reason or reasons for such cancellation.

(c) After a covered policy has been in effect for sixty days, or upon

the effective date if the policy is a renewal, no notice of cancellation shall be issued to become effective unless required pursuant to a program approved by the superintendent as necessary because a continuation of the present premium volume would be hazardous to the interests of policyholders of the insurer, its creditors or the public, or unless it is based on one or more of the following:

(1) With respect to automobile insurance policies:

(A) nonpayment of premium, provided, however, that a notice of cancellation on this ground shall inform the insured of the amount due;

(B) suspension or revocation during the required policy period of the driver's license of the named insured or any other person who customarily operates an automobile insured under the policy, other than a suspension issued pursuant to subdivision one of section five hundred ten-b of the vehicle and traffic law or one or more administrative suspensions arising from the same incident which has or have been terminated prior to the effective date of cancellation; or

(C) discovery of fraud or material mis-representation in obtaining the policy or in the presentation of a claim thereunder.

(2) With respect to personal lines insurance policies:

(A) nonpayment of premium, provided, however, that a notice of cancellation on this ground shall inform the insured of the amount due;

(B) conviction of a crime arising out of acts increasing the hazard insured against;

(C) discovery of fraud or material misrepresentation in obtaining the policy or in the presentation of a claim thereunder;

(D) discovery of willful or reckless acts or omissions increasing the hazard insured against;

(E) physical changes in the property insured occurring after issuance or last annual anniversary date of the policy which result in the property becoming uninsurable in accordance with the insurer's objective, uniformly applied underwriting standards in effect at the time the policy was issued or last voluntarily renewed; or

(F) a determination by the superintendent that the continuation of the policy would violate or would place the insurer in violation of this chapter.

(3) The provisions of this subsection shall apply to each and every coverage or limit afforded under the policy.

(d) (1) Unless the insurer, at least forty-five but not more than sixty days in advance of the end of the policy period, mails or delivers to the named insured, at the address shown in the policy, a written notice of its intention not to renew a covered policy, or to condition its renewal upon change of limits or elimination of any coverages, the named insured shall be entitled to renew the policy upon timely payment of the premium billed to the insured for the renewal. The specific reason or reasons for nonrenewal or conditioned renewal shall be stated in or shall accompany the notice. This paragraph shall not apply when the named insured, an agent or broker authorized by the named insured, or an insurer of the named insured, has mailed or delivered written notice to the insurer that the policy has been replaced or is no longer desired.

(2) If an insurer has the right to cancel a policy it may, in lieu of cancellation, condition continuation of such policy upon change of limits or elimination of any coverage not required by law, if written notice of such intention is mailed or delivered to the insured at the address shown in the policy at least twenty days prior to the effective date of such action.

(3) At its discretion, the insurer may, in lieu of renewing the policy in the form as last issued, substitute at the annual renewal date another approved policy form which contains at least substantially equivalent value in the aggregate of benefits, as determined by the superintendent. Notice of intention to substitute a different policy form on a renewal shall be made in the same manner as is prescribed in paragraph one of this subsection for a conditioned renewal but with respect to automobile insurance policies shall not be subject to the percentage limitations contained in subsection (f) of this section applicable to a conditioned renewal. Notice of intention to substitute a different policy form shall be accompanied by a full and clear comparison of the differences between the policy form as last issued and the substitute policy form.

(e) With respect to personal lines insurance policies, no notice of nonrenewal or conditional renewal of a covered policy shall be issued to become effective during the required policy period unless it is based upon a ground for which the policy could have been cancelled. With respect to homeowners' policies as defined in section two thousand three

hundred fifty-one of this chapter, on properties located in areas served by a market assistance program established by the superintendent for the purpose of facilitating placement of homeowners' insurance, notices of cancellation, nonrenewal or conditional renewal shall conform with standards established by the superintendent in regulation. Such standards shall require that the notice include, at a minimum: notification of the possibility of eligibility for coverage through a market assistance program or the New York property insurance underwriting association; information on how to apply; and such other information as required by the superintendent.

(f) (1) With respect to automobile insurance policies, the total number (rounded to the nearest whole number) of notices of intention not to renew a covered policy, and of notices of intention to condition renewal upon reduction of limits or elimination of any coverages, which an insurer may issue shall be limited for each calendar year to two percent of the total number of covered policies of the insurer in force at last year-end in each such insurer's rating territory in use in this state which have completed their required policy period under this section, except as set forth in subsection (r) of this section. However, the insurer may non-renew or conditionally renew one policy in any such insurer's rating territory in use in this state, if the applicable percentage limitation results in less than one policy. Cancellations made pursuant to subsection (b) or (c) of this section shall be independent of and in addition to the number of notices of intention not to renew or to condition renewal upon reduction of limits or elimination of any coverages not required by law, permitted under this subsection.

(2) For every two new automobile policies which the insurer voluntarily writes in each such territory, such insurer shall be permitted to non-renew or conditionally renew one additional automobile policy in that territory in excess of the two percent limit established in paragraph one of this subsection, subject to a fair and nondiscriminatory formula developed by the superintendent, which shall consider the number of automobile policies written less cancellations initiated by the insurer within the first sixty days of the policy period.

(3) The superintendent shall revoke the rights of any insurer or group of insurers under paragraph two of this subsection, upon a

determination, after a public hearing, that such an insurer or group of insurers has utilized such rights to the detriment of any class or group of classes within a rating territory.

(g) Notwithstanding any of the provisions and limitations of this section, any property/casualty insurance company organized for the sole and exclusive purpose of providing insurance policies to members of an organization, and providing such insurance policies on risks in New York, may refuse to renew automobile liability policies of persons who fail to meet the requirements contained in the by-laws of such company prohibiting the sale of policies to non-members of the organization, provided that such company shall continue to participate in any assigned risk plans established pursuant to article fifty-three of this chapter.

(h) (1) Proof of mailing of a notice of cancellation, reduction of limits, substitution of policy form, elimination of coverages, conditioned renewal or of intention not to renew, or proof of the mailing of the reasons therefor, to the named insured at the address shown in the policy, shall be sufficient proof of the giving of notice and the giving of reasons required by this section.

(2) No notice of cancellation, reduction of limits, substitution of policy form, elimination of coverages, conditioned renewal or of intention not to renew, or notice of the reasons therefor, that fails to include a provision required by this section shall be an effective notice for purposes of this section.

(3) A copy of every notice of cancellation, reduction of limits, substitution of policy form, elimination of coverages, conditioned renewal or of intention not to renew, including the reasons therefor, or a summary of such notice, shall be mailed, delivered or transmitted to the insured's authorized agent or broker within seven days of the time such notice is mailed to the named insured. Electronic transmission or any other means of delivery or transmission of information commonly used by the insurer to communicate with agents or brokers shall be deemed sufficient for compliance with this paragraph. Failure to mail, deliver or transmit a copy of such notice to the insured's authorized agent or broker pursuant to this paragraph shall not render any such notice ineffective, provided that all of the other requirements of this section are met and shall not be considered failure to include a provision required by this section for purposes of paragraph two of this

subsection.

(i) No insurer shall refuse to issue or renew a covered policy solely on the ground of the advanced age of the applicant or insured.

(j) (1) Where an insurer or an agent who is authorized by such insurer to accept lines of insurance from licensed agents or brokers notifies a licensed agent or broker that its contract or account shall be terminated:

(A) with respect to a personal lines insurance policy required to be continued by this section, the insurer shall offer to continue the policy for any remaining part of the required policy period and any statutory extension and the insurer shall offer to continue the policy through the terminated agent or broker for at least its next one year policy period which commences within one year following the date of mailing or delivery to the terminated agent or broker of written notice of termination of such contract or account, and thereafter, at the specific request of the insured, shall offer to continue the policy through such terminated agent or broker for any remaining part of the required policy period including statutory extension;

(B) with respect to an automobile insurance policy subject to this section, the insurer shall offer to continue the policy for any remaining part of the required policy period and, unless the policy is cancelled or non-renewed in accordance with the provisions of either subsection (b), (c) or (f) of this section, it shall, at the specific request of the insured, offer to continue the policy through the terminated agent or broker for three successive one year policy periods which commence within the year following the date of mailing or delivery to the terminated agent or broker of written notice of termination of such contract or account;

(C) with respect to all new personal lines and automobile insurance business offered by such terminated agent or broker which is subject to the provisions of this section, the insurer shall accept all such business meeting the insurer's then current underwriting standards during the period of one hundred twenty days next following the date of mailing or delivery to the agent or broker of written notification of such termination;

(D) the terminated agent or broker shall be entitled to receive commissions on account of all business continued or written pursuant to

this paragraph at the insurer's prevailing commission rate for such lines of insurance; and

(E) the provisions of subparagraph (B) hereof in relation to continuation of coverage for three successive one year policy periods are subject to the rights of the insurer pursuant to subsection (b), (c) or (f) of this section to cancel or non-renew. The provisions of subparagraph (D) hereof in relation to commissions shall not be mandatory after completion of the three one year policy periods provided for in subparagraph (B) hereof.

(2) This subsection shall not apply to an agent who agrees to represent exclusively one insurer or a group of insurers under common management or an agent or broker whose license has been revoked by the superintendent or whose contract or account has been terminated for insolvency, abandonment, gross and willful misconduct, or failure to pay over to the insurer moneys due to the insurer after receipt of a written demand therefor.

(k) The superintendent may, after public hearing, promulgate rules and regulations implementing and coordinating the provisions of this section and article fifty-three of this chapter.

(l) (1) The superintendent shall monitor the operation of this section. Every insurer subject to the provisions of this section shall file in the office of the superintendent periodic reports in such form as the superintendent may prescribe.

(2) The superintendent shall collect, analyze and compile such reports with regard to the number of new insureds, non-renewed insureds and business written by each insurer in each rating territory of each such insurer and, in each case, the class of insureds (including age and sex) affected so that a statistical analysis of the results obtained pursuant to subsections (f) and (m) of this section, and the reasons in the aggregate for the non-renewal of policies shall be provided to the speaker of the assembly, the temporary president of the senate, the chair of the assembly insurance committee, and the chair of the senate insurance committee on or before June thirtieth, two thousand twenty and every two years thereafter.

(m) (1) Paragraphs eight and nine of subsection (a), subsection (f) and subparagraphs (B) and (E) of paragraph one of subsection (j) of this section shall not apply to any new covered policy of automobile

insurance voluntarily written on or after August first, nineteen hundred eighty-five and prior to January first, nineteen hundred eighty-six, and on or after August second, two thousand one and prior to the effective date of the property/casualty insurance availability act, and on or after June thirtieth, two thousand twenty-nine, but the legal rights granted to insurers or policyholders under such provisions shall not be extinguished or impaired thereby.

(2) In lieu of such provisions, paragraph seven of subsection (a), subparagraph (A) of paragraph one of subsection (j) of this section and paragraph three of this subsection shall apply to such automobile insurance policies that are newly and voluntarily written to have an effective date on or after August first, nineteen hundred eighty-five and prior to January first, nineteen hundred eighty-six, and on or after August second, two thousand one and prior to the effective date of the property/casualty insurance availability act, and on or after June thirtieth, two thousand twenty-nine.

(3) On and after August first, nineteen hundred eighty-five and prior to January first, nineteen hundred eighty-six, and on or after August second, two thousand one and prior to the effective date of the property/casualty insurance availability act, and on or after June thirtieth, two thousand twenty-nine, no notice of nonrenewal or conditional renewal of such covered automobile insurance policies referred to in this subsection shall be issued to become effective during the required policy period unless it is based upon a ground for which the policy could have been cancelled or unless it is based upon one or more of the following grounds that occurred during the thirty-six month period ending on the last day of the fourth month preceding the month of the effective date of such notice of nonrenewal or conditional renewal:

(A) Where a named insured and/or any other person who customarily operates an automobile insured under the policy is convicted of any of the following:

(i) operating a motor vehicle while intoxicated or impaired by the consumption of alcohol; or

(ii) operating a motor vehicle while impaired by the use of a drug (within the meaning of section eleven hundred ninety-two of the vehicle and traffic law); or

(iii) homicide or assault arising out of the use or operation of a motor vehicle, or criminal negligence in the use or operation of a motor vehicle resulting in the injury or death of another person, or use or operation of a motor vehicle directly or indirectly in the commission of a felony; or

(iv) operating a motor vehicle in excess of the speed limit, or in a reckless manner, where injury or death results therefrom; or

(v) operating a motor vehicle in excess of the speed limit, or reckless driving, or any combination thereof, on three or more occasions; or

(vi) operating a motor vehicle insured under the policy without a valid license or registration in effect (except when the person convicted had possessed a valid license or registration which had expired and was subsequently renewed), or during a period of revocation or suspension thereof, or in violation of the limitations applicable to a license issued pursuant to article twenty-one or article twenty-one-A of the vehicle and traffic law; or

(vii) operating a motor vehicle while seeking to avoid apprehension or arrest by a law enforcement officer; or

(viii) filing or attempting to file a false or fraudulent automobile insurance claim, or knowingly aiding or abetting in the filing or attempted filing of any such claim; or

(ix) leaving the scene of an incident without reporting; or

(x) filing a false document with the department of motor vehicles, or using a license or registration obtained by filing a false document with the department of motor vehicles; or

(xi) operating a motor vehicle in a race or speed test; or

(xii) knowingly permitting or authorizing an unlicensed driver to operate a motor vehicle insured under the policy.

(B) Where a named insured or any other person who operates a motor vehicle insured under the policy is individually or are aggregately involved in three or more vehicle accidents while operating a motor vehicle insured under the policy, resulting in either personal injury, or in property damage in excess of two hundred dollars. For the purpose of this paragraph any of the following occurrences involving a motor vehicle operated by a named insured or such other person shall not be considered an accident:

(i) such motor vehicle was struck in rear; or

(ii) such motor vehicle was struck while legally parked; or

(iii) only the operator of another motor vehicle involved in the accident was convicted of a crime, offense or violation contributing to the accident; or

(iv) the named insured or other operator of the motor vehicle insured under the policy, or the insurer thereof, was reimbursed by or on behalf of a person responsible for the accident or has a judgment against such person.

Where more than one motor vehicle in a household is insured by the same insurer, the number of accidents which would permit conditional renewal or non-renewal shall, as for the aggregate, be increased by two for each additional motor vehicle insured. For the purposes of this paragraph accidents occurring as a result of the use or operation of a motor vehicle in response to an emergency, where the operator was responding to a call of duty as a paid or volunteer member of any police or fire department, first aid squad, or of any law enforcement agency; or was performing any other governmental function in a public emergency, shall not be accidents which afford an insurer the right to cancel or to refuse to renew.

(C) Where there is a material change in the type of motor vehicle insured which so substantially increases the hazard insured against as to render the motor vehicle uninsurable in accordance with the insurer's objective, uniformly applied underwriting standards in effect at the time the policy was issued or last voluntarily renewed and which are currently in effect; provided, however, that if the insured motor vehicle is uninsurable for physical damage coverages only, the insurer must offer to renew the policy without the physical damage coverages.

(D) Where such other objective, uniformly applied standards for cancellation or non-renewal exists, as may be prescribed by regulation promulgated by the superintendent.

* (n) Notice of cancellation/real property escrow accounts. With respect to all covered policies for which the insurer submits bills for real property insurance premiums directly to a mortgage investing institution, or such other institution or agent as designated in writing by the mortgage investing institution, under a real property insurance

escrow account, the insurer must send copies of a notice of cancellation for nonpayment of premiums to both (i) the insured mortgagor of the real property and (ii) the mortgage investing institution, or such other designated institution or agent. Failure to send this notice to both parties in paragraph (i) and paragraph (ii) shall render the notice of no force and effect.

* NB There are 2 sb§(n)'s

* (n) Withdrawal from writing automobile and homeowners' insurance. In the event of a determination by the superintendent that an insurer's elimination of premium installment plans, reduction in commission, or any other marketing action was implemented to effectuate a withdrawal or substantial withdrawal from writing automobile insurance:

(1) an agent shall be permitted to terminate its contract with the insurer, or that portion of the contract authorizing the agent to accept automobile insurance, and the insurer shall be required to accept new business and issue renewals in accordance with paragraph one of subsection (j) of this section;

(2) notwithstanding the provisions of subparagraph (D) of paragraph one of subsection (j) of this section, where an agent's contract is terminated or a portion thereof is terminated pursuant to this subsection, commissions for automobile insurance shall be paid at the rate in effect applicable to the agent for the longest duration during the twelve-month period immediately preceding the action which is determined by the superintendent to have been implemented to effectuate a withdrawal or substantial withdrawal from writing automobile insurance;

(3) premium payment installment options shall be maintained in a manner substantially similar to options offered by the automobile insurance plan established pursuant to article fifty-three of this chapter;

(4) paragraphs one and two of this subsection shall not apply to an agent who agrees to represent exclusively one insurer or group of insurers; and

(5) with respect to homeowners' insurance, in the event that an insurer intends to materially reduce the volume of policies written pursuant to paragraph two of subsection (o) of this section, any commissions payable pursuant to an agent contract shall be mandatory for

an additional one year period beyond the completion of the required policy period specified in paragraph seven of subsection (a) of this section. The provisions of this paragraph shall not apply to policies cancelled or nonrenewed by the insured or policies not renewed or cancelled pursuant to subparagraph (A), (B), (C), (D) or (E) of paragraph two of subsection (c) of this section.

* NB There are 2 sb§(n)'s

(o) (1) An insurer that intends to materially reduce its volume of policies written, covered by this section, shall submit to the superintendent, at least thirty days in advance of implementing such actions, a plan for orderly reduction that: (i) describes the contemplated actions; (ii) sets forth the reasons for such actions; (iii) describes the measures such insurer intends to take in order to minimize market disruption; and (iv) provides such other information as the superintendent may require.

(2) (A) An insurer that writes homeowners insurance policies as defined in subsection (a) of section two thousand three hundred fifty-one of this chapter, who intends to materially reduce its volume of such policies written, shall submit to the superintendent, at least sixty days in advance of implementing such actions, a plan for the orderly reduction of the number of policies written. Such plan shall: (i) describe the contemplated actions; (ii) set forth the reasons for such actions; (iii) describe the measures such insurer intends to take in order to minimize market disruption; and (iv) provide such other information as the superintendent may require.

(B) The superintendent after receiving such plan shall have thirty days in which to approve it or disapprove it. The superintendent shall approve such plan if the applicant demonstrates that such material reduction is accomplished in a manner that minimizes market disruption in areas of material reduction. In the review of each plan submitted prior to the submission of the report required by subparagraph (E) of this paragraph, the superintendent shall assess the impact of the planned withdrawal in the counties of Nassau and Suffolk; areas within one mile of a saltwater shoreline, canal or bay in the counties of Queens, Kings, Richmond, Bronx or Westchester; and areas where policies issued by the New York property insurance underwriting association have increased by an amount deemed significant by the superintendent since

January first, nineteen hundred ninety-two. For plans filed subsequent to the submission of the report required by subparagraph (E) of this paragraph, the superintendent shall assess the impact of the planned withdrawal on such areas as the superintendent may identify pursuant to subparagraph (E) of this paragraph. In the event that the plan is disapproved, the superintendent shall state the points of objection with such plan and any amendments to such plan that the superintendent may require consistent with the provisions of this section, including, but not limited to, amendments designed to accomplish such material reduction in a manner that minimizes market disruption. The insurer shall file an amended plan within fifteen days from the date of return. Any intended withdrawal pursuant to the plan is prohibited until such time as the original or any amended plan is approved by the superintendent.

(C) The superintendent shall promulgate rules and regulations to establish standards for the definition of "materially reduce its volume of policies" as used in this paragraph. Such definition shall require that a plan be filed with the superintendent if the insurer plans to reduce the net number of homeowners insurance policies as defined in subsection (a) of section twenty-three hundred fifty-one of this chapter by twenty percent or more, or plans to reduce the net number of such policies it writes by five hundred, whichever is greater, within a five year period of time; provided, however, that if an insurer is not otherwise required to file a plan pursuant to this subparagraph, a plan shall be filed if the insurer plans to reduce the net number of such policies it has in force in a twelve month period by four percent or more or the net number of such policies it writes by one hundred, whichever is greater.

The provisions of this subparagraph shall not apply to policies cancelled or nonrenewed by the insured or policies not renewed or cancelled pursuant to subparagraph (A), (B), (C), (D) or (E) of paragraph two of subsection (c) of this section.

(D) The superintendent shall promulgate rules and regulations to establish standards to approve such an application and to define "minimizes market disruption."

(E) The superintendent shall conduct a study of market dynamics and

homeowners insurance policies written as defined in subsection (a) of section twenty-three hundred fifty-one of this chapter, cancelled or nonrenewed in geographic regions as he designates, including but not limited to coastal regions, urban regions and rural areas and shall report such findings to the governor and legislature on or before February fifteenth, nineteen hundred ninety-eight.

(p) Notwithstanding the provisions and limitations of this section or any other provision of law, the superintendent may, for a stated period not to exceed three months (which the superintendent may thereafter extend another three months), declare a moratorium precluding policy termination, or suspend or otherwise adjust the provisions and limitations of this section, for any area of the state that has been declared by the president of the United States or by the governor to be in a state of emergency due to disaster or catastrophe.

(q)(1) Notwithstanding any other provision of this section, a covered policy shall not be subject to a required policy period if the policy is:

(A) a policy issued to an insured for a seasonal purpose;

(B) a policy issued to cover a specific event or particular project that will be performed in less than one year;

(C) a new policy where the specific term is made to coincide with the term of an insured's already existing covered policy with the same insurer; with any insurer, at the insured's written request; or, in the case of a personal umbrella policy, with different insurers. The new policy shall have the same required policy period as that of the existing policy, except where one policy is an automobile insurance policy and the other policy is a personal lines insurance policy; or

(D) a new policy issued pursuant to a mass merchandising program where the specific term is made to coincide with the term of all other policies in the program.

(2) In regard to a policy subject to subparagraphs (A) and (B) of paragraph one of this subsection, the insurer shall not be required to give the notice of nonrenewal or conditional renewal required by subsection (d) of this section if:

(A) the policy provides coverage for sixty days or less;

(B) the policy contains a prominent and explicit notice of expiration, specifying the date the policy will expire and stating that no notice of

nonrenewal will be issued; and

(C) the policy is accompanied by a conspicuous notice in bold type, explaining that the policy provides short-term coverage for the policy period as specified on the declarations page.

(3) Subsection (f) of this section shall not apply to an automobile insurance policy subject to subparagraphs (A) and (B) of paragraph one of this subsection.

(r) An insurer that has no more than seven hundred fifty automobile insurance policies in-force at last year-end and intends to non-renew all of the policies shall submit to the superintendent a plan for the orderly nonrenewal of the policies. The proposed plan shall not become effective without the approval of the superintendent. The plan shall:

(1) describe the contemplated action;

(2) set forth the reasons for the action;

(3) describe the measures the insurer will take or has taken to minimize market disruption as set forth in subsection (o) of this section;

(4) explain why the action would not be detrimental to the interests of the people of this state; and

(5) provide any other information as the superintendent may require.

(s) With respect to automobile insurance, no insurer shall refuse to issue or renew a covered individually-owned private passenger policy solely on the ground that the motor vehicle to be insured under such policy shall be used for volunteer firefighting.

§ 3426. Commercial lines insurance; cancellation and renewal provisions. (a) Definitions. As used in this section:

(1) "Covered policy" means, for purposes of this section, a policy of commercial risk insurance, professional liability insurance or public entity insurance, and shall include any contract, certificate or other evidence of such insurance.

(2) "Required policy period" means a period of one year from the date as of which a covered policy is renewed or first issued.

(3) "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance or any installment of such premium, whether the

premium is payable directly to the insurer or its agent, or indirectly under any premium finance plan or extension of credit. Payment to the insurer, or to an agent or broker authorized to receive such payment, shall be timely for the purpose of this section if made within fifteen days after the mailing to the insured of a notice of cancellation for nonpayment of premium.

(4) "Renewal" or "to renew" means the issuance or offer to issue by an insurer of a policy superseding a policy previously issued and delivered by the same insurer, or another insurer under common control, or the issuance or delivery of a certificate or notice extending the term of a policy beyond its policy period or term; provided, however, that any policy with a policy period or term of less than one year shall, for the purpose of this section, be considered as if written for a policy period or term of one year, and any policy with no fixed expiration date shall, for the purpose of this section, be considered as if written for successive policy periods or terms of one year.

(5) "Administrative suspension" means a temporary suspension of a driver's license pending a hearing, prosecution or investigation, or an indefinite suspension of a driver's license because of the failure of the person suspended to perform an act, which suspension will be terminated by the performance of the act by the person suspended.

(6) "Excess liability policy" means a policy of commercial risk, public entity or professional liability insurance, including a commercial umbrella policy, when written over one or more underlying liability policies that provide with respect to the same risk coverage of at least five hundred thousand dollars in the aggregate.

(7) "Hyper limits excess liability policy" means an excess liability policy of commercial risk, public entity or professional liability insurance, including a commercial umbrella policy, when written over one or more underlying liability policies issued by authorized insurers that provide with respect to the same risk coverage of at least ten million dollars in the aggregate.

(8) "Jumbo risk" means a business entity that generates gross revenues exceeding one hundred million dollars annually and that develops an annual liability premium for the policy of at least five hundred thousand dollars, but shall not include any public entity or not-for-profit corporation.

(9) "Renewal date" means the date specified in a conditional renewal notice, renewal certificate or in the renewal policy itself, for coverage under a renewal policy to take effect.

(10) "Blanket" or "mass" nonrenewal means a situation where the insurer within a six month period is nonrenewing policies representing more than one percent of a market.

(11) "Market" shall have the meaning ascribed by paragraph one of subsection (a) of section two thousand three hundred forty-four of this chapter.

(b) During the first sixty days a covered policy is initially in effect, except for the bases for cancellation set forth in paragraph one, two or three of subsection (c) of this section, no cancellation shall become effective until twenty days after written notice is mailed or delivered to the first-named insured at the mailing address shown in the policy and to such insured's authorized agent or broker.

(c) After a covered policy has been in effect for sixty days unless cancelled pursuant to subsection (b) of this section, or on or after the effective date if such policy is a renewal, no notice of cancellation shall become effective until fifteen days after written notice is mailed or delivered to the first-named insured and to such insured's authorized agent or broker, and such cancellation is based on one or more of the following:

(1) With respect to covered policies:

(A) nonpayment of premium provided, however, that a notice of cancellation on this ground shall inform the insured of the amount due;

(B) conviction of a crime arising out of acts increasing the hazard insured against;

(C) discovery of fraud or material misrepresentation in the obtaining of the policy or in the presentation of a claim thereunder;

(D) after issuance of the policy or after the last renewal date, discovery of an act or omission, or a violation of any policy condition, that substantially and materially increases the hazard insured against, and which occurred subsequent to inception of the current policy period;

(E) material physical change in the property insured, occurring after issuance or last annual renewal anniversary date of the policy, which results in the property becoming uninsurable in accordance with the insurer's objective, uniformly applied underwriting standards in effect

at the time the policy was issued or last renewed; or material change in the nature or extent of the risk, occurring after issuance or last annual renewal anniversary date of the policy, which causes the risk of loss to be substantially and materially increased beyond that contemplated at the time the policy was issued or last renewed;

(F) a determination by the superintendent that continuation of the present premium volume of the insurer would jeopardize that insurer's solvency or be hazardous to the interests of policyholders of the insurer, its creditors or the public;

(G) a determination by the superintendent that the continuation of the policy would violate, or would place the insurer in violation of, any provision of this chapter; or

(H) where the insurer has reason to believe, in good faith and with sufficient cause, that there is a probable risk or danger that the insured will destroy, or permit to be destroyed, the insured property for the purpose of collecting the insurance proceeds, provided, however, that:

(i) a notice of cancellation on this ground shall inform the insured in plain language that the insured must act within ten days if review by the department of the ground for cancellation is desired pursuant to item (iii) of this subparagraph (H);

(ii) notice of cancellation on this ground shall be provided simultaneously by the insurer to the department; and

(iii) upon written request of the insured made to the department within ten days from the insured's receipt of notice of cancellation on this ground, the department shall undertake a review of the ground for cancellation to determine whether or not the insurer has satisfied the criteria for cancellation specified in this subparagraph; if after such review the department finds no sufficient cause for cancellation on this ground, the notice of cancellation on this ground shall be deemed null and void.

(2) With respect to that portion of a covered policy providing motor vehicle coverage, in addition to the basis for cancellation set forth in paragraph one of this subsection, suspension or revocation during the required policy period of the driver's license of any person who continues to operate a motor vehicle insured under the policy, other than a suspension issued pursuant to subdivision one of section five

hundred ten-b of the vehicle and traffic law or one or more administrative suspensions arising from the same incident which has or have been terminated prior to the effective date of cancellation.

(3) With respect to professional liability insurance policies, in addition to the bases for cancellation set forth in paragraph one of this subsection, revocation or suspension of the insured's license to practice his profession or, if the insured is a hospital, it no longer possesses a valid operating certificate under section twenty-eight hundred one-a of the public health law.

(4) With respect to an excess liability policy, in addition to the basis for cancellation set forth in paragraph one of this subsection, cancellation of one or more of the underlying policies providing primary or intermediate coverage, where: (A) such cancellation is based upon paragraph one, two or three of this subsection; and (B) such policies are not replaced without lapse.

(5) Written notice of cancellation in accordance with this subsection shall be mailed or delivered to the first-named insured, at the address shown on the policy, and to the insured's authorized agent or broker.

(d) (1) After a covered policy has been in effect for sixty days, or on and after the effective date if such policy is a renewal, no premium increase for the term of the policy shall be made to become effective unless due to and commensurate with insured value added, subsequent to issuance or the last renewal date, pursuant to the policy or at the insured's request or, in lieu of cancellation, where such increase is based upon one or more of the grounds for cancellation set forth in subparagraph (D) or (E) of paragraph one of subsection (c) of this section.

(2) No covered policy which provides for a policy term of less than one year may be issued, or issued for delivery, in this state, except:

(A) a policy issued to an insured for a seasonal purpose;

(B) a policy issued to cover a specific event or particular project that will be performed in less than one year;

(C) a new policy where the specific term is made to coincide with the term of an insured's already existing policy with the same insurer, with any insurer at the insured's written request or, in the case of an excess liability policy, with different insurers;

(D) a group property/casualty policy or certificates, policies issued

pursuant to a safety group or mass merchandising program, or a medical malpractice or for-hire vehicle policy whose expiration date is common to all other policies issued by an insurer; in any of which events the first policy period may be for a period of less than one year with subsequent renewals requiring at least a one year policy period, and any such policies issued since the effective date of this section may be amended to conform to a common expiration date; or

(E) where an insured requests a liability insurance policy with a term of less than one year from an insurer that offers such policies; provided that the insurer also offers the insured the option of purchasing a policy with a term of one year, and:

(i) the insurer writes the policy on an occurrence basis;

(ii) the insurer writes the policy on a defense cost outside limits basis;

(iii) the insurer may extend the policy, provided that:

(a) the coverage remains in effect at the same terms and conditions;

(b) the rate accords with the rates filed with the superintendent at the policy's inception; and

(c) the extension does not result in the policy period exceeding eleven months in total;

(iv) the policy has no annual aggregate liability limit but may have aggregate limits for the term of the policy, and such aggregate limits shall continue with any policy extension provided pursuant to item (iii) of this subparagraph;

(v) the policy does not provide medical malpractice coverage; liability insurance required by articles six, eight, or forty-four-B of the vehicle and traffic law or under any other financial responsibility law of this state; or public entity insurance;

(vi) the policy provides for a term of at least one month;

(vii) the policy does not contain a clause limiting the timely filing of a claim;

(viii) the policy provides for a return of premium on a pro-rata basis if the insured cancels or otherwise terminates the policy before the policy's expiration; and

(ix) the insurer provides a written disclosure to the insured that explains that a policy issued pursuant to this subparagraph may be more expensive than a policy with a term of one year.

(e) (1) A covered policy shall remain in full force and effect pursuant to the same terms, conditions and rates unless written notice is mailed or delivered by the insurer to the first-named insured, at the address shown on the policy, and to such insured's authorized agent or broker, indicating the insurer's intention:

(A) not to renew such policy; or

(B) to condition its renewal upon change of limits, change in type of coverage, reduction of coverage, increased deductible or addition of exclusion, or upon increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of increased exposure units, pursuant to subsection (d) of this section, or as a result of experience rating, loss rating, retrospective rating or audit), except that with respect to an excess liability policy, the insurer may also, consistent with regulations promulgated by the superintendent, condition its renewal upon requirements relating to the underlying coverage, in which event the conditional renewal notice shall be treated as an effective notice of nonrenewal if such requirements are not satisfied as of the later of the expiration date of the policy or sixty days after mailing or delivery of such notice; or

(C) that the policy will not be renewed or will not be renewed upon the same terms, conditions or rates; such alternative renewal notice must be mailed or delivered on a timely basis and advise the insured that a second notice shall be mailed or delivered at a later date indicating the insurer's intention as specified in subparagraph (A) or (B) of this paragraph and that coverage shall continue on the same terms, conditions and rates as the expiring policy, until the later of the expiration date or sixty days after the second notice is mailed or delivered; such alternative renewal notice also shall advise the insured of the availability of loss information pursuant to subsection (g) of this section and, upon written request, the insurer shall furnish such loss information within ten days consistent with the provisions of such subsection.

(2) A nonrenewal notice as specified in subparagraph (A), a conditional renewal notice as specified in subparagraph (B), and the second notice described in subparagraph (C) of paragraph one of this subsection shall contain the specific reason or reasons for nonrenewal or conditional renewal, set forth the amount of any premium increase

(or, where such amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based upon the information available to the insurer at that time), and describe in plain and concise terms the nature of any other proposed changes specified in paragraph one of this subsection. The superintendent shall by regulation specify the permissible range of such estimate (which shall not exceed five percent of the actual amount) and the permissible methods by which an insurer may satisfy the notice requirements of this section.

(3) The notice required by paragraph one of this subsection shall be mailed or delivered at least sixty, but not more than one hundred twenty, days in advance of the expiration date of the policy, except that for an excess liability policy or a policy issued to a jumbo risk, the notice shall be mailed or delivered at least thirty, but not more than one hundred twenty, days in advance of the expiration date of the policy.

(4) Paragraphs one, two and three of this subsection shall not apply when the named insured, an agent or broker authorized by the named insured, or another insurer of the named insured has mailed or delivered written notice that the policy has been replaced or is no longer desired.

(5) (A) If the insurer employs an alternative renewal notice as authorized by subparagraph (C) of paragraph one of this subsection, the insurer shall provide coverage on the same terms, conditions, and rates as the expiring policy, until the later of the expiration date or sixty days after the mailing or delivery of the second notice described in such subparagraph, except to the extent that, prior thereto, the insured has replaced the coverage or elects to cancel, in which event such cancellation shall be on a pro rata premium basis.

(B) In the event that a late conditional renewal notice or a late nonrenewal notice is provided by the insurer prior to the expiration date of the policy, coverage shall remain in effect, at the same terms and conditions of the expiring policy and at the lower of the current rates or the prior period's rates, until sixty days after such notice is mailed or delivered, except to the extent that, prior thereto, the insured has replaced the coverage or elects to cancel, in which event such cancellation shall be on a pro rata premium basis; provided,

however, that if the insured elects to renew on the basis of the conditional renewal notice, then such terms, conditions and rates shall govern the policy upon expiration of such sixty day period unless such notice was provided at least thirty days prior to the expiration date of the policy, in which event the terms, conditions and rates set forth in the conditional renewal notice shall apply as of the renewal date.

(C) (i) In the event that a late conditional renewal notice or a late nonrenewal notice is provided by the insurer on or after the expiration date of the policy, coverage shall remain in effect on the same terms and conditions of the expiring policy for another required policy period, and at the lower of the current rates or the prior period's rates unless the insured during the additional required policy period has replaced the coverage or elects to cancel, in which event such cancellation shall be on a pro rata premium basis.

(ii) Every notice mailed or delivered pursuant to this subsection shall advise the insured of the insured's rights to coverage and the duration thereof.

(6) Paragraph five of this subsection shall not create a new annual aggregate liability limit (if any) for the covered policy, except that the annual aggregate limit of the expiring policy shall be increased in proportion to the policy extension pursuant to such paragraph five; provided, however, that if the insured elects to accept the terms, conditions and rates of the conditional renewal notice pursuant to subparagraph (B) of paragraph four of this subsection, a new annual aggregate limitation (if any) shall become effective as of the inception date of the renewal, subject to regulations promulgated by the superintendent.

(7) Each insurer subject to this section shall adopt and implement reasonable standards and procedures to ensure compliance with the provisions of subparagraphs (A), (B) and (C) of paragraph one and paragraphs two and three of this subsection. Each such insurer shall maintain a written or electronic record of any notice not in compliance with such provisions. Such record shall indicate the expiration date of the policy, the date notice should have been sent, the date when notice was sent, the policy number, and the name and address of the insured. Such records shall be available for inspection upon request by the superintendent.

(8) No insurer may issue blanket or mass nonrenewal notices for any market, except upon submission to the superintendent, at least forty-five days in advance of mailing or delivery of such notices, of a plan for orderly withdrawal that describes the proposed nonrenewals, states the basis for such nonrenewals, and identifies any measures such insurer intends to take in order to minimize market disruption.

(9) This subsection shall not apply to a hyper limits excess liability policy except in regard to nonrenewal or to a policy of the type specified in subparagraph (A), (B), or (E) of paragraph two of subsection (d) of this section.

(f) If an insurer provides the notice described in paragraphs one, two and three of subsection (e) of this section, and thereafter the insurer extends the policy for ninety days or less, an additional notice of nonrenewal is not required with respect to the extension.

(g) (1) Every notice mailed or delivered by an insurer pursuant to this section shall advise the first-named insured and such insured's authorized agent or broker of the availability of loss information consistent with paragraph two of this subsection.

(2) Upon written request by the first-named insured or such insured's authorized agent or broker, the insurer shall mail or deliver the following loss information covering a period of years specified by the superintendent by regulation or the period of time coverage has been provided by the insurer, whichever is less, within ten days of such request:

(A) Information on closed claims, including date and description of occurrence, and any payments;

(B) Information on open claims, including date and description of occurrence, and amounts of any payments; and

(C) Information on notice of any occurrences, including date and description of occurrence.

(3) The insurer may charge a reasonable fee as determined by the superintendent only for such information provided upon request, but not for such information (even in the absence of a request therefor) required to be provided.

(4) For purposes of this subsection, the term first-named insured shall include an individual certificate holder under a property/casualty group policy with respect to such certificate holder's loss information.

(h) Every notice of cancellation issued pursuant to this section shall specify the grounds for cancellation and shall contain where applicable a reference to the pertinent paragraph or subparagraph of subsection (c) of this section. Every notice of nonrenewal issued pursuant to this section shall set forth or be accompanied by the reason for nonrenewal, and any such stated reason shall be valid and effective unless such reason violates this chapter or any other state or federal law.

(i) No cancellation, conditional renewal or nonrenewal notice that fails to include a provision required by this section shall be an effective notice for purposes of this section.

(j) The provisions of subsection (e) of this section, regarding conditional renewal shall apply to the master contract under a property/casualty group policy, but shall not apply to individual certificate holders under such group policy.

(k) (1) Subject to the rights of an insurer to cancel a policy pursuant to subsection (b) or (c) of this section, in the event that an insurer terminates the contract or account of a licensed agent or broker, the insurer shall offer in regard to any policy written through such terminated agent or broker to continue each such policy with that agent or broker for any remaining part of the required policy period.

(2) The terminated agent or broker shall be entitled to receive commissions on all business continued pursuant to paragraph one of this subsection at the commission rate applicable to such agent or broker at the time of termination.

(3) This subsection shall not apply to an agent or broker: (A) who exclusively represents one insurer or a group of insurers under common management; (B) whose license has been revoked by the superintendent; or (C) whose contract or account has been terminated due to the agent's or broker's insolvency or gross misconduct.

(l) (1) This section shall apply to any policy issued or issued for delivery in this state covering risks with multi-state locations, where the insured is principally headquartered in this state or where the policy provides that this section, as a matter of choice of law, is to govern the policy in regard to such locations.

(2) This section shall not apply to policies issued pursuant to a plan established under article fifty-three, fifty-four or fifty-five of this chapter, surety policies, policies providing workers' compensation or

employers' liability coverage, financial guaranty insurance, policies providing mortgage guaranty or credit insurance, policies principally marine insurance as defined by paragraph twenty of subsection (a) of section one thousand one hundred thirteen of this chapter, legal services insurance, reinsurance contracts, policies written on an excess line basis, or policies subject to section three thousand four hundred twenty-five of this chapter.

(m) Nothing in this section shall be construed to prohibit an insurer from providing terms more favorable to an insured or other party in interest with regard to cancellation, nonrenewal or conditional renewal; nor shall anything herein be construed to limit the grounds for which an insurer may lawfully rescind or suspend a policy or decline to pay a claim under a policy.

(n) (1) Except for subparagraphs (B) and (C) of paragraph five and paragraph seven of subsection (e), an insurer doing business in this state which violates the provisions of subsection (e) with such frequency as to indicate a general business practice shall be subject to the penalties provided in paragraph two of this subsection.

(2) If it is found, after notice and an opportunity to be heard, that an insurer has violated subsection (e) of this section, each instance of noncompliance with paragraph one of this subsection may be treated as a separate violation of this section for purposes of ordering a penalty pursuant to section one hundred nine of this chapter.

(o) The provisions of subsections (e) and (h) of this section shall not apply to a policy the term of which expires during the period commencing with the original effective date of this section and ending on the sixtieth day after such effective date, provided, however, that in the interim the provisions of former sections three thousand four hundred twenty-six and three thousand four hundred twenty-seven of this article as in effect on the day preceding the original effective date of this section shall apply, as if such sections were not repealed by a chapter of the laws of nineteen hundred eighty-six, but in the event any such policy is at any time reexecuted, renewed, altered, modified or amended, such provisions shall apply to such policy.

§ 3427. Gap insurance; cancellation, renewal and other provisions. (a)

Definitions. As used in this section:

(1) "Covered policy" means, for purposes of this section, a policy or contract of gap insurance, issued or issued for delivery in this state, on a risk located or resident in this state.

(2) "Nonpayment of premium" means the failure of the named insured to discharge any obligations in connection with the payment of premiums on a policy of insurance or any installment of such premium, whether the premium is payable directly to the insurer or its agent, or indirectly under any premium finance plan or extension of credit. Payment to the insurer, or to an agent or broker authorized to receive such payment, shall be timely, if made within fifteen days after the mailing to the insured of a notice of cancellation for nonpayment of premium.

(b) Lessor gap insurance:

(1) A covered policy of lessor gap insurance shall be subject to all the provisions of section three thousand four hundred twenty-six of this article, except as otherwise provided in this section.

(2) Subject to the notice requirements of subsection (c) of section three thousand four hundred twenty-six of this article, a covered policy of lessor gap insurance may be cancelled only for:

(A) one or more of the bases for cancellation set forth in subparagraphs (A) through (D), and (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article;

(B) material change in the nature or extent of the risk, occurring after issuance or last annual renewal anniversary date of the policy, which causes the risk of loss to be substantially and materially increased beyond that contemplated at the time the policy was issued or last renewed; or

(C) if the policy automatically provides coverage for the gap amount waived under new leases entered into by the lessor, or acquired by the lessor's assignee, the lessor's or assignee's (whichever is the insured) failure to provide, within sixty days or as otherwise specified in the policy, the insurer with the name and address of each lessee and other information reasonably required by the insurer.

(c) Lessee gap insurance: (1) Except as provided in this section, the provisions of sections three thousand four hundred twenty-five and three thousand four hundred twenty-six of this article shall not apply to a

covered policy of lessee gap insurance.

(2) During the first sixty days a covered policy of lessee gap insurance is initially in effect, no cancellation shall become effective until twenty days after written notice is mailed to the first named insured at the mailing address shown in the policy, except for the bases for cancellation set forth in subparagraphs (A) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article for which fifteen days notice shall be given.

(3) After a covered policy of lessee gap insurance has been in effect for sixty days, or on or after the effective date if the policy is a renewal, no cancellation or nonrenewal shall become effective until fifteen days after written notice is mailed or delivered to the first named insured at the mailing address shown in the policy and cancellation or nonrenewal is conditioned upon the termination of the lease for reasons other than a total loss of the personal property caused by its theft or physical damage, or is based on one or more of the reasons set forth in subparagraphs (A) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; except that where the lease is for ten years or longer, the policy may be cancelled or nonrenewed forty-five days after written notice is mailed or delivered to the first named insured at the mailing address shown in the policy if the cancellation or nonrenewal is to be effective upon the tenth anniversary date of the policy or any subsequent annual anniversary date.

(4) If the policy is not issued for a term coextensive with the length of the lease, the insurer shall renew it for successive terms for the duration of the lease, unless cancelled or nonrenewed in accordance with the provisions of this subsection.

(d) Creditor gap insurance:

(1) A covered policy of creditor gap insurance shall be subject to all the provisions of section three thousand four hundred twenty-six of this article, except as otherwise provided in this section.

(2) Subject to the notice requirements of subsection (c) of section three thousand four hundred twenty-six of this article, a covered policy of creditor gap insurance may be cancelled only for:

(A) One or more of the bases for cancellation set forth in subparagraphs (A) through (D), and (F) through (H) of paragraph one of

subsection (c) of section three thousand four hundred twenty-six of this article;

(B) Material change in the nature or extent of the risk, occurring after issuance or last annual renewal anniversary date of the policy, which causes the risk of loss to be substantially and materially increased beyond that contemplated at the time the policy was issued or last renewed; or

(C) If the policy automatically provides coverage for the gap amount waived under new loans or other credit transactions entered into by the creditor or acquired by the creditor's assignee, the creditor's or assignee's (whichever is the insured) failure to provide, within sixty days or as otherwise specified in the policy, the insurer with the name and address of each debtor and other information reasonably required by the insurer.

(e) Debtor gap insurance:

(1) Except as provided in this section, the provisions of sections three thousand four hundred twenty-five and three thousand four hundred twenty-six of this article shall not apply to a covered policy of debtor gap insurance.

(2) During the first sixty days a covered policy of debtor gap insurance is initially in effect, no cancellation shall become effective until twenty days after written notice is mailed to the first named insured at the mailing address shown in the policy, except for the bases for cancellation set forth in subparagraphs (A) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article for which fifteen days notice shall be given.

(3) After a covered policy of debtor gap insurance has been in effect for sixty days, or on or after the effective date if the policy is a renewal, no cancellation or nonrenewal shall become effective until fifteen days after written notice is mailed or delivered to the first named insured at the mailing address shown in the policy and cancellation or nonrenewal is conditioned upon the termination of the loan for reasons other than a total loss of the personal property caused by its theft or physical damage, or is based on one or more of the reasons set forth in subparagraphs (A) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; except that where the loan or other credit transaction is for

ten years or longer, the policy may be cancelled or nonrenewed forty-five days after written notice is mailed or delivered to the first named insured at the mailing address shown in the policy if the cancellation or nonrenewal is to be effective upon the tenth anniversary date of the policy or any subsequent annual anniversary date.

(4) If the policy is not issued for a term coextensive with the length of the loan or other credit transaction, the insurer shall renew it for successive terms for the duration of the loan or other credit transaction, unless cancelled or nonrenewed in accordance with the provisions of this subsection.

(f) For purposes of this section, "property insured", as used in subparagraphs (E) and (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article, means the property which is the subject of the lease or loan or other credit transaction.

(h) Every notice of cancellation issued pursuant to this section shall specify the grounds for cancellation.

(i) If a lessor, creditor or assignee charges the lessee or debtor for the waiver of the gap amount, the lessor or creditor, or, in the absence of a waiver by the creditor or lessor, the assignee, as part of the waiver offer, shall provide the lessee or debtor with a notice specifying the name of the insurer that has issued the lessor or creditor gap insurance policy, the cost of the lessor or creditor gap insurance coverage, and the charge for the waiver. Any person having been found, after notice and hearing, to have wilfully violated this subsection shall be liable to the people of this state for a civil penalty in a sum not exceeding five hundred dollars for each violation.

(j) Notwithstanding any other provision of this chapter, the cancellation and nonrenewal provisions of this section shall apply only to the gap insurance provisions of a policy or contract that also provides other coverages and the gap insurance coverage shall be severable from the other coverages for the purposes of cancellation and nonrenewal; except that lessor or debtor gap insurance coverage included within a policy insuring a mobile home shall be subject to the cancellation and nonrenewal requirements applicable to the mobile home policy.

(k) Notwithstanding section three thousand four hundred thirty-five of

this article, a covered policy of lessor or creditor gap insurance that insures a lessor or creditor and the lessor's or creditor's assignees shall not be considered a group insurance policy.

(l) The superintendent may prescribe by regulation minimum policy provisions for gap insurance which the superintendent deems to be necessary or appropriate for lessor gap insurance, creditor gap insurance, lessee gap insurance and debtor gap insurance contracts or policies.

§ 3428. Cancellation of insurance contracts; return premiums; financed insurance premiums. (a) Except as provided in subsection (e) of this section, whenever an insurance contract made or issued in this state is cancelled or otherwise terminated by the insured before the expiration thereof in accordance with the terms of such contract, the earned premium to be retained by the insurer shall be determined by the applicable rate filing, if any, otherwise in accordance with the provisions of such contract.

(b) No authorized insurer or its agent may knowingly accept payment of premiums, for an insurance contract made or issued in this state, advanced under a premium finance agreement as defined in section five hundred fifty-four of the banking law by or for any person, firm, corporation or association who is not authorized either to engage in the business of a premium finance agency or to make loans for the purpose of financing insurance premiums in accordance with the banking law, or to include an amount for insurance in a retail instalment contract or obligation in accordance with the personal property law.

(c) No authorized insurer shall honor a power of attorney or other authority to cancel an insurance contract executed by an insured in connection with insurance premium financing, except in accordance with section five hundred seventy-six of the banking law. Voluntary advancement of a premium to the insurer by an agent or broker, where no additional charge over and above the premium has been imposed upon the insured and the insured has not signed a note or other obligation to pay the premium shall not be construed to be within the meaning of insurance premium finance agreement as defined in article twelve-b of the banking law.

(d) Whenever an insurance contract the premiums for which are advanced under a premium finance agreement as defined in section five hundred fifty-four of the banking law, is cancelled, the insurer or insurers within a reasonable time not to exceed sixty days after the effective date of the cancellation shall return whatever gross unearned premiums are due under the insurance contract or contracts to the bank, lending institution, premium finance agency or sales finance company, for the benefit of the insured.

(e) Whenever an insurance contract, issued by or on behalf of an authorized insurer or insurers, the premiums for which are advanced under a premium finance agreement as defined in section five hundred fifty-four of the banking law, is cancelled, upon such cancellation the authorized insurer or insurers shall return the gross unearned premiums due under the insurance contract or contracts, on a pro rata basis to the bank, lending institution, premium finance agency or premium finance company, for the benefit of the insured, provided, however, that such authorized insurer or insurers shall be entitled to retain a minimum earned premium on the policy of ten percent of the gross premium or sixty dollars, whichever is greater.

§ 3429. Geographical location of risks; fire, fire and extended coverage policies; private passenger automobile insurance policies. (a) No insurer shall refuse to issue or renew or shall cancel a policy of:

(1) fire insurance or fire and extended coverage insurance, or

(2) automobile insurance subject to section three thousand four hundred twenty-five of this article

based solely on the geographical location of the risk within this state. Such prohibition shall not preclude an insurer from refusing to issue or renew or from cancelling such policies based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience subject to the applicable provisions of section three thousand four hundred twenty-five of this article.

(b) The superintendent shall by regulation establish procedures with respect to notification to insureds of the insurer's specific reason or reasons for refusal to issue or renew or for cancellation of such policy.

§ 3429-a. Geographical location of risks in area serviced by a volunteer fire department; fire, fire and extended coverage policies. (a) No insurer shall refuse to issue or renew or shall cancel a homeowner's insurance policy including fire insurance or fire and extended coverage insurance based solely on the insured residing in an area that is serviced by a volunteer fire department. Such prohibition shall not preclude an insurer from refusing to issue or renew or from canceling such policies based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience subject to the applicable provisions of section three thousand four hundred twenty-five of this article.

(b) The superintendent shall by regulation establish procedures with respect to notification to insureds of the insurer's specific reason or reasons for refusal to issue or renew or for cancellation of such policy.

§ 3430. Right of insured, agent or broker aggrieved on basis of geographical location of property or risks. (a) An insured aggrieved by an inability to obtain:

(1) homeowner's insurance, including fire insurance or fire and extended coverage insurance, other than from the New York property insurance underwriting association, or

(2) automobile insurance subject to section three thousand four hundred twenty-five of this article, other than through the New York automobile insurance plan,

from any insurer or through any insurance agent or broker because of the geographical location of the risk or property within the state or a licensed agent or broker whose contract or account was terminated or not renewed because of the geographical location of the agent or broker or the geographical location of the risks within the state for which coverage is afforded through the agent or broker and the grievance was not the result of the application of sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience may file a complaint to that effect with the superintendent on a form

prescribed by him.

(b) The superintendent shall investigate the complaint pursuant to rules and regulations promulgated by him. In addition to any other power or procedure authorized by this chapter, the superintendent may require the physical inspection of the risk or property or hold a hearing, or both, for the purpose of assisting him in his determination of the issues raised by the complaint.

§ 3431. Immunity; insurers' reports to insureds, to applicants for insurance and to terminated agents or brokers. (a) In any written notice of:

(1) refusal to issue,

(2) cancellation,

(3) reduction of limits,

(4) substitution of policy form,

(5) elimination of coverages,

(6) conditioned renewal,

(7) non-renewal, or

(8) termination or refusal to renew a contract or account of a licensed agent or broker, or in any other communication, oral or written, specifying the reasons for such action, there shall be no liability on the part of, and no cause of action of any nature shall arise against any insurer, its authorized representatives, agents, or employees or any licensed agent or broker for any statement made in good faith by any of them or for providing information pertaining thereto or for statements made or evidence submitted at any hearings in connection therewith.

(b) Subsection (a) hereof shall provide immunity with respect to all obligations and duties performed pursuant to sections three thousand four hundred twenty-five, three thousand four hundred twenty-six, three thousand four hundred twenty-nine and three thousand four hundred thirty-three of this article.

(c) Notwithstanding subsection (a) hereof in the case of any statement made pursuant to section three thousand four hundred twenty-six of this article, there shall be no liability unless the statement is shown to have been in bad faith and with malice in fact.

§ 3432. Immunity; reports to certain public officials and to designated organizations. (a) In the absence of fraud or bad faith, there shall be no liability on the part of, and no cause of action of any nature shall arise against, an insurer or a hospital or any person acting on their behalf, with respect to obligations and duties performed pursuant to the sections referred to in subsection (b) hereof.

(b) The immunity shall apply to:

(1) reports and statements, made in good faith, to the commissioner of motor vehicles required by subsection (l) of section three thousand four hundred eleven of this article;

(2) information, reports, notification and assistance in investigations, made in the absence of fraud or bad faith, pursuant to section three thousand four hundred twelve of this article and this immunity extends to a central organization designated by the superintendent pursuant to such section or any person acting on its behalf;

(3) reports required by section three hundred fifteen of this chapter, made in good faith (which shall be presumed) and without malice, and this immunity includes any liability, civil or criminal;

(4) information, reports, assistance in investigations, notification, made in the absence of fraud or bad faith, to any authorized law enforcement agency pursuant to section three hundred nineteen of this chapter, and this immunity, civil or criminal, extends to an authorized law enforcement agency defined in such section or any person acting on its behalf; and

(5) reports required by section three hundred eighteen of this chapter, made in the absence of fraud or bad faith, to a central organization designated by the superintendent, and this immunity extends to the central organization or any person acting on its behalf.

(6) information required by the insurer or provided by the insurer in the absence of fraud or bad faith to a local fire investigation agency pursuant to section three thousand four hundred fifteen of this article.

§ 3433. Termination of contracts or accounts of licensed agents or

brokers; prohibition; geographical location. (a) No insurer shall terminate or refuse to renew a contract or account of a licensed agent or broker who negotiated policies of:

(1) fire insurance or fire and extended coverage insurance or

(2) automobile insurance subject to section three thousand four hundred twenty-five of this article when such termination or refusal to renew is based solely on the geographical location of the agent or broker or of the risks for which coverage is afforded through such agent or broker.

(b) The superintendent shall by regulation establish procedures requiring notification to such agents or brokers of the insurer's specific reason or reasons for termination or refusal to renew the agent's or broker's contract or account.

§ 3434. Motor vehicle insurance policies; disabled persons; prohibitions against cancelling, refusing to issue or renew policies. Insurers shall be prohibited from cancelling or refusing to issue or renew a motor vehicle insurance policy to any person with a disability, as defined in subdivision twenty-one of section two hundred ninety-two of the executive law, unless based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.

§ 3435. Group property/casualty insurance.

(a) This section shall apply to public entities as defined in section one hundred seven of this chapter, organizations described by section 501(c)(3) of the United States internal revenue code, charitable corporations as defined in paragraph (a) of section one hundred two (Definitions) of the not-for-profit corporation law and formed pursuant to paragraph (a) of section two hundred one of the not-for-profit corporation law, and organizations described by section two hundred sixteen-a of the education law.

(b) Notwithstanding any other provision of this chapter, group coverage for homogeneous groups formed for purposes other than obtaining insurance may be approved, subject to regulations to be promulgated by the superintendent, for the kinds of insurance permitted in subsection

(c) of this section, provided such policies shall be available to all eligible members of such group upon application.

(c) Group policies may be written pursuant to this section for any of the kinds of insurance authorized by subsection (a) of section one thousand one hundred thirteen of this chapter, except the kinds of insurance authorized by paragraphs one, two, three, sixteen, seventeen, eighteen, twenty-one, twenty-two, twenty-three and twenty-five of such subsection.

(d) Group policies approved pursuant to this section shall not be eligible for the filing exemptions specified in section six thousand three hundred one of this chapter.

§ 3435-a. Motor vehicle insurance policies; New York state licensed drivers; prohibitions against refusing to issue policies or renew policies. (a) Insurers shall be prohibited from refusing to issue a motor vehicle liability insurance policy to any person with a valid New York state driver's license which has been maintained by such person for at least thirty-nine months prior to the time of application for such policy of insurance solely on the basis that such person has not owned or leased a vehicle during such period, unless such decision is based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience. Provided, however, that an applicant demonstrating a continuous, valid out-of-state or out-of-country driver's license during such thirty-nine month period due to active service in the United States army, navy, air force, space force or marines shall be treated as if continuous licensing had been maintained in New York and such person shall not be rejected based solely on the fact that such person served in the military.

(b) Insurers shall be prohibited from refusing to renew an existing motor vehicle liability insurance policy solely upon the basis of the named insured having reached sixty years of age and shall be prohibited for the purpose of policy renewal from requesting a physical examination or medical questionnaire solely on the basis of the named insured having reached sixty years of age unless such decision is based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.

(c) Insurers shall be prohibited from refusing to renew an existing motor vehicle liability insurance policy solely upon the basis of the age of the motor vehicle to be insured unless such decision is based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience.

*** § 3436. Medical malpractice insurance; type of coverage.** (a) Every insurer which issues or renews policies for primary levels of medical malpractice insurance covering physicians licensed to practice in this state shall issue such policies on a claims-made or occurrence basis, as prescribed by the superintendent by regulation; provided, further, that nothing in this section shall preclude any insurer from applying otherwise applicable underwriting standards in determining whether to issue or renew such policies.

(b) A claims-made policy shall contain the following provisions:

(1) if the insured has purchased a claims-made policy from an admitted insurer for a period of five or more consecutive years and the insured, after attaining the age of sixty-five or older, retires permanently and totally from the practice of medicine or if the insured has purchased such a policy for a period of ten or more consecutive years, and the insured, after attaining the age of fifty-five or older, retires permanently and totally from the practice of medicine, the insurer shall, without charging an additional premium therefor at the time of, or subsequent to, such retirement, also cover all occurrences between the inception date of the first such consecutive policy from such insurer and such retirement date which, subsequent to the termination date, are reported in accordance with statutory and policy requirements;

(2) if the insured dies or becomes permanently disabled and unable to practice medicine while covered by such a policy, the insurer shall, without charging an additional premium therefor at the time of, or subsequent to, such event, also cover all occurrences between the inception date of the first such consecutive policy from such insurer and the death or disability of the insured; and

(3) the insurer shall make available and shall advise the insured of the availability and cost of coverage for occurrences between the inception date of the first such consecutive policy from such insurer

and the termination of such policy which, subsequent to the termination date, are reported in accordance with statutory and policy requirements, pursuant to such terms and conditions as may be specified by the superintendent by regulation. The insured shall have the option of purchasing such coverage either in a single payment, or in three annual installments with an additional finance charge.

(c) Such regulation shall also provide that if the coverage of an insured who continues to practice in this state is transferred from an admitted insurer or the medical malpractice insurance association to another admitted insurer or the medical malpractice insurance association without any gap in coverage, the former entity shall pay over to the successor an actuarially appropriate dollar amount to provide for the requirements of subsection (b) of this section, and the insured shall be entitled to the benefits of such subsection as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

(d) Such regulation shall also provide that if the coverage of an insured is transferred from an insurer in liquidation to another insurer not in liquidation without any gap in coverage, then the successor entity shall accept the amounts payable from the property-casualty insurance security fund as provided in subparagraph (G) of paragraph one of subsection (a) of section seven thousand six hundred three of this chapter, to provide for the requirements of subsections (b) and (c) of this section, and the insured shall be entitled to the benefits of such subsections as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

(e) An insurer may issue a claims-made policy with more liberal policy provisions than are required in this section, subject to the approval of the superintendent. Such liberal policy provisions may include but not be limited to a provision which, for all of the policyholders of the insurer, grants credit toward the cost of the coverage provided in subsection (b) of this section in proportion to the number of years the insured has purchased a claims-made policy.

* NB There are 2 § 3436's

*** § 3436. Group credit unemployment insurance and individual credit unemployment insurance.** (a) Any policy of credit unemployment insurance which covers more than one person shall be deemed a group credit unemployment policy.

(b) No policy of group credit unemployment insurance, and no certificate thereunder, shall be delivered or issued for delivery in this state unless it conforms to the requirements of this section and section three thousand two hundred one of this chapter.

(c) A policy of group credit unemployment insurance may only be issued to a creditor, vendor, trustee, trustees or agent insuring a group of debtors or vendees, all as defined and set forth in paragraph three of subsection (b) of section four thousand two hundred sixteen of this chapter and under the same conditions and limitations and subject to the definitions as specified therein; provided, however, that the amount of benefits payable with respect to any person insured thereunder shall not at any time exceed:

(1) in all cases except as hereinafter provided the lesser of fifty-five thousand dollars and the total of payments scheduled to be paid by the person to whom credit has been extended;

(2) 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 for minors, the lesser of fifty-five thousand dollars and the total amount 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;

(3) in the case of a transaction secured by a real estate mortgage, the lesser of one hundred ten thousand dollars and the total of payments scheduled to be paid by the person to whom credit has been extended; or

(4) in all cases the amounts of the payment or payments due during the period of unemployment of the covered person, excluding such amounts which may have become due by acceleration or default.

(d) Benefits under a policy of group credit unemployment insurance may be provided to a debtor or vendee only if such debtor or vendee qualifies for unemployment insurance benefits in this state pursuant to article eighteen of the labor law or would qualify thereunder but for exclusion therefrom pursuant to subdivision three, four, five, six, ten

or eleven of section five hundred eleven of the labor law, or by reason of exhaustion of benefits or length of employment. No insurance company writing a policy permitted by this section shall, directly or indirectly, through an agent or representative, have standing to participate in a hearing or court proceeding in which the eligibility for unemployment insurance benefits of an insured under this section shall be in controversy, unless the insured was an employee of said company.

(e) Credit unemployment insurance may be written separately or in combination with all or any of the kinds of insurance authorized in paragraphs three, seven and twenty of subsection (a) of section one thousand one hundred thirteen of this chapter. The superintendent may by regulation prohibit or limit any combination based upon the amount of insured indebtedness or the amount of premium. The premium rate for each kind of insurance shall be disclosed and the total premium charge for the combination shall likewise be disclosed.

(f) Acceptance of credit unemployment insurance by a debtor must be voluntary and not a condition of extending credit nor a factor in the cost of the credit agreement other than the cost of credit unemployment insurance. The insurance agreement must be signed and dated separately from the request for credit and must clearly and conspicuously disclose to the debtor (1) that the insurance coverage is not required by the creditor and (2) the cost of the credit unemployment insurance.

(g) (1) 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 this section, 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. 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.

(2) The provisions of paragraph one of this subsection shall apply to New York residents insured under a policy issued in any other jurisdiction to a group which is described in this section.

* NB There are 2 § 3436's

§ 3436-a. Adverse action against legal reproductive health care or gender-affirming care. (a) Every insurer that issues or renews medical malpractice insurance or professional liability insurance covering a health care provider licensed to practice in this state shall be prohibited from taking any adverse action against a health care provider solely on the basis that the health care provider engages in legally protected health activity, as defined by section 570.17 of the criminal procedure law. The superintendent is expressly authorized to interpret "legally protected health activity" as if such definition was stated within this section. Such policy shall include health care providers who prescribe abortion medication to out-of-state patients by means of telehealth.

(b) Every insurer that issues or renews medical malpractice or professional liability insurance covering a health care provider licensed to practice in this state shall be prohibited from refusing to issue or renew, canceling, or charging or imposing an increased premium or rate for, or excluding, limiting, restricting, or reducing coverage under a medical malpractice or professional liability insurance policy based solely upon the legal use or prescription in this state of any drug prescribed for the purpose of an abortion, including both generic and brand name drugs, that has not been approved by the food and drug administration for abortion, provided, however, that such drug shall be a recognized medication for abortion in one of the following established reference compendia:

(1) The WHO Model Lists of Essential Medicines;

(2) The WHO Abortion Care Guidance; or

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

(c) As used in this section, "adverse action" shall mean but not be limited to: (1) refusing to renew or execute a contract or agreement

with a health care provider; (2) making a report or commenting to an appropriate private or governmental entity regarding practices of such provider which may violate abortion laws in other states; and (3) increasing in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount for, any medical malpractice or professional liability insurance contract or agreement with a health care provider.

(d) As used in this section, "medical malpractice insurance" shall have the meaning set forth in section five thousand five hundred one of this chapter.

(e) As used in this section, "professional liability insurance" shall mean insurance against legal liability of the insured, and against loss, damage, or expense incident to a claim of such liability arising out of the death or injury of any person due to medical, psychiatric, mental health, or other malpractice by any licensed physician assistant, physical therapist, physical therapist assistant, pharmacist, registered pharmacy technician, nurse, psychologist, psychiatrist, social worker, occupational therapist, speech-language pathologist, or mental health practitioner.

(f) As used in this section, "health care provider" shall mean a person who is licensed, certified, or authorized under title eight of the education law and acting within their lawful scope of practice and includes, but is not limited to persons subject to articles one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-six, one hundred thirty-seven, one hundred thirty-seven-A, one hundred thirty-nine, one hundred forty, one hundred fifty-three, one hundred fifty-four, one hundred fifty-six, one hundred fifty-nine, or one hundred sixty-three of the education law or any other person designated as a health care provider by law, rule, or regulation.

§ 3437. Credit insurance for in-vitro fertilization or intrauterine insemination. (a) Except as provided in subsection (b) of this section, an insurer that issues a credit insurance policy pursuant to clause (III) of item (i) of subparagraph (D) of paragraph seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter shall provide a statement in the application for the insurance

policy and in a prominent writing upon policy issuance that the credit insurance policy is not a substitute for comprehensive health insurance.

(b) An excess line broker who procures such a credit insurance policy pursuant to section two thousand one hundred five of this chapter shall provide the statement required by subsection (a) of this section on behalf of the insurer.

§ 3439. Reinsurance contracts excepted. The provisions of this article shall not apply to contracts of reinsurance, except as otherwise provided by law.

§ 3440. Insurance covering private passenger motor vehicles; rental vehicle coverage. (a) For the purposes of this section, a "private passenger motor vehicle" is a motor vehicle: (1) of the private passenger or station wagon type that is owned or hired by an individual or by husband and wife under a long-term contract and is neither used as a public or livery conveyance for passengers nor rented to others without a driver; or

(2) with a pick-up body, a delivery sedan, panel truck or van, owned by an individual or by husband and wife who are residents of the same household or by a family farm co-partnership or a family farm corporation, and not customarily used in the occupation, profession or business of the insured other than farming or ranching, whether or not used in the course of driving to or from work.

(b) Subject to subsection (d) of this section, every motor vehicle liability insurance policy which insures less than five private passenger motor vehicles registered in this state shall by endorsement, provide coverage for the obligation of the insured for actual damage to, or loss of, vehicles (including loss of use) rented by an insured in the United States, its territories or possessions and Canada under a rental agreement with a term of thirty continuous days or less, regardless of where within those areas such rental vehicle is registered, rented, or operated, subject to such maximum coverage limitations as the superintendent may by regulation prescribe or any other applicable limits in the policy, whichever is higher. The term "rental vehicle"

shall be used as defined in section one hundred thirty-seven-a of the vehicle and traffic law, if a private passenger motor vehicle and not used for the transportation of persons or property for hire.

(c) In no event shall payment be made by more than one insurer or under more than one policy, and where a person is insured under more than one policy, such coverage shall apply in the following order of priority: (1) the policy or policies with respect to which the person is a named insured; (2) if the person is not a named insured on any policy, the policy with respect to which the person is an insured; (3) where two or more policies provide coverage of equal priority, the insurer to which the claim is first submitted.

(d) (1) Every policy to which this section applies shall, either upon issuance or upon the first renewal after April first, nineteen hundred eighty-nine, be accompanied or supplemented by a notice, in a form prescribed or approved by the superintendent, advising the insured of the rental vehicle coverage provided pursuant to this section.

(2) In the event that a separate charge based upon rental vehicle coverage experience is included in the rate or policy premium, the insurer shall thereafter advise each new insured and with the initial renewal notice for policies thereafter renewed of the insured's opportunity to reject such coverage within ten days following such notice.

(e) Nothing in this section shall be construed to require an insurer to make payment under the coverage herein for damage to, or loss of, a rental vehicle (including loss of use) which the rental vehicle company is precluded from recovering from the insured whether pursuant to the terms of the rental agreement or due to the prohibitions of section three hundred ninety-six-z of the general business law or similar statutory provisions of other jurisdictions; or which is not otherwise recoverable under the applicable insurance policy or policies.

(f) Nothing in this section shall preclude an insurer from pursuing subrogation rights in connection with claims involving rental vehicle coverage.

§ 3442. Credit card, debit card, or checking account group policies. (a) For purposes of this section, unless the context requires otherwise:

(1) "Account group member" means a person:

(A) to whom a credit card account or debit card account is issued by a sponsor or who has agreed with the sponsor to pay obligations arising from the use of a credit card or debit card issued to another person; or

(B) who may access by check an account maintained by the sponsor.

(2) "Account group policy" means a group policy, including certificates issued to the group members, where the group policyholders, and each additional group policyholder, if any, is:

(A) a sponsor and the policy's group members are its account group members or other authorized users of the account group member's payment medium; or

(B) an interchange organization, or the trustee or trustees of a trust established, or participated in, by one or more interchange organizations or one or more sponsors who are members of the interchange organization, where the policy's group members are the authorized users of the payment medium administered by the interchange organization or by its member sponsors.

(3) "Authorized user" means a group member or any other person designated by the group member as an authorized user of the account group member's payment medium.

(4) "Beneficiary" means an authorized user of a payment medium or any other person who is a recipient of the benefits of the payment medium who is designated as an additional insured under an account group policy.

(5) "Certificate" or "certificate of insurance" means any policy, contract, or other evidence of insurance, or rider or endorsement thereto, issued to a group member under an account group policy.

(6) "Check" means a check, draft, credit union share draft, negotiable order of withdrawal, or other written, electronic or telephonic order but does not include a traveler's check.

(7) "Commercial creditor" means a corporation, partnership, association or other organization that, as part of its vocation, extends credit by making loans, issuing credit cards, or otherwise, including:

(A) a bank, trust company, savings bank, savings and loan association, or credit union, as those terms are defined in section two of the banking law;

(B) a national bank, federal savings bank, federal savings and loan

association, or federal credit union, as those terms are defined in title twelve of the United States Code;

(C) a foreign banking corporation licensed to maintain a branch or agency in New York under article five of the banking law or title twelve of the United States Code;

(D) a creditor, as defined in section one thousand six hundred two of title fifteen of the United States Code;

(E) an issuer of a credit card, within the meaning of article twenty-nine-A of the general business law;

(F) a transmitter of money, within the meaning of article thirteen-A of the banking law; or

(G) a retailer.

(8) "Conditional renewal" means change of limits, change in type of coverage, reduction or elimination of coverage, increased deductible or addition of exclusion, or increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of increased exposure units or as a result of experience rating, loss rating, retrospective rating, or audit).

(9) "Credit card" means a payment medium that takes the form of a credit card, credit plate, charge plate, courtesy card, or other identification card or device, issued by a sponsor to an account group member (or a check drawn by an authorized user against the credit card account), which an authorized user may use to obtain a loan, credit, or cash advance, or to purchase, hire, rent or lease property or services.

(10) "Debit card" means a payment medium that takes the form of a card, plate, or other identification card or device, issued by an issuer to an account group member who is an owner of a deposit account maintained by the issuer, which an authorized user drawing upon the deposit account may use to purchase, hire, rent or lease property or services. "Debit card" does not include a credit card or a check.

(11) "Group member" means an account group member who is insured under the account group policy.

(12) "Interchange organization" means a person that administers a payment medium for the benefit of one or more sponsors and the sponsor's account group members.

(13) "Motor vehicle" means a motor vehicle as defined in section three hundred eleven of the vehicle and traffic law, whether or not used on a

public highway, and includes a snowmobile as defined in section two thousand two hundred twenty-one of the vehicle and traffic law.

(14) "Payment medium" means a credit card, debit card or check.

(15) "Person" includes an individual, corporation, partnership, association, or other legal entity.

(16) "Sponsor" means:

(A) a commercial creditor that issues a credit card or debit card to its account group members;

(B) a commercial creditor that maintains an account which may be accessed by check by the commercial creditor's account group members; or

(C) the trustee or trustees of a trust established, or participated in, by one or more commercial creditors for the benefit of the commercial creditor's account group members.

(b) An account group policy or certificate may be issued or issued for delivery in this state only in compliance with the provisions of this section.

(c) Coverage under an account group policy shall extend only to beneficiaries and shall be associated with the direct use or employment of a payment medium by an authorized user to purchase, hire, lease or rent property or services.

(d) An account group policy may provide only one or more of the following property/casualty insurance coverages, subject to the following limitations:

(1) Loss of or damage to personal property, other than loss of use or loss resulting from a defect in materials or workmanship, where:

(A) the article of personal property is owned by;

(i) an authorized user; or

(ii) a beneficiary other than an authorized user, if coverage is provided under the account group policy to the beneficiary as an additional insured;

(B) the article of personal property is purchased using the account group member's payment medium;

(C) the amount of coverage is limited to the amount charged, debited, or drawn, unless the insurer repairs or replaces the article of personal property, but in no event shall the coverage exceed ten thousand dollars per article and fifty thousand dollars in the aggregate per group member per policy year;

(D) the period of coverage for each article of personal property does not exceed ninety days from date of purchase; and

(E) the coverage is excess over any other valid and collectible insurance covering the same article of personal property, except that the coverage need not be excess over insurance issued pursuant to this paragraph.

(2) Obligation to a person engaged in the business of renting or leasing motor vehicles, for loss of or damage to a motor vehicle rented or leased from that person, where:

(A) the obligation is incurred by:

(i) an authorized user; or

(ii) another person driving the motor vehicle with the authorized user's permission, if coverage under the account group policy is provided to such beneficiary as an additional insured;

(B) the rental or lease of the motor vehicle is paid wholly by means of the account group member's payment medium;

(C) the period of the rental or lease coverage does not exceed:

(i) forty-five consecutive days where the payment medium used for the rental or lease was a credit card issued to an account group member that is an employee of a person that has contracted with a sponsor to provide credit cards to the person's employees primarily for business use; or

(ii) thirty-one consecutive days for all other authorized users;

(D) the coverage is excess over any other valid and collectible insurance covering the same motor vehicle, except that the coverage may be primary for motor vehicle rentals or leases:

(i) when the motor vehicle is used outside the United States, its territories and possessions; or

(ii) where the payment medium used for the rental or lease was a credit card issued to an account group member that is an employee of a person that has contracted with a sponsor to provide credit cards to the person's employees primarily for business use; or

(E) the motor vehicle is rented or leased without a driver.

(3) Loss of, damage to, or loss of use of baggage and its contents, where:

(A) (i) the authorized user owns or uses the baggage and its contents, and the loss, damage, or loss of use occurs in connection with the authorized user being in transit; or

(ii) a beneficiary other than an authorized user owns or uses the baggage and its contents, and the loss, damage, or loss of use occurs while in connection with that beneficiary being in transit, if coverage under the policy is provided in regard to the beneficiary as an additional insured;

(B) the account group member's payment medium is used to obtain transportation or accommodations for the owner of the baggage and its contents, in connection with that owner being in transit; and

(C) the amount of coverage does not exceed two thousand dollars per bag, including contents, and ten thousand dollars in the aggregate for all insureds per trip.

(4) Loss of, damage to, or loss of use of personal property resulting from a defect in materials or workmanship in that property, where:

(A) the article of personal property is owned by:

(i) an authorized user; or

(ii) a beneficiary other than an authorized user, if coverage is provided under the account group policy to the beneficiary as an additional insured;

(B) the article of personal property is purchased by means of the account group member's payment medium;

(C) the amount of coverage is limited to the amount charged, debited, or drawn, but in no event shall exceed ten thousand dollars; and

(D) the article of personal property has one or more warranties issued by a manufacturer, distributor or seller.

(5) Loss of, damage to, or loss of use of personal property occurring in connection with the use of rented or leased motor vehicles where:

(A) the article of personal property is owned by:

(i) an authorized user; or

(ii) a beneficiary other than an authorized user if coverage is provided under the account group policy to the beneficiary as an additional insured;

(B) the rental or lease of the motor vehicle is paid for wholly by means of the account group member's payment medium;

(C) the period of coverage does not exceed the lesser of:

(i) the rental or lease period; or

(ii) forty-five consecutive days where the payment medium used for the rental or lease was a credit card issued to an account group member that

is an employee of an entity that has contracted with a sponsor to provide credit cards to the entity's employees primarily for business use; or thirty-one consecutive days for all other authorized users;

(D) the motor vehicle is rented or leased without a driver; and

(E) the amount of the coverage does not exceed five thousand dollars.

(6) Losses incurred in connection with the unauthorized use of a payment medium, where:

(A) one or more individuals are designated authorized users of a payment medium by virtue of their status as employees of a group member in accordance with procedures established by such group member for authorized use of the payment medium;

(B) the group member that employs such authorized users has agreed with another group member to pay obligations arising from the use of such payment medium by such authorized users;

(C) an authorized user uses such payment medium in a manner that is unauthorized by the group member that employs the authorized user;

(D) the obligation of the group member that employs the authorized users to such other group member, pursuant to the agreement described in subparagraph (B) of this paragraph for a loss incurred in connection with use in an unauthorized manner, is discharged by payment of the insurance benefit to such other group member;

(E) the amount of coverage shall be limited to the amount of the loss, but in no event shall exceed fifteen thousand dollars; and

(F) for purposes of this paragraph only, the term "group member" shall include (i) those entities specified in subparagraphs (A) through (F) of paragraph seven of subsection (a) of this section which are insureds under the insurance described in subparagraph (D) of this paragraph, and (ii) employers of account group members who are designated authorized users of a payment medium by virtue of their employee status.

(7) Loss resulting from an inability to use a ticket to an event where:

(A) the ticket was purchased with the account group member's payment medium;

(B) the event does not fully reimburse the person for the expenses disbursed or to be disbursed for the ticket, including any fees, or provide a ticket of equal value or a rain check;

(C) the amount of coverage is limited to the amount charged, debited,

or drawn, but shall not exceed seven hundred fifty dollars per ticket; and

(D) the coverage is excess over any other reimbursement.

(8) Loss due to cancellation of a catered affair where:

(A) the expenses were paid by means of the account group member's payment medium;

(B) the amount of coverage is limited to the amount charged, debited, or drawn, but shall not exceed thirty thousand dollars in any twelve month period; and

(C) the coverage is excess over any other reimbursement.

(9) Loss of tuition and other educational expenses due to a student's dismissal or withdrawal from an educational institution where:

(A) expenses were paid by means of the account group member's payment medium;

(B) the amount of coverage is limited to the amount charged, debited, or drawn, but shall not exceed sixty thousand dollars in any twelve month period; and

(C) the coverage is excess over any other reimbursement.

(10) Loss resulting from the cancellation or interruption of a trip, where:

(A) coverage is limited to a specific trip;

(B) the trip was paid by means of the account group member's payment medium;

(C) the amount of coverage is limited to the amount charged, debited, or drawn, but shall not exceed fifteen thousand dollars per trip; and

(D) the coverage is excess over any other reimbursement.

(11) Loss of or damage to personal property, where:

(A) (i) the authorized user owns or uses the personal property, and the loss or damage occurs in connection with a specific trip; or

(ii) a beneficiary other than an authorized user owns or uses the personal property, and the loss or damage occurs in connection with a specific trip, if coverage is provided under the account group policy to the beneficiary as an additional insured;

(B) the trip was paid by means of the account group member's payment medium;

(C) the amount of coverage does not exceed one thousand dollars per article of personal property, and five thousand dollars in the aggregate

for all insureds per trip; and

(D) the coverage is excess over any other valid and collectible insurance covering the same article of personal property.

(12) Loss of or damage to wireless communications equipment or loss of use resulting from a defect in materials or workmanship to wireless communication equipment, where:

(A) the wireless communications equipment is owned or leased by;

(i) an authorized user; or

(ii) a beneficiary other than an authorized user, if coverage is provided under the account group policy to the beneficiary as an additional insured;

(B) the account group member's payment medium is used to obtain the wireless services related to the wireless communication equipment;

(C) the amount of coverage does not exceed ten thousand dollars per wireless communications equipment, but in no event shall the coverage exceed fifty thousand dollars in the aggregate per group member per policy year;

(D) the period of coverage for the wireless communication equipment does not exceed 60 days from each date wireless services are charged, debited, or drawn; and

(E) For purposes of this paragraph, the term "wireless communications equipment" shall mean wireless handsets, pagers, personal digital assistants, wireless telephones or wireless telephone batteries and other wireless devices and accessories related to such devices that are used to access wireless communications services and includes wireless services.

(13) Coverages which, in the opinion of the superintendent, are determined to be substantially similar to one of the foregoing coverages specified in paragraphs one through twelve of this subsection, or such other coverages that the superintendent determines are limited in scope, and not duplicative or a substitute for other more comprehensive coverages, and thereupon for purposes of this section shall be deemed to be permissible pursuant to regulations promulgated by the superintendent.

(e) (1) An account group policy shall not cover a motor vehicle, except in regard to coverage under paragraph two of subsection (c) of this section.

(2) An account group policy shall not be considered a motor vehicle policy for purposes of this chapter.

(f) The premium for the account group policy, including certificates, may be paid by the group policyholder from funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the group members; or

(3) jointly by the group policyholder and group members.

(g) (1) Any policy dividend, retrospective premium credit, or retrospective premium refund in respect of premiums paid by the group policyholder may:

(A) be applied to reduce the premium contribution of the group policyholder, but not in excess of the proportion to its contribution; or

(B) be retained by the group policyholder.

(2) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed under paragraph one of this subsection shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group members, or both; or

(B) paid or refunded to those group members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) the insurer shall be responsible for determining the allocation of the payment or refund to the group members;

(ii) if the group policyholder distributes the payment or refund, the insurer shall be responsible for audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) if the group policyholder fails to make the payment or refund, the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(3) Notwithstanding paragraphs one and two of this subsection, if a dividend accrues upon termination of coverage under an account group policy, the premium for which was paid out of funds contributed by group members specifically for the coverage, the dividend shall be paid or refunded by the group policyholder to the group members insured on the date the payment or refund is made to the group policyholder, net of

reasonable expenses incurred by the group policyholder in paying or refunding the dividend to such group members.

(4) For the purposes of this subsection, "dividend" means a return by an insurer to a group policyholder of excess premiums paid by that group policyholder in light of favorable loss experience, including retrospective premium credits or retrospective premium refunds. The term "dividend" does not include reimbursements or fees received by a group policyholder in connection with the operation or administration of an account group policy, including administrative reimbursements, fees for services provided by the group policyholder, or transactional service fees.

(h) The insurer must treat in like manner all eligible account group members of the same class and account status.

(i) The group shall consist of at least one thousand members.

(j) An account group policy or certificate shall not be eligible for placement by an excess line broker licensed pursuant to article twenty-one of this chapter.

(k) Coverage provided under an account group policy or certificate issued pursuant to paragraph four of subsection (d) of this section shall be deemed miscellaneous property insurance, as enumerated in paragraph five of subsection (a) of section one thousand one hundred thirteen of this chapter.

(l) (1) The insurer shall be responsible for the mailing or delivery of a certificate of insurance to each group member insured under the account group policy. The insurer shall also be responsible for the mailing or delivery to each group member of an amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of exclusion, under the account group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the group member, unless the account group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If coverage afforded to the group member is excess of other applicable insurance coverage, the certificate shall contain a notice advising the group member that, if the member has other insurance

coverage, specified coverages under the account group policy will be excess over the other insurance.

(m) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an agent or broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under an account group policy or certificate.

(n) An account group policy or certificate shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply in regard to termination of coverage:

(1) (A) An account group policy or certificate may be cancelled by an insurer only if cancellation is based on one or more of the reasons set forth in subparagraphs (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission by a group member which would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the account group policy.

(B) Where the premium is derived wholly from funds contributed by the group policyholder, an individual certificate may be cancelled by the insurer only if cancellation is based on one or more of the reasons set forth in subparagraph (B), (C) or (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article.

(2) (A) An insurer's cancellation of an account group policy, including all certificates, shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy.

(i) Where all or part of the premium is derived from funds contributed by a group member specifically for the coverage, written notice of cancellation of the account group policy shall also be mailed or delivered by the insurer to the group member at the group member's mailing address.

(ii) Where none of the premium is derived from funds contributed by a group member specifically for the coverage, the group policyholder shall mail or deliver written notice to the group member advising the group member of the cancellation of the account group policy and the effective

date of cancellation. The written notice shall be mailed or delivered by the group policyholder within ninety days after receiving notice of cancellation from the insurer.

(B) An insurer's cancellation of an individual certificate shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group member at the group member's mailing address and to the group policyholder at the mailing address shown in the account group policy.

(C) (i) A group policyholder may cancel an account group policy, including all certificates, or any individual certificate, for any reason upon thirty days written notice to the insurer and each group member; and

(ii) The group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the account group policy or certificate and the effective date of cancellation. Such written notice shall be mailed or delivered to the group member's mailing address at least thirty days prior to the effective date of the cancellation.

(3) (A) Unless an account group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The group policyholder shall be entitled to renew the account group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless:

(i) the insurer mails or delivers to the group policyholder and all group members written notice of nonrenewal, or conditional renewal; and

(ii) the written notice is mailed or delivered at least thirty, but not more than one hundred twenty days prior to the expiration date specified in the policy or, if no date is specified, the next anniversary date of the policy.

(C) Notwithstanding subparagraph (A) of this paragraph, an account group policy insuring an experimental program that is test marketed for a period of one hundred twenty days or less may be issued for that policy period. The provisions of subparagraph (B) of this paragraph shall not apply if the group members were previously notified of the expiration date of the account group policy.

(4) (A) Where the account group policy is nonrenewed by the group

policyholder, the group policyholder shall mail or deliver written notice to each group member advising the group member of nonrenewal of the account group policy and the effective date of nonrenewal. The written notice shall be mailed or delivered by the group policyholder at least thirty days prior to the nonrenewal.

(B) The provisions of subparagraph (A) of this paragraph shall not apply in the case of a sponsor's nonrenewal in connection with an account group policy insuring an experimental program test marketed for a period of one hundred twenty days or less, if the group members were previously notified of the expiration date of the account group policy.

(5) Every notice of cancellation, nonrenewal, or conditional renewal shall contain the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(6) (A) An insurer shall not be required under this subsection to give notice to a group member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to a group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(7) (A) If, prior to the effective date of cancellation, nonrenewal, or conditional renewal of the account group policy, or a certificate, whether initiated by the insurer, group policyholder or by the group member in regard to the group member's certificate, coverage attaches pursuant to the terms of an account group policy providing insurance of one or more of the types enumerated in this section, then the coverage shall be effective until expiration of the applicable period of coverage provided in the account group policy notwithstanding the cancellation, nonrenewal or conditional nonrenewal of the account group policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate coverage under an individual certificate on the effective date of cancellation, if the certificate is cancelled in accordance with the provisions of subparagraph (B) of paragraph one of this subsection.

(o) The superintendent may, pursuant to regulation, adjust the monetary limitations set forth in subsection (d) of this section for inflation.

§ 3443. Workers' compensation and employers' liability insurance; optional policyholder deductibles. An insurer issuing a workers' compensation and employers' liability insurance policy, may offer, as part of the policy or by endorsement, deductibles optional to the policyholder for benefits payable under the policy, subject to approval by the superintendent and subject to underwriting by the insurer, consistent with the following standards or factors:

(a) claimants' rights are properly protected and claimants' benefits are paid without regard to any such deductible;

(b) appropriate premium reductions reflect the type and level of any deductible approved by the superintendent and selected by the policyholder;

(c) premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount;

(d) recognition is given to policyholder characteristics, including size, financial capabilities, nature of activities, and number of employees;

(e) if the policyholder selects a deductible, the policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims;

(f) the insurer pays all of the deductible amount, applicable to a compensable claim, to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount; and

(g) failure to reimburse deductible amounts by the policyholder to the insurer is treated under the policy in the same manner as nonpayment of premiums.

§ 3444. Flood insurance notice. 1. Insurers shall provide to their homeowners and dwelling fire personal lines insureds an annual notice prescribed or approved by the superintendent, explaining clearly and in plain language that: (a) such policies do not provide coverage for loss caused by mudslide or flood; and (b) insurance is available under

separate policies issued in accordance with the National Flood Insurance Program, 42 U.S.C. § 4001 et seq., including information regarding flood insurance eligibility and access.

2. The policyholder notice required by this section shall accompany all new homeowners and dwelling fire personal lines policies and all renewal homeowners and dwelling fire policies.

§ 3445. Windstorm insurance notice; deductible trigger standards. (a) The superintendent shall by regulation establish disclosure requirements with respect to the operation of any deductible in a homeowner's insurance policy or dwelling fire personal lines policy which applies as the result of a windstorm. Such regulations shall prescribe the form of a notice to be provided by an insurer to an insured. The notice shall explain in clear and plain language the amount of the deductible, the circumstances under which the deductible applies and any other matters which the superintendent, in his or her discretion, shall deem necessary or appropriate.

(b) The superintendent shall by regulation establish standards for hurricane windstorm deductibles, which create, to the greatest extent possible, uniformity in the operation of such deductibles with respect to the triggering event.

The superintendent shall promulgate such regulations by emergency adoption or otherwise, within one hundred eighty days of the effective date of the chapter of the laws of two thousand twenty-three which added this subsection. Notwithstanding paragraph seven of subsection (a) of section three thousand four hundred twenty-five of this article, any changes in a homeowner's insurance policy or dwelling, fire, or personal policy registered as a result of the adoption by the superintendent of regulations under this section, may be applied to such policies on the policy's initial renewal date or the policy's next annual renewal after the effective date of such regulations.

§ 3446. Product or system group insurance policies. (a) A group policy

may be issued to a group policyholder, who shall be a manufacturer, distributor, or installer of a product or system, or a trustee of a trust established, or participated in, by one or more manufacturers, distributors, or installers, in accordance with the provisions of this section.

(b) The group shall consist only of members who have purchased or own the product or system where the manufacturer, distributor, or installer has represented that the product or system is designed to prevent loss or damage to property from a specific cause (other than loss or damage resulting from defect in materials or workmanship, or wear and tear), and the policy shall only cover such loss or damage.

(c) The policy, and certificates issued thereunder, may provide coverage for a kind of insurance authorized by paragraphs four through twelve, nineteen and twenty of subsection (a) of section one thousand one hundred thirteen of this chapter, and may be issued or delivered in this state only by an insurer authorized in this state to write the coverage.

(d) The coverage shall not be duplicative of coverage under any other applicable insurance policy.

(e) The insurer must treat in like manner all eligible group members of the same class.

(f) The premium for the group policy, including certificates thereunder, shall be paid by the group policyholder from funds contributed wholly by the group policyholder.

(g) The superintendent may promulgate regulations regarding product and system group policies, including regulations governing issuance of certificates to group members; minimum provisions of certificates; policy cancellation and renewal; minimum number of group members; payment of premium; and policy dividends, retrospective premium credits, or retrospective premium refunds; and may establish other reasonable limitations.

(h) A product or system group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an insurance agent or broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a group policy or certificate.

(i) A product or system group policy or certificate shall not be

subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article.

(j)(1) "Manufacturer" means a person that:

(A) manufactures or produces the product or system and sells it under its own trade name or label;

(B) does not manufacture or produce the product or system but sells it under its own trade name or label;

(C) manufactures or produces the product or system and it is sold under the trade name or label of another person; or

(D) does not manufacture or produce the product or system but, pursuant to a written contract, licenses the use of its trade name or label to another person that sells the product or system under the licensor's trade name or label.

(2) "Manufacturer" shall also include a distributor which is a parent, affiliate, or subsidiary of a manufacturer.

(3) The holder of a patent shall not be considered a manufacturer solely because it receives royalties on its patents.

§ 3447. Qualification of environmental remediation insurance for tax credit. (a) The superintendent of financial services is hereby authorized to promulgate regulations relating to the certification of policies of insurance which qualify for the environmental remediation insurance tax credit provided for under section twenty-three of the tax law. Such tax credit shall only apply against a portion of the premium paid for coverage provided under subsection (b) of this section.

(b) In order to qualify for the environmental remediation insurance tax credit provided for under section twenty-three of the tax law, the insurance must be written pursuant to the provisions of paragraph thirteen or fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter and contain any of the following coverages or substantially similar coverages or combination of coverages:

(1) coverage for the costs of on-site clean-up of pre-existing pollution conditions from the insured property which are outside the scope of the remedial work plan pursuant to section 27-1411 of the environmental conservation law for such insured property;

(2) coverage for third-party claims for on-site bodily injury and property damage resulting from pre-existing pollution conditions outside the scope of such remedial work plan for the insured property;

(3) coverage which caps clean-up costs relating to such remedial work plan; and

(4) coverage for the costs of state re-openers pursuant to section 27-1421 of the environmental conservation law or modifications to such remedial work plan to fill any gap in any liability limitation provided pursuant to section 27-1421 of the environmental conservation law for environmental conditions.

§ 3448. Involuntary unemployment insurance policies. (a) In this section, the term "policy of involuntary unemployment insurance" includes any policy covering the kind of insurance described in paragraph thirty of subsection (a) of section one thousand one hundred thirteen of this chapter.

(b) A policy of involuntary unemployment insurance shall not be subject to section three thousand four hundred twenty-five or three thousand four hundred twenty-six of this article.

(c) The superintendent may promulgate regulations regarding involuntary unemployment insurance policies, including, but not limited to, regulations governing policy terms and conditions, and may establish other reasonable limitations.

§ 3449. Wireless communications equipment insurance policies. (a) In this section:

(1) "Policy of wireless communications equipment insurance" means an insurance policy covering the kind of insurance described in paragraph two of subsection (d) of section two thousand one hundred thirty-one of this chapter.

(2) "Wireless communications equipment" shall have the same meaning as described in section two thousand one hundred thirty-one of this chapter.

(3) "Wireless communications equipment protection plan member" means any individual who purchased a wireless communications equipment

protection plan and such wireless communications protection equipment plan has not expired or been terminated.

(4) "Wireless communications equipment protection plan" means an optional plan offered for sale by a wireless communications equipment vendor licensed pursuant to section two thousand one hundred thirty-one of this chapter and the plan provides:

(A) a policy of wireless communications equipment insurance covering the wireless communications equipment under a group policy subject to this section where the wireless communications equipment vendor is the group policyholder;

(B) a service contract subject to article seventy-nine of this chapter, provided that the service contract provider or its affiliate recycles, reuses, or disposes the wireless communications equipment in accordance with section 27-2303 of the environmental conservation law, as added by chapter seven hundred thirty of the laws of two thousand six; and

(C) may include one or more of the following:

(i) a wireless communications equipment upgrade program, provided that the program recycles, reuses, or disposes the wireless communications equipment in accordance with section 27-2303 of the environmental conservation law, as added by chapter seven hundred thirty of the laws of two thousand six;

(ii) technical support with respect to the wireless communications equipment; and

(iii) any other services related to the use of the wireless communications equipment that the superintendent deems to be meaningful and appropriate, in accordance with subsection (h) of this section.

(5) "Wireless communications equipment vendor" means a retail seller, manufacturer or distributor of the wireless communications equipment or the entity providing the telecommunications service that is licensed pursuant to section two thousand one hundred thirty-one of this chapter.

(b) (1) A group policy of wireless communications equipment insurance, and certificates issued thereunder, may be issued only by an authorized insurer.

(2) A group policy of wireless communications equipment insurance may only be issued to a wireless communications equipment vendor.

(3) A group policy of wireless communications equipment insurance may

be offered as part of a wireless communications equipment protection plan, provided that the wireless communications equipment vendor at the same time also offers the wireless communication equipment insurance from the same insurer on a stand-alone basis. The stand-alone wireless communication equipment insurance coverage may be issued either on a group or individual basis.

(c) Where a group policy of wireless communications equipment insurance is provided as part of a wireless communications equipment protection plan, the premium for the group policy, including certificates, may be paid by the group policyholder from funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the wireless communications equipment protection plan members; or

(3) jointly by the group policyholder and wireless communications equipment protection plan members.

(d) For the purposes of this section, a wireless communications equipment protection plan member shall be a certificate holder of wireless communications insurance and a service contract holder as defined in section seven thousand nine hundred two of this chapter.

(e) (1) A group policy of wireless communications equipment insurance, and certificates issued thereunder, shall not be subject to the provisions of section three thousand four hundred twenty-five or three thousand four hundred twenty-six of this article.

(2) An insurer shall not terminate or otherwise change the terms and conditions of a group policy of wireless communications equipment insurance, and certificates issued thereunder, whether offered on a stand-alone basis or as part of a wireless communications equipment protection plan, except upon providing the policyholder and certificate holders with at least sixty days notice. If the insurer changes the terms and conditions, then the insurer shall provide the policyholder with a revised policy or endorsement and each certificate holder with a revised certificate or endorsement, an updated brochure or facsimile thereof and an explanation of the changes.

(3) Notwithstanding paragraph two of this subsection, an insurer may terminate a certificate upon fifteen days notice for:

(A) nonpayment of premium; or

(B) discovery of fraud or material misrepresentation in obtaining the certificate or in the presentation of a claim thereunder.

(4) Notwithstanding paragraph two of this subsection, an insurer may automatically terminate a certificate if the certificate holder:

(A) ceases to have active telecommunications service with the wireless communications equipment vendor; or

(B) exhausts the aggregate limit of liability, if any, under the certificate and the insurer sends notice of termination to the certificate holder within fifteen business days after exhaustion of the limit. However, if notice is not timely sent, coverage shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the certificate holder.

(5) Notwithstanding paragraph two of this subsection, an insurer may terminate a certificate of wireless communications equipment insurance upon the termination of a wireless communications equipment protection plan by a wireless communications equipment protection plan member when the insurance is provided as part of such a plan program and the wireless communications equipment protection plan member had been provided clear and express notice in the plan documents when the plan was initially purchased that the certificate of wireless communications equipment insurance will cease upon termination of the wireless communications equipment protection plan program. The insurer shall give the wireless communications equipment protection plan member the option to purchase a policy of wireless communications insurance on a stand-alone basis.

(6) Notwithstanding the provisions of subparagraph (B) of paragraph four of this subsection, upon the request of a certificate holder, the certificate holder's coverage shall be eligible for reinstatement not more than twelve months following the date of exhaustion of the coverage limit in accordance with the terms of the policy and subject to the enrollment criteria then applicable to prospective certificate holders generally.

(7) Where the group policy of a wireless communications equipment insurance, whether offered on a stand-alone basis or as part of a wireless communications protection equipment plan, is terminated by the policyholder, the policyholder shall mail or deliver written notice to each certificate holder advising the certificate holder of the

termination of the group policy and the effective date of termination. The written notice shall be mailed or delivered to the certificate holder at least thirty days prior to the termination.

(f) Whenever notice is required pursuant to this section, it shall be in writing and mailed or delivered to the policyholder at the policyholder's mailing address and to affected certificate holders at the certificate holders' last known mailing addresses on file with the insurer or delivered by electronic means pursuant to section three thousand four hundred fifty-eight of this chapter. Every notice of termination shall specify the reason or reasons for termination.

(g) (1) Notwithstanding subsection (f) of this section, an insurer shall not be required to give notice of termination to the certificate holder if the insurer has been advised by either the policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(2) A policyholder shall not be required to give notice of termination to a certificate holder if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(h) The superintendent may promulgate regulations regarding policies of wireless communications equipment insurance, including, but not limited to, regulations governing policy terms and conditions, the inclusion of such policies in wireless communications equipment protection plans, treatment of dividends, and may establish other reasonable limitations.

§ 3450. Insurance for expenses incurred as a result of an act or threatened act of violence. (a) Insurance authorized by subparagraph (D) of paragraph seven of subsection (a) of section one thousand one hundred thirteen of this chapter may be written only as provided in this section, except for ransom or reward payment coverage incurred as the result of the theft of property.

(b) As part of a homeowners' insurance policy, as such term is defined in section two thousand three hundred fifty-one of this chapter, or motor vehicle physical damage insurance policy, an insurer may provide insurance for loss to any person as the result of an act or threatened act of violence against an insured person.

(c) For purposes of this section, an "insured person" may include:

(1) with respect to a homeowners' policy, a member of the household, a minor under the custody or care of the named insured, or a minor child of the named insured, regardless of where the act or threatened act occurs; or a person on the insured premises, or any other premises within the temporary control of the named insured, or in a vehicle owned, operated, leased or rented by the named insured.

(2) with respect to a motor vehicle policy, a person engaged in the lawful use or operation of the vehicle.

(d) "Loss" for purposes of this section shall include loss or damage to property; reimbursement of a deductible under another policy of property/casualty insurance; ransom or reward payment; travel and lodging expense; lost wages; expense incurred to locate or identify a missing or abducted insured person; or other expenses to respond to a violent act or threatened act or to prevent a reoccurrence thereof.

(e) A policy written pursuant to this section providing coverage for loss to any person as the result of an act or threatened act of violence against an insured person may also provide coverage for medical expenses to any such person incurred as a result of the act or threatened act of violence. For purposes of this subsection, coverage for such medical expenses shall be deemed included in medical, hospital, surgical and disability benefits to injured persons, and funeral and death benefits to dependents, beneficiaries or personal representatives of persons who are killed, irrespective of legal liability of the insured as authorized by paragraph thirteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(f) The superintendent may promulgate regulations necessary to effectuate the purposes of this section.

*** § 3451. Identity theft group insurance policies.** (a)(1) An identity theft group insurance policy, and certificates thereunder, may be issued or delivered in this state only in accordance with the provisions of this section.

(2) An identity theft group insurance policy, and certificates thereunder, may be issued only by an authorized insurer.

(3) The policy may be issued to:

(A) an employer, or a trustee or trustees of the fund established by an employer, which employer or trustee shall be deemed the policyholder, where the policy insures the employees of the employer;

(B) a labor union, or a trustee or trustees of a fund established by a labor union, which labor union or trustee shall be deemed the policyholder, where the policy insures the members of the labor union;

(C) a trustee of a trust established, or participated in, by two or more employers or labor unions, or by one or more employers and one or more labor unions, which the trustee shall be deemed the policyholder, where the policy insures the employees of the employers, and the members of the labor unions;

(D) a sponsor, where the policy insures account group members, as the terms are defined in subsection (a) of section three thousand four hundred forty-two of this article;

(E) an association, or to a trustee or trustees of a fund established, created, or maintained for the benefit of one or more associations, which the association or trustee shall be deemed the policyholder; where all the eligible members of the association or associations have the same profession, trade, or occupation, and the 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, and where the policy insures the members of the associations;

(F) a business that sells services or products designed to prevent, or to minimize the effects of stolen identity events, which the business shall be deemed to be the policyholder, where the policy insures the persons that purchase the services or products;

(G) any other business or association that has in its possession individuals' personal identification information, where the policy insures the individuals whose information the business or association possesses; or

(H) any other entity where the superintendent has determined in a regulation that the members are engaged in a common enterprise, or have an economic or social affinity or relationship, and that the issuance of the policy would not be contrary to the best interests of the public.

(4) For purposes of this section, the term "employer" shall include subsidiaries or affiliates of the employer.

(b) The group shall consist only of natural persons, hereinafter referred to as group members, as specified in paragraph three of subsection (a) of this section, and may also include a member of the group member's immediate family or household or, where the group policyholder is a sponsor, an authorized user, as the terms are defined in subsection (a) of section three thousand four hundred forty-two of this chapter.

(c)(1) The policy shall cover losses and expenses incurred because of stolen identity events, as defined in subparagraph (E) of paragraph seven of subsection (a) of section one thousand one hundred thirteen of this chapter.

(2) An insurer shall treat in a like manner all eligible group members of the same class.

(3) Except for groups as described in subparagraph (F) of paragraph three of subsection (a) of this section, a group member shall not be required to purchase any product or service to be eligible for the coverage.

(d) The premium for the group policy, including certificates, may be paid by the group policyholder from funds contributed: (1) wholly by the group policyholder; (2) wholly by the group members; or (3) jointly by the group policyholder and the group members, except that with regard to subparagraph (G) of paragraph three of subsection (a) of this section, the premium for the group policy shall be paid from funds contributed wholly by the group policyholder.

(e) A group identity theft insurance policy or certificate issued thereunder, shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply with regard to cancellation, nonrenewal, or conditional renewal of coverage:

(1) Unless the group policy provides for a longer policy period, the policy shall be issued or renewed for a one-year policy period.

(2) A group policy, or any certificate thereunder, may be cancelled by an insurer only if cancellation is based upon one or more of the reasons set forth in paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article, provided, however, that an act or omission by a group member shall not constitute the basis for cancellation of the policy and provided further, that coverage for an

individual group member shall terminate upon termination of the member's employment by, or other affiliation with, the group policyholder that constitutes membership in the group.

(3) An insurer's cancellation, nonrenewal, or conditional renewal of a group policy, or any certificate issued thereunder, shall not become effective until at least forty-five days, or twenty days if based upon non-payment of premium, after the insurer mails or delivers written notice of the cancellation or nonrenewal to the group policyholder at the mailing address shown in the policy and to affected certificate holders at each certificate holder's last known mailing address. If so authorized by the insurer, the group policyholder may mail or deliver the notice to the certificate holder on behalf of the insurer. For purposes of this section, the term "conditional renewal" shall mean a renewal that is conditioned upon change of limits, change in type of coverage, reduction or elimination of coverage, increased deductible or addition of exclusion, or increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of increased exposure units or as a result of experience rating, loss rating, retrospective rating, or audit).

(4) Every notice of cancellation, nonrenewal, or conditional renewal shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(5) A group policyholder may cancel the group policy for any reason upon thirty days written notice to the insurer and each affected group member. A group policyholder shall not be required to give notice to a group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(6) If prior to the effective date of cancellation, nonrenewal, or conditional renewal of the group policy, or cancellation, nonrenewal, conditional renewal or termination of a certificate, whether initiated by the insurer, group policyholder, or by the group member, with respect to the group member's certificate, a group member sustains an identity theft loss, the loss shall remain covered in accordance with the coverage provided under the policy, notwithstanding the cancellation, nonrenewal, conditional renewal, or termination.

(f) The superintendent may promulgate regulations pertaining to identity theft group insurance, including regulations regarding:

payments of dividends or retrospective premium refunds; minimum provisions; minimum number of group members; and other reasonable limitations.

* NB There are 2 § 3451's

*** § 3451. Regulations.** Notwithstanding any other provision of this article or article twenty-three of this chapter, and subject to the superintendent's approval of the rates and forms in accordance with such article, the superintendent may promulgate regulations authorizing an insurer licensed to write workers' compensation and employers' liability insurance, as defined in paragraph fifteen of subsection (a) of section one thousand one hundred thirteen of this chapter, to provide coverage as afforded under article six-G of the executive law in a manner to effectuate the intent and purposes of such article.

* NB There are 2 § 3451's

§ 3452. Group property travel insurance policies. (a)(1) A group property travel insurance policy, and certificates thereunder, may be issued or delivered in this state only in accordance with the provisions of this section.

(2) A group property travel insurance policy, and certificates thereunder, may be issued only by an authorized insurer.

(3) The policy may be issued to:

(A) any railroad company, steamship company, carrier by air, public bus carrier, or other common carrier of passengers, which shall be deemed the policyholder, where the policy insures its passengers;

(B) an institution of higher education as provided in paragraph two of subsection (a) of section three thousand two hundred forty of this chapter; or

(C) any other group where the superintendent has determined in a regulation that the members are engaged in a common enterprise, or have an economic or social affinity or relationship, and that the issuance of the policy would not be contrary to the best interests of the public.

(4) (A) Except as provided in subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this

chapter, the policy may provide coverage for trip cancellation, trip interruption, baggage, and personal effects when limited to a specific trip. The policy shall be sold in connection with transportation provided by the common carrier or, with respect to other groups as permitted by the superintendent in accordance with subparagraph (C) of paragraph three of this subsection, subject to such limitations provided in the regulation promulgated by the superintendent.

(B) A policy issued to an institution of higher education shall comply with clause (V) of item (iv) of subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this chapter.

(5) Coverage under the policy shall be limited to the group member's risks with respect to a particular trip, except a policy issued to an institution of higher education shall comply with item (iv) of subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this chapter.

(6) A person shall not be required to purchase any product or service to be eligible for group property travel insurance coverage, or required to purchase coverage as a condition of becoming a passenger or a group member.

(b) An insurer shall treat in a like manner all eligible group members of the same class.

(c) A group travel insurance policy or certificate issued thereunder, shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply with regard to cancellation, nonrenewal, or conditional renewal of coverage:

(1) Unless the group policy provides for a longer policy period, the policy shall be issued or renewed for a one-year policy period, except a policy issued to an institution of higher education shall be issued or renewed for a period consistent with item (iv) of subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this chapter.

(2) An insurer may cancel a group policy, only if cancellation is based upon one or more of the reasons set forth in paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article, provided, however, that an act or omission by a group member

shall not constitute the basis for cancellation of the policy.

(3) An insurer's cancellation, nonrenewal, or conditional renewal of a group policy shall not become effective until at least sixty days after the insurer mails or delivers written notice of the cancellation, nonrenewal, or conditional renewal to the group policyholder at the mailing address shown in the policy. For purposes of this section, the term "conditional renewal" shall mean a renewal that is conditioned upon change of limits, change in type of coverage, reduction or elimination of coverage, increased deductible or addition of exclusion, or an increase in premiums in excess of ten percent per group member.

(4) Every notice of cancellation, nonrenewal, or conditional renewal shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(5) A group policyholder may cancel the group policy for any reason upon thirty days written notice to the insurer.

(6) Any certificate in effect when the group policy is cancelled, nonrenewed or otherwise terminated shall continue to be in effect for the period of coverage specified in the certificate.

(7) (A) An insurer may terminate a certificate upon fifteen days notice for:

(i) nonpayment of premium; or

(ii) discovery of fraud or material misrepresentation in obtaining the certificate or in the presentation of a claim thereunder.

(B) The coverage shall terminate as provided in the certificate, which shall in no event be later than the conclusion of the trip, except coverage under a policy issued to an institution of higher education as provided in item (iv) of subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this chapter shall terminate in accordance with the provisions of that section.

(d) The superintendent may promulgate regulations pertaining to group property travel insurance, including regulations regarding: payments of dividends or retrospective premium refunds; minimum provisions; minimum number of group members; and other reasonable limitations.

*** § 3453. Group policy for service providers listed in a commercial directory.** (a) For purposes of this section, the following definitions

shall apply:

(1) "Commercial directory" means any listing of businesses in print or electronic form that is issued by an entity that publishes both white and yellow page directories.

(2) "Group member" means a service provider that is insured under the group policy.

(3) "Group policyholder" means an entity that publishes commercial directories.

(4) "Service provider" means any individual or business entity who is listed in a commercial directory; purchases advertising services from a publisher of a commercial directory; and provides certain types of services as specified by the publisher of the commercial directory.

(b) A group policy may be issued or issued for delivery in this state to a group policyholder only in accordance with the provisions of this section.

(c) Coverage under a group policy shall extend only to service providers, and shall be associated with the performance of contracts entered into by service providers.

(d) A group policy may provide coverage for the kind of insurance authorized by paragraph sixteen of subsection (a) of section one thousand one hundred thirteen of this chapter, and the amount of coverage shall not exceed five thousand dollars for each contract guaranteed by the coverage.

(e) The premium for the group policy, including certificates, may be paid by the group policyholder from the funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the group members; or

(3) jointly by the group policyholder and the group members.

(f)(1) A group policy, including certificates, on which all or part of the premium is to be derived from funds contributed by the group members specifically for their insurance may be placed in force only if the group policy insures not less than fifty percent of the then eligible service providers, or, if less, one hundred or more of such eligible service providers excluding any as to whom evidence of individual insurability is not satisfactory to the insurer. A group policy, including certificates, on which no part of the premium is to be derived from funds contributed by the group members specifically for their

insurance must insure all eligible service providers, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) The group policy shall insure at least one hundred service providers at date of issue, except that if part of the premium is to be derived from funds to be contributed by the group members specifically for their insurance, then the group policy shall insure at least two hundred service providers at date of issue.

(g) (1) Any policy dividend, retrospective premium credit, or retrospective premium refund in respect of premiums paid by the group policyholder may:

(A) be applied to reduce the premium contribution of the group policyholder, but not in excess of the proportion to its contribution; or

(B) be retained by the group policyholder.

(2) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed under paragraph one of this subsection shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group members, or both; or

(B) paid or refunded to those group members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) the insurer shall be responsible for determining the allocation of the payment or refund to the group members;

(ii) if the group policyholder distributes the payment or refund, the insurer shall be responsible for audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) if the group policyholder fails to make the payment or refund, the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(3) Notwithstanding paragraphs one and two of this subsection, if a dividend accrues upon termination of coverage under a group policy, the premium for which was paid out of funds contributed by group members specifically for the coverage, then the dividend shall be paid or refunded by the group policyholder to the group members insured on the

date the payment or refund is made to the group policyholder net of reasonable expenses incurred by the group policyholder in paying or refunding the dividend to such group members.

(4) For the purposes of this subsection, "dividend" means a return by an insurer to a group policyholder of excess premiums paid by that group policyholder in light of favorable loss experience, including retrospective premium credits or retrospective premium refunds. The term "dividend" does not include reimbursements or fees received by a group policyholder in connection with the operation or administration of a group policy, including administrative reimbursements, fees for services provided by the group policyholder, or transactional service fees.

(h) The insurer must treat in like manner all eligible group members of the same class and status.

(i) A group policy or certificate shall not be eligible for placement by an excess line broker licensed pursuant to article twenty-one of this chapter.

(j)(1) The insurer shall be responsible for the mailing or delivery of a certificate of insurance to each group member. The insurer also shall be responsible for the mailing or delivery to each group member of an amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of exclusion, under the group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the group member, unless the group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If coverage afforded to the group member is in excess of other applicable insurance coverage, then the certificate shall contain a notice advising the group member that if the member has other insurance coverage, specified coverages under the group policy will be excess over the other insurance.

(k) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an agent or broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a group policy or certificate.

(l) A group policy or certificate shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply in regard to termination of coverage:

(1)(A) An insurer may terminate a group policy or certificate only if cancellation is based on one or more of the reasons set forth in subparagraphs (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission by a group member that would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the group policy.

(B) Where the premium is derived wholly from funds contributed by the group policyholder, an insurer may cancel an individual certificate only if cancellation is based on one or more of the reasons set forth in subparagraph (B), (C) or (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article.

(2)(A) An insurer's cancellation of a group policy, including all certificates, shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy.

(i) Where all or part of the premium is derived from funds contributed by the group member specifically for the coverage, the insurer also shall mail or deliver written notice of cancellation of the group policy to the group member at the group member's mailing address.

(ii) Where none of the premium is derived from funds contributed by a group member specifically for the coverage, the group policyholder shall mail or deliver written notice to the group member advising the group member of the cancellation of the account group policy and the effective date of cancellation. The group policyholder shall mail or deliver the written notice within ninety days after receiving notice of cancellation from the insurer.

(B) An insurer's cancellation of an individual certificate shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group member at the group member's mailing address and to the group policyholder at the mailing address shown in the group policy.

(C)(i) A group policyholder may cancel a group policy, including all certificates, or any individual certificate, for any reason upon thirty days written notice to the insurer and each group member; and

(ii) The group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the group policy or certificate and the effective date of cancellation. The group policyholder shall mail or deliver the written notice to the group member's mailing address at least thirty days prior to the effective date of cancellation.

(3)(A) Unless a group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The group policyholder shall be entitled to renew the group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless:

(i) the insurer mails or delivers to the group policyholder and all group members written notice of nonrenewal, or conditional renewal; and

(ii) the insurer mails or delivers the written notice at least thirty, but not more than one hundred twenty days prior to the expiration date specified in the policy or, if no date is specified, the next anniversary date of the policy.

(4) Where the group policyholder nonrenews the group policy, the group policyholder shall mail or deliver written notice to each group member advising the group member of nonrenewal of the group policy and the effective date of nonrenewal. The group policyholder shall mail or deliver written notice at least thirty days prior to the nonrenewal.

(5) Every notice of cancellation, nonrenewal, or conditional renewal shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(6)(A) An insurer shall not be required under this subsection to give notice to a group member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to a group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(7)(A) If, prior to the effective date of cancellation, nonrenewal, or conditional renewal of the group policy, or a certificate, whether initiated by the insurer, group policyholder or by the group member in regard to the group member's certificate, coverage attaches pursuant to the terms of a group policy, then the coverage shall be effective until expiration of the applicable period of coverage provided in the group policy notwithstanding the cancellation, nonrenewal or conditional nonrenewal of the group policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate coverage under an individual certificate on the effective date of cancellation, if the certificate is cancelled in accordance with the provisions of subparagraph (B) of paragraph one of this subsection.

(m) Notwithstanding any regulation to the contrary, rates and forms for any group policy issued or issued for delivery in this state pursuant to this section shall be filed with the superintendent in accordance with article twenty-three of this chapter.

* NB There are 3 § 3453's

*** § 3453. Self-service storage company group insurance policies.** (a) For purposes of this section, unless the context requires otherwise:

(1) "Self-service storage company group policy" means a group policy, including certificates issued to the group members, where the group policyholder is a self-service storage company and the policy provides insurance to group members of the type described in paragraph three of subsection (d) of section two thousand one hundred thirty-one of this chapter.

(2) "Group member" means a person who rents storage space from a self-service storage company and who is insured under the self-service storage company group policy.

(3) "Certificate" or "certificate of insurance" means any policy, contract, or other evidence of insurance, or rider or endorsement thereto, issued to a group member under a self-service storage company group policy.

(b) A self-service storage company group policy or certificate may be issued or issued for delivery in this state only in compliance with the provisions of this section.

(c) Coverage under a self-service storage company group policy shall extend only to group members.

(d) A self-service storage company group policy may provide only the insurance coverages described in paragraph three of subsection (d) of section two thousand one hundred thirty-one of this chapter.

(e) The premium for the self-service storage company group policy, including certificates, shall be paid wholly by the group members if the group policyholder is licensed pursuant to section two thousand one hundred thirty-one of this chapter. In all other cases, such premium may be paid by the group policyholder from funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the group members; or

(3) jointly by the group policyholder and group members.

(f)(1) Any policy dividend, retrospective premium credit, or retrospective premium refund in respect of premiums paid by the group policyholder may:

(A) be applied to reduce the premium contribution of the group policyholder, but not in excess of the proportion to its contribution; or

(B) be retained by the group policyholder.

(2) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed under paragraph one of this subsection shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group members, or both; or

(B) paid or refunded to those group members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) the insurer shall be responsible for determining the allocation of the payment or refund to the group members;

(ii) if the group policyholder distributes the payment or refund, the insurer shall be responsible for audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) if the group policyholder fails to make the payment or refund, the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(3) Notwithstanding paragraphs one and two of this subsection, if a dividend accrues upon termination of coverage under a self-service storage company group policy, the premium for which was paid out of funds contributed by group members specifically for the coverage, the dividend shall be paid or refunded by the group policyholder to the group members insured on the date the payment or refund is made to the group policyholder, net of reasonable expenses incurred by the group policyholder in paying or refunding the dividend to such group members.

(4) For the purposes of this subsection, "dividend" means a return by an insurer to a group policyholder of excess premiums paid by that group policyholder in light of favorable loss experience, including retrospective premium credits or retrospective premium refunds. The term "dividend" does not include reimbursements or fees received by a group policyholder in connection with the operation or administration of a self- service storage company group policy, including administrative reimbursements, fees for services provided by the group policyholder, or transactional service fees.

(g) The insurer must treat in like manner all eligible group members of the same class.

(h) A self-service storage company group policy or certificate shall not be eligible for placement by an excess line broker licensed pursuant to article twenty-one of this chapter.

(i) (1) The insurer shall be responsible for the mailing or delivery of a certificate of insurance to each group member insured under the self-service storage company group policy. The insurer shall also be responsible for the mailing or delivery to each group member of an amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of exclusion, under the self-service storage company group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the group member, unless the self-service storage company group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If coverage afforded to the group member is excess of other applicable insurance coverage, the certificate shall contain a notice

advising the group member that, if the member has other insurance coverage, specified coverages under the self-service storage company group policy will be excess over the other insurance.

(j) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an agent or broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a self-service storage company group policy or certificate.

(k) A self-service storage company group policy or certificate shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply in regard to termination of coverage:

(1) (A) A self-service storage company group policy or certificate may be cancelled by an insurer only if cancellation is based on one or more of the reasons set forth in subparagraphs (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission by a group member that would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the self-service storage company group policy.

(B) Where the premium is derived wholly from funds contributed by the group policyholder, an individual certificate may be cancelled by the insurer only if cancellation is based on one or more of the reasons set forth in subparagraph (B), (C) or (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article.

(2) (A) An insurer's cancellation of a self-service storage company group policy, including all certificates, shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy.

(i) Where all or part of the premium is derived from funds contributed by a group member specifically for the coverage, written notice of cancellation of the self-service storage company group policy shall also be mailed or delivered by the insurer to the group member at the group member's mailing address.

(ii) Where none of the premium is derived from funds contributed by a group member specifically for the coverage, the group policyholder shall

mail or deliver written notice to the group member advising the group member of the cancellation of the self-service storage company group policy and the effective date of cancellation. The written notice shall be mailed or delivered by the group policyholder within ninety days after receiving notice of cancellation from the insurer.

(B) An insurer's cancellation of an individual certificate shall not become effective until fifteen days after the insurer mails or delivers written notice of cancellation to the group member at the group member's mailing address and to the group policyholder at the mailing address shown in the self-service storage company group policy.

(C) (i) A group policyholder may cancel a self-service storage company group policy, including all certificates, or any individual certificate, for any reason upon thirty days written notice to the insurer and each group member; and

(ii) The group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the self-service storage company group policy or certificate and the effective date of cancellation. Such written notice shall be mailed or delivered to the group member's mailing address at least thirty days prior to the effective date of the cancellation.

(3) (A) Unless a self-service storage company group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The group policyholder shall be entitled to renew the self-service storage company group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless:

(i) the insurer mails or delivers to the group policyholder and all group members written notice of nonrenewal, or conditional renewal; and

(ii) the written notice is mailed or delivered at least thirty, but not more than one hundred twenty days prior to the expiration date specified in the policy or, if no date is specified, the next anniversary date of the policy.

(4) Where the self-service storage company group policy is nonrenewed by the group policyholder, the group policyholder shall mail or deliver written notice to each group member advising the group member of nonrenewal of the self-service storage company group policy and the effective date of nonrenewal. The written notice shall be mailed or

delivered by the group policyholder at least thirty days prior to the nonrenewal.

(5) Every notice of cancellation, nonrenewal, or conditional renewal shall contain the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(6) (A) An insurer shall not be required under this subsection to give notice to a group member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to a group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

* NB There are 3 § 3453's

*** § 3453. Employer sponsored group personal excess insurance.** (a) For purposes of this section, the following definitions shall apply:

(1) "Certificate" or "certificate of insurance" means any policy, contract or other evidence of insurance, or rider or endorsement thereto, issued to a group member under an employer sponsored group personal excess insurance policy.

(2) "Conditional renewal" means any change of limits, change in type of coverage, reduction or elimination of coverage, increased deductible or addition of exclusion, or increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of experience rating, loss rating or retrospective rating).

(3) "Employee" means a director of the employer, or an individual or partner who receives or has received income, wages or salaries from the employer.

(4) "Employer" means a person, partnership, corporation or other entity which pays or has paid income, wages or salaries to a person or persons.

(5) "Employer sponsored group personal excess insurance" means a group policy of insurance providing the kind of insurance defined in paragraph thirteen or fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter, written as an excess policy with

premiums remitted by the employer, insuring groups of active and/or retired employees designated by the employer.

(6) "Group member" means a designated active or retired employee insured under this section and also may include the employee's domestic partner or any person related to the employee by blood, marriage, adoption, or operation of law, who resides in the same household (including a ward or foster child) or who is a dependent child away at school.

(7) "Group policy" means employer sponsored group personal excess insurance written for the designated employees of an employer or other group members as defined in this section.

(b) Employer sponsored group personal excess insurance may be written in this state pursuant to this section.

(c) The premium for the group policy may be paid by the employer from funds contributed:

(1) wholly by the employer;

(2) wholly by the employees or group members; or

(3) jointly by the employer and employees or group members.

(d) An employee or group member shall have the right to refuse coverage offered by an employer under this section.

(e) Each policy written pursuant to this section shall provide separate limits of coverage for each group member.

(f)(1) The insurer shall be responsible for the mailing or delivery to the employer a group policy and certificates of insurance for each group member insured under the group policy. The insurer shall also be responsible for the mailing or delivery to the employer for each group member any amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; addition, reduction, or elimination of coverage; or addition of an exclusion, under the group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the group member, including, but not limited to, the disclosure in clear and easily understandable language of any limitations, exclusions or required underlying coverages, unless the group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(g)(1) A group policy or certificate shall not be subject to section

three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply to authorized insurers in regard to termination of coverage.

(2) A group policy or certificate may be cancelled by an insurer only if cancellation is based on one or more of the reasons set forth in paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article, provided, however, that an individual group member may also be canceled upon termination of his or her employment with the employer.

(3) An insurer's cancellation of a group policy, or any certificate, shall not become effective until forty-five days, or twenty days if based upon non-payment of premium, after the insurer mails or delivers written notice of cancellation to the employer at the mailing address shown in the policy. The employer shall mail or deliver written notice of such cancellation to each affected group member within ten days of receiving a cancellation notice from the insurer advising the group member of the cancellation and the effective date of the cancellation.

(h) An authorized insurer may nonrenew or conditionally renew a group policy, or any certificate, under this section, for any reason upon forty-five days written notice to the employer. The employer shall mail or deliver written notice of such nonrenewal or conditional renewal to each affected group member within ten days of receiving such notice from the insurer.

(i) An employer may cancel a group policy, or any certificate, for any reason upon thirty days written notice to the insurer and each affected group member.

(j) Unless a group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period commencing with a common inception date. A new employee may be added to the group policy for less than one year to conform with a common expiration date.

(k) No policy form shall be delivered or issued for delivery by an authorized insurer unless it has been filed with the superintendent and the superintendent has either approved it, or thirty days have elapsed and the superintendent has not disapproved such form as misleading or violative of public policy. The initial rate of filing pursuant to this section shall be subject to the prior approval of the superintendent,

and any subsequent rate filing shall not be subject to prior approval.

* NB There are 3 § 3453's

§ 3454. Sponsored group personal insurance. (a) For purposes of this section, the following definitions shall apply:

(1) "Certificate" or "certificate of insurance" means any policy, contract or other evidence of insurance, or rider or endorsement thereto, issued to a group member under a group policy.

(2) "Conditional renewal" means any change of limits, change in type of coverage, reduction or elimination of coverage, increased deductible or addition of exclusion, or increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of experience rating, loss rating or retrospective rating).

(3) "Personal excess insurance" means insurance as defined in paragraph thirteen or fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter, written as an excess insurance policy.

(4) "Personal property floater insurance" means insurance as defined in subparagraph (C) of paragraph seven of subsection (a) of section one thousand one hundred thirteen of this chapter.

(5) "Group policy" means a group insurance policy providing personal excess insurance, personal property floater insurance, renters' insurance, and vintage vehicle insurance, or any combination thereof, insuring sponsor group members.

(6) "Group policyholder" means a sponsor.

(7) "Renters' insurance" means insurance insuring residential property tenants, housing cooperative shareholders, or condominium owners against the contingencies described in subparagraphs (A), (B) and (C), or (B) and (C) of paragraph two of subsection (a) of section three thousand four hundred twenty-five of this article.

(8) "Vintage vehicle insurance" means insurance insuring against losses or liabilities arising out of the ownership, operation, or use of a motor vehicle, and covering a motor vehicle that is antique, classic, or made from a kit. For the purposes of this paragraph:

(A) an "antique" motor vehicle means a private passenger motor vehicle that is at least twenty-five years old, and is maintained primarily for

use in exhibitions, club activities, parades, or other functions of public interest, and occasionally used for other purposes; and

(B) a "classic" motor vehicle is a private passenger motor vehicle that is at least ten years old, may be used on a regular basis, and the motor vehicle's value is significantly higher than the average value of other motor vehicles of the same make and model year.

(9) "Sponsor" means:

(A) an association, organization, labor union, federation, fraternity, club or similar entity:

(i) in which the members are engaged in a common pursuit or enterprise;

(ii) that was formed for purposes other than obtaining insurance;

(iii) that has been in existence for more than three years;

(iv) that has twenty-five or more members; and

(v) that has adopted by-laws or similar governance rules, and a method to enroll or register members; or

(B) a bank, corporation, partnership, trust company, or trustee of a trust that owns twenty-five or more residential properties or living units or a tenants' association, condominium association, or similar organization, with respect to renters' insurance sold to lessees or occupants of residential properties or living units owned by the bank, corporation, partnership or trust, or who are members of the tenants' association, condominium association, or similar organization.

(10) "Sponsor group member" means:

(A) an enrolled member, officer, or director of a sponsor;

(B) any domestic partner of the enrolled member, officer, or director;

(C) any person related to the enrolled member, officer, or director by blood, marriage, adoption, or operation of law, who resides in the same household (including a ward or foster child) or who is a dependent child away at school; or

(D) a lessee or occupant of a residential property or living unit owned by a bank, corporation, partnership or trust when the bank, corporation, partnership, trust company, or trustee of the trust is the sponsor, or when the sponsor is a tenants' association, condominium association, or similar organization.

(b) A group policy written pursuant to this section may be issued or issued for delivery in this state only in compliance with the provisions

of this section.

(c) The premium for the group policy, including certificates, shall be paid by the sponsor group members. An insurer shall not provide coverage in regard to a group policy that requires the purchase of insurance as a condition of sponsor group membership or imposes any penalty upon a sponsor group member if the sponsor group member does not purchase insurance. If so authorized by the insurer, the sponsor group may aggregate the group members' premiums and remit them to the insurer or to the licensed insurance agent or broker representing the sponsor group. If an insurer authorizes a sponsor group to aggregate and remit the premiums of sponsor group members, then payment to the sponsor group by a sponsor group member shall be deemed to be payment to the insurer.

(d) (1) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group sponsor members, or both; or

(B) paid or refunded to those sponsor group members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) the insurer shall be responsible for determining the allocation of the payment or refund to the sponsor group members;

(ii) if the group policyholder distributes the payment or refund, the insurer shall be responsible for audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) if the group policyholder fails to make the payment or refund, the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(2) Notwithstanding paragraph one of this subsection, if a dividend accrues upon termination of coverage under a group policy, then the group policyholder shall pay or refund the dividend to the sponsor group members insured on the date the payment or refund is made to the group policyholder.

(e) The insurer shall treat in like manner all eligible sponsor group members of the same class and sponsor status.

(f) A group policy or certificate written pursuant to this section

shall not be eligible for placement by an excess line broker licensed pursuant to article twenty-one of this chapter.

(g) A group policy written pursuant to this section shall provide separate limits of coverage under the certificate issued to a sponsor group member.

(h)(1) The insurer shall be responsible for the mailing or delivery of a certificate of insurance to each sponsor group member insured under the group policy. The insurer also shall be responsible for the mailing or delivery to each sponsor group member of any amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of an exclusion, under the group policy or certificate. If so authorized by the insurer, the sponsor group may mail or deliver certificates, endorsements and other coverage notices to the sponsor group members on behalf of the insurer.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the sponsor group member, unless the group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If the coverage afforded to a sponsor group member is excess of other applicable insurance coverage, then the certificate shall contain a notice advising the sponsor group member that, if the member has other insurance coverage, specified coverages under the group policy shall be excess over the other insurance.

(i) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an insurance producer, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a group policy or certificate.

(j) A group policy or certificate shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article. The following requirements shall apply in regard to termination of coverage:

(1) An insurer may cancel a group policy or certificate only if cancellation is based on one or more of the reasons set forth in paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission

by a sponsor group member that would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the group policy.

(2)(A) An insurer's cancellation of a group policy, including all certificates, shall not become effective until forty-five days, or twenty days if based upon non-payment of premium, after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy, and to the sponsor group member at the sponsor group member's mailing address.

(B) An insurer's cancellation of an individual certificate shall not become effective until forty-five days after the insurer mails or delivers written notice of cancellation to the sponsor group member at the sponsor group member's mailing address and to the group policyholder at the mailing address shown in the group policy.

(C) (i) A group policyholder may cancel a group policy, including all certificates, or any individual certificate, for any reason, upon ninety days written notice to the insurer and each sponsor group member.

(ii) The group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the group policy or certificate and the effective date of cancellation. The group policyholder shall mail or deliver the written notice to the sponsor group member's mailing address at least ninety days prior to the effective date of the cancellation.

(3)(A) Unless the group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The sponsor group member shall be entitled to renew the certificate upon timely payment of the premium billed to the sponsor group member for the renewal, unless:

(i) the insurer mails or delivers to the sponsor group member written notice of nonrenewal or conditional renewal; and

(ii) the insurer mails or delivers written notice at least ninety, but not more than two hundred forty days prior to the expiration date specified in the policy or, if the policy does not specify a date, then the next anniversary date of the policy.

(4) Where the group policyholder nonrenews the group policy, the group policyholder shall mail or deliver written notice to each sponsor group

member advising the sponsor group member of nonrenewal of the group policy and the effective date of nonrenewal. The group policy holder shall mail or deliver the written notice at least ninety days prior to the nonrenewal.

(5) Every notice of cancellation, nonrenewal, or conditional renewal shall contain the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(6)(A) An insurer shall not be required under this subsection to give notice to a sponsor group member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to sponsor group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(k) If an insurer cancels or nonrenews a renters' insurance group policy, then the insurer shall offer to convert a certificate to an individual insurance policy, using the insurer's filed rates and forms for individual policies, for any remaining part of the required policy period set forth in section three thousand four hundred twenty-five of this article.

§ 3455. Transportation network company group insurance policies. (a) For purposes of this section, the following definitions shall apply:

(1) "Transportation network company" shall have the same meaning as set forth in article forty-four-B of the vehicle and traffic law.

(2) "Certificate" or "certificate of insurance" means any policy, contract or other evidence of insurance, or endorsement thereto, issued to a group member under a transportation network company group policy.

(3) "Transportation network company group policy" or "group policy" means a group policy, including certificates issued to the group members, where the group policyholder is a transportation network company and the policy provides insurance to the transportation network company and to group members:

(A) in accordance with the requirements of article forty-four-B of the vehicle and traffic law;

(B) of the type described in paragraph thirteen, fourteen, or nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter; and

(C) in satisfaction of the financial responsibility requirements set forth in section three thousand four hundred twenty of this article, subdivision four of section three hundred eleven of the vehicle and traffic law, article fifty-one of this chapter, and such other requirements or regulations that may apply for the purposes of satisfying the financial responsibility requirements with respect to the use or operation of a motor vehicle.

(4) "Group member" means a transportation network company driver as defined in article forty-four-B of the vehicle and traffic law.

(5) "Group policyholder" means a transportation network company.

(6) "TNC vehicle" shall have the meaning set forth in article forty-four-B of the vehicle and traffic law.

(b) An insurer may issue or issue for delivery in this state a transportation network company group policy to a transportation network company as a group policyholder only in accordance with the provisions of this section.

(c)(1) A transportation network company group policy shall provide coverage for a TNC vehicle in accordance with the requirements of article forty-four-B of the vehicle and traffic law.

(2) A transportation network company group policy may provide:

(A) coverage for limits higher than the minimum limits required pursuant to article forty-four-B of the vehicle and traffic law.

(B) supplementary uninsured/underinsured motorists insurance for bodily injury pursuant to paragraph two of subsection (f) of section three thousand four hundred twenty of this article;

(C) supplemental spousal liability insurance pursuant to subsection (g) of section three thousand four hundred twenty of this chapter; and

(D) motor vehicle physical damage coverage as described in paragraph nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(3) The coverage described in paragraphs one and two of this subsection may be provided in one group policy or in separate group policies.

(4) A transportation network company group policy, including

certificates, shall be issued by authorized insurers or from excess line brokers pursuant to section sixteen six hundred ninety-three of the vehicle and traffic law.

(5) A policyholder also may be an insured under a group policy.

(d) The premium for the transportation network company group policy, including certificates may be paid by the group policyholder from the funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the group members; or

(3) jointly by the group policyholder and the group members.

(e) (1) Any policy dividend, retrospective premium credit, or retrospective premium refund in respect of premiums paid by the group policyholder may:

(A) be applied to reduce the premium contribution of the group policyholder, but not in excess of the proportion to its contribution; or

(B) be retained by the group policyholder.

(2) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed under paragraph one of this subsection shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group members, or both; or

(B) paid or refunded to those group members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) The insurer shall be responsible for determining the allocation of the payment of refund to the group members;

(ii) If the group policyholder distributes the payment or refund, the insurer shall be responsible for audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) If the group policyholder fails to make the payment or refund, the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(3) Notwithstanding paragraphs one and two of this subsection, if a dividend accrues upon termination of coverage under a transportation network company group policy, the premium for which was paid out of

funds contributed by group members specifically for the coverage, the dividend shall be paid or refunded by the group policyholder to the group members insured on the date the payment or refund is made to the group policyholder, net of reasonable expenses incurred by the group policyholder in paying or refunding the dividend to such group members.

(4) For the purposes of this subsection, "dividend" means a return by the insurer of a transportation network company group policy of excess premiums to the group policyholder in light of favorable loss experience, including retrospective premium credits or retrospective premium refunds. The term "dividend" does not include reimbursements or fees received by a group policyholder in connection with the operation or administration of a transportation network company group policy, including administrative reimbursements, fees for services provided by the group policyholder, or transactional service fees.

(f) The insurer shall treat in like manner all eligible group members of the same class and status.

(g) Each policy written pursuant to this section shall provide per occurrence limits of coverage for each group member in an amount not less than that required by this article, and may provide coverage for limits higher than the minimum limits required under the law.

(h) (1) The insurer shall be responsible for mailing or delivery of a certificate of insurance to each group member insured under the transportation network company group policy, provided, however, that the insurer may delegate the mailing or delivery to the transportation network company. The insurer shall also be responsible for the mailing or delivery to each group member of an amended certificate of insurance or endorsement to the certificate, whenever there is a change in limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of exclusion, under the transportation network company group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to group members, unless the transportation network company group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If any coverage afforded to the group member is excess of applicable insurance coverage, the certificate shall contain a notice advising the group members that, if the member has other insurance

coverage, specified coverages under the transportation network company group policy will be excess over the other insurance.

(i) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an agent or broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a transportation network company group policy or certificate.

(j) A transportation network company group policy shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article; provided that the following requirements shall apply with regard to termination of coverage:

(1)(A) An insurer may terminate a group policy or certificate only if cancellation is based on one or more of the reasons set forth in subparagraph (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission by a group member that would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the group policy.

(B) Where the premium is derived wholly from funds contributed by the group policyholder, an insurer may cancel an individual certificate only if cancellation is based on one or more of the reasons set forth in subparagraph (B), (C) or (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article.

(2) (A) An insurer's cancellation of a group policy, including all certificates, shall not become effective until thirty days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy.

(i) Where all or part of the premium is derived from funds contributed by the group member specifically for the coverage, the insurer shall also mail or deliver written notice of cancellation of the group policy to the group member at the group member's mailing address. Such cancellation shall not become effective until thirty days after the insurer mails or delivers the written notice to the group member.

(ii) Where none of the premium is derived from funds contributed by a group member specifically for the coverage, the group policy holder

shall mail or deliver written notice to the group member advising the group member of the cancellation of the group policy and the effective date of cancellation. The group policy holder shall mail or deliver the written notice within ninety days after receiving notice of cancellation from the insurer.

(B) An insurer's cancellation of an individual certificate shall not become effective until thirty days after the insurer mails or delivers written notice of cancellation to the group member at the group member's mailing address and to the group policyholder at the mailing address shown in the group policy.

(3) (A) A group policyholder may cancel a group policy, including all certificates, or any individual certificate, for any reason upon thirty days written notice to the insurer and each group member; and

(B) The group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the group policy or certificate and the effective date of cancellation. The group policyholder shall mail or deliver the written notice to the group member's mailing address at least thirty days prior to the effective date of cancellation.

(4) (A) Unless a group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The group policyholder shall be entitled to renew the group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless:

(i) the insurer mails or delivers to the group policyholder and all group members written notice of nonrenewal, or conditional renewal; and

(ii) the insurer mails or delivers the written notice at least thirty, but not more than one hundred twenty days prior to the expiration date specified in the policy or, if no date is specified, the next anniversary date of the policy.

(5) Where the group policyholder nonrenews the group policy, the group policyholder shall mail or deliver written notice to each group member advising the group member of nonrenewal of the group policy and the effective date of nonrenewal. The group policyholder shall mail or deliver written notice at least thirty days prior to the nonrenewal.

(6) Every notice of cancellation, nonrenewal, or conditional renewal

shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(7) (A) An insurer shall not be required under this subsection to give notice to a group member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to a group member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(8) (A) If, prior to the effective date of cancellation, nonrenewal, or conditional renewal of the group policy, or a certificate, whether initiated by the insurer, group policyholder or by the group member in regard to the group member's certificate, coverage attaches pursuant to the terms of a group policy, then the coverage shall be effective until expiration of the applicable period of coverage provided in the group policy notwithstanding the cancellation, nonrenewal or conditional nonrenewal of the group policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate coverage under an individual certificate on the effective date of cancellation, if the certificate is cancelled in accordance with the provisions of subparagraph (B) of paragraph one of this subsection.

(k) Any mailing or delivery to a group member required or permitted under this section may be made by electronic mail if consent to such method of delivery has been previously received from such group member.

(l) An insurer may issue a transportation network company group policy to a transportation network company, notwithstanding that it may be a condition of operating a vehicle on the transportation network company's digital network for the TNC driver to participate in such group policy.

(m) An insurer shall not include a mandatory arbitration clause in a policy that provides financial responsibility coverage under this section except as permitted in section five thousand one hundred five of the insurance law.

§ 3456. Prohibition against cancellation of policy when motor vehicle is used or operated through a transportation network company program.

(a) An insurer shall not cancel an existing motor vehicle insurance policy solely on the basis that the motor vehicle covered by the insurance has been made available pursuant to a transportation network company program in compliance with article forty-four-B of the vehicle and traffic law.

(b) The definitions set forth in section three thousand four hundred fifty-five of this article shall apply to this section.

§ 3457. Group insurance policies for certain for hire motor vehicles. (a) For purposes of this section, the following definitions shall apply:

(1) "Certificate" or "certificate of insurance" means any policy, contract or other evidence of insurance, or endorsement thereto, issued to a group member under a for hire motor vehicle group policy.

(2) "For hire motor vehicle" or "vehicle" means a motor vehicle engaged in the business of carrying or transporting passengers for hire, having a seating capacity of not less than eight passengers, excluding the driver.

(3) "For hire motor vehicle group policy" or "group policy" means a group policy, including certificates issued to the group members, where the group policy provides insurance to the group members or both the group policyholder and the group members of the type described in paragraph twelve, thirteen, fourteen, or nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(4) "Group member" means the owner of a for hire motor vehicle.

(5) "Group policyholder" means a sponsoring entity.

(6) "Owner" shall have the same meaning as set forth in section one hundred twenty-eight of the vehicle and traffic law.

(7) "Sponsoring entity" means:

(A) an association or other organization, or a trustee or trustees of a fund established, created, or maintained for the benefit of one or more associations or other organizations, where all the eligible members of the association or associations or other organization or organizations have the same profession, trade, or occupation, and the association or associations or other organization or organizations 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;

(B) an entity that owns for hire motor vehicles and leases them to drivers; or

(C) any other entity where the superintendent has determined in a regulation that the members are engaged in a common enterprise, or have an economic or social affinity or relationship, and that the issuance of the group policy would not be contrary to the best interests of the public.

(b) An authorized insurer may issue or issue for delivery in this state a group policy to a sponsoring entity as a group policyholder only in accordance with the provisions of this section.

(c)(1) A group policy shall provide coverage in satisfaction of the financial responsibility requirements set forth in section three thousand four hundred twenty of this article, section three hundred seventy of the vehicle and traffic law, article fifty-one of this chapter, and such other requirements or regulations that may apply for the purposes of satisfying the financial responsibility requirements with respect to the use or operation of a for hire motor vehicle.

(2) A group policy may provide:

(A) coverage for limits higher than the minimum limits required pursuant to section three hundred seventy of the vehicle and traffic law and paragraph two of subsection (f) of section three thousand four hundred twenty of this article;

(B) supplemental spousal liability insurance pursuant to subsection (g) of section three thousand four hundred twenty of this article; and

(C) motor vehicle physical damage coverage as described in paragraph nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(3) A group policy, including certificates, shall be issued by an authorized insurer.

(4) A policyholder also may be an insured under a group policy.

(d) The premium for the group policy, including certificates, may be paid by the group policyholder from the funds contributed wholly by the group members or jointly by the group policyholder and the group members.

(e) Each policy written pursuant to this section shall provide per occurrence limits of coverage for each group member in an amount not

less than that required by this article and may provide coverage for limits higher than the minimum limits required pursuant to law.

(f)(1) The insurer shall be responsible for mailing or delivery of a certificate of insurance to each group member insured under the group policy. The insurer shall also be responsible for the mailing or delivery to each group member of an amended certificate of insurance or endorsement to the certificate whenever there is a change in limits, change in type of coverage, addition, reduction, or elimination of coverage or addition of an exclusion, under the group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to group members, unless the group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(g) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an insurance agent or insurance broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a group policy or certificate.

(h) A group policy shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article, provided that the following requirements shall apply with regard to termination of coverage:

(1) An insurer may cancel a group policy or certificate only if cancellation is based on one or more of the reasons set forth in subparagraph (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that:

(A) an insurer may cancel an individual certificate if the driver's license of the group member insured under that certificate is suspended or revoked during the period of coverage, other than a suspension issued pursuant to subdivision one of section five hundred ten-b of the vehicle and traffic law or one or more administrative suspensions arising from the same incident that has or have been terminated prior to the effective date of the cancellation; and

(B) an act or omission by a group member that would constitute the basis for cancellation of an individual certificate shall not constitute

the basis for cancellation of the group policy.

(2) An insurer's cancellation of a group policy, including all certificates, shall not become effective until thirty days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy. The insurer shall also mail or deliver written notice of cancellation of the group policy, including all certificates, to the group member at the group member's mailing address. Such cancellation shall not become effective until thirty days after the insurer mails or delivers the written notice to the group member.

(3)(A) A group policyholder may cancel a group policy, including all certificates, or any individual certificate, for any reason upon at least thirty days written notice to the insurer and each group member; and

(B) the group policyholder shall mail or deliver written notice to each affected group member of the group policyholder's cancellation of the group policy or certificate and the effective date of cancellation. The group policyholder shall mail or deliver the written notice to the group member's mailing address at least thirty days prior to the effective date of cancellation.

(4)(A) Unless a group policy provides for a longer policy period, the policy and all certificates shall be issued or renewed for a one-year policy period.

(B) The group policyholder shall be entitled to renew the group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless:

(i) the insurer mails or delivers to the group policyholder and all group members written notice of nonrenewal or conditional renewal; and

(ii) the insurer mails or delivers the written notice at least sixty, but not more than one hundred twenty days, prior to the expiration date specified in the policy or, if no date is specified, the next anniversary date of the policy.

(5) Every notice of cancellation, nonrenewal, or conditional renewal shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal and the insurer shall also mail or deliver the notice to the insurance producer that procured the group policy when the group policy and any certificates are cancelled,

nonrenewed, or conditionally renewed.

(6)(A) If, prior to the effective date of cancellation, nonrenewal, or conditional renewal of the group policy, or cancellation of a certificate, whether initiated by the insurer, group policyholder, or group member in regard to the group member's certificate, coverage attaches pursuant to the terms of the group policy, then the coverage shall be effective until expiration of the applicable period of coverage provided in the group policy notwithstanding the cancellation, nonrenewal or conditional nonrenewal of the group policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate coverage under an individual certificate on the effective date of cancellation if the certificate is cancelled in accordance with the provisions of paragraph one of this subsection.

(i) An insurer shall not include a mandatory arbitration clause in a policy that provides financial responsibility coverage under this section, except as permitted in section five thousand one hundred five of this chapter.

(j) The superintendent may promulgate regulations pertaining to a for hire motor vehicle group policy, including regulations regarding payments of dividends or retrospective premium refunds, minimum number of group members, and other reasonable limitations.

*** § 3458. Electronic notices and documents.** (a) As used in this section, the following words shall have the following meanings:

(1) "Delivered by electronic means" includes:

(A) delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(B) posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notice or by any other electronic delivery method that has been consented to by the party.

(2) "Party" means any recipient of any notice or document required as part of a property/casualty insurance transaction, including but not limited to an applicant, an insured, or a policyholder.

(3) "Property/casualty insurance" means basic kinds of insurance and non-basic kinds of insurance, as defined in section four thousand one hundred one of this chapter, provided that "property/casualty insurance" shall not include accident and health insurance as defined in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter.

(b) Subject to the requirements of this section, any notice to a party or any other document required under this chapter in a property/casualty insurance transaction or that is to serve as evidence of property/casualty insurance coverage may be delivered by electronic means so long as it meets the requirements of article three of the state technology law. Where this chapter requires that notice be mailed or delivered to an address shown in the policy, the notice may be delivered by electronic means to an electronic address not specified in the policy.

(c) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under this chapter, other than section three thousand one hundred eleven of this chapter, including delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

(d) A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(1) the party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(2) the party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(A) the right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn;

(B) the types of notices and documents to which the party's consent would apply;

(C) the right of a party to have a notice or document delivered in paper form; and

(D) the procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address;

(3) the party:

(A) before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(B) consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent; and

(4) after consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

(A) provides the party with a statement that describes:

(i) the revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(ii) the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent; and

(B) complies with paragraph two of this subsection.

(c) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under this chapter, other than section three thousand one hundred eleven of this chapter, including delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

(e) (1) Before a notice or document is delivered by electronic means, an insurer shall obtain a party's consent to deliver that kind of notice or document by electronic means. A party's consent to receive one type of notice or document shall not be construed as a blanket consent for every kind of notice and document to be delivered by electronic means. A party's consent shall only apply to the types of notices and documents identified in the clear and conspicuous information statement provided to the consenting party, as required by subparagraph (B) of paragraph two of subsection (d) of this section.

(2) Any electronic mail being sent by an insurer to a party in

connection with the delivery of a cancellation notice, non-renewal notice or conditional renewal notice delivered by electronic means shall include in the subject line and body of the communication clear and conspicuous language alerting the receiving party as to the importance of the communication and the type of notice being delivered by electronic means to such party.

(f) This section does not affect requirements related to content or timing of any notice or document required under this chapter.

(g) If a provision of this chapter requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(h) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subparagraph (B) of paragraph three of subsection (d) of this section.

(i) (1) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(2) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(3) Failure by an insurer to comply with paragraph four of subsection (d) and subsection (k) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(j) This section does not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this section to a party who, before that date, has consented to receive a notice or document in an electronic form otherwise allowed by law.

(k) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this section, and pursuant to this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or

documents electronically, the insurer shall:

(1) provide the party with a statement that describes:

(A) the notices or documents that shall be delivered by electronic means under this section that were not previously delivered electronically; and

(B) the party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

(2) comply with paragraph two of subsection (d) of this section.

(l) An insurer shall deliver a notice or document by any other delivery method permitted by law other than delivery by electronic means if:

(1) the insurer attempts to deliver by electronic means the notice or document and has a reasonable basis for believing that the notice or document has not been received by the party; or

(2) the insurer becomes aware that the electronic mail address provided by the party is no longer valid.

(m) This section may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229, as amended.

* NB There are 2 § 3458's

*** § 3458. Group insurance for peer-to-peer car sharing programs.** (a) For the purposes of this section, the following definitions shall apply:

(1) "Certificate" or "certificate of insurance" means any policy, contract or other evidence of insurance, or endorsement thereto, issued to a group member under a peer-to-peer car sharing group policy.

(2) "Group policyholder" means an administrator.

(3) "Group policy member" means a shared vehicle owner or a shared vehicle driver participating in a program.

(4) "Peer-to-peer car sharing group policy" or "group policy" means a group policy, including certificates issued to the group members, where the group policyholder is an administrator and the policy provides insurance to the administrator and to group members:

(A) in accordance with the requirements of article forty of the general business law;

(B) of the type described in paragraph thirteen, fourteen, or nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter; and

(C) in satisfaction of the financial responsibility requirements set forth in section three thousand four hundred twenty of this article, subdivision four of section three hundred eleven of the vehicle and traffic law, article fifty-one of this chapter, and such other requirements or regulations that may apply for the purposes of satisfying the financial responsibility requirements with respect to the use or operation of a motor vehicle.

(5) "Peer-to-peer car sharing program" or "program" shall have the same meaning as set forth in article forty of the general business law.

(6) "Peer-to-peer car sharing program administrator" or "administrator" shall have the same meaning as set forth in article forty of the general business law.

(7) "Shared vehicle driver" shall have the same meaning as set forth in article forty of the general business law.

(8) "Shared vehicle owner" shall have the same meaning as set forth in article forty of the general business law.

(9) "Peer-to-peer car sharing period" or "car sharing period" shall have the same meaning as set forth in article forty of the general business law.

(10) "Motor vehicle" shall have the same meaning as set forth in article forty of the general business law.

(b) An insurer may issue or issue for delivery in this state a group policy to an administrator as a group policyholder only in accordance with the provisions of this section.

(c) (1) A group policy shall provide coverage for a shared vehicle owner's motor vehicle in accordance with the requirements of article forty of the general business law.

(2) A group policy may provide:

(A) coverage for limits higher than the minimum limits required by subdivision two of section nine hundred one of the general business law, with regard to financial responsibility coverage;

(B) supplemental spousal liability insurance pursuant to subsection (g) of section three thousand four hundred twenty of this chapter; and

(C) motor vehicle physical damage coverage as described in paragraph

nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(3) The coverage described in paragraphs one and two of this subsection may be provided in one group policy or in separate group policies.

(4) A group policy, including certificates, shall be issued by authorized insurers or through excess line brokers pursuant to section two thousand one hundred eighteen of this chapter.

(5) A policyholder also may be an insured under a group policy.

(d) The premium for the group policy, including certificates, may be paid by the group policyholder from the funds contributed:

(1) wholly by the group policyholder;

(2) wholly by the group policy members; or

(3) jointly by the group policyholder and the group policy members.

(e)(1) Any policy dividend, retrospective premium credit, or retrospective premium refund in respect of premiums paid by the group policyholder may:

(A) be applied to reduce the premium contribution of the group policyholder, but not in excess of the proportion to its contribution; or

(B) be retained by the group policyholder.

(2) Any policy dividend, retrospective premium credit, or retrospective premium refund not distributed under paragraph one of this subsection shall be:

(A) applied to reduce future premiums and, accordingly, future contributions, of existing or future group policy members, or both; or

(B) paid or refunded to those group policy members insured on the date the payment or refund is made to the group policyholder, if distributed by the group policyholder, or on the date of mailing, if distributed directly by the insurer, subject to the following requirements:

(i) the insurer shall be responsible for determining the allocation of the payment or refund to the group policy members;

(ii) if the group policyholder distributes the payment or refund, then the insurer shall be responsible for conducting an audit to ascertain that the payment or refund is actually made in accordance with the allocation procedure; and

(iii) if the group policyholder fails to make the payment or refund,

then the insurer shall make the payment or refund directly or use the method provided in subparagraph (A) of this paragraph.

(3) Notwithstanding paragraphs one and two of this subsection, if a dividend accrues upon termination of coverage under a group policy, the premium for which was paid out of funds contributed by group policy members specifically for the coverage, then the dividend shall be paid or refunded by the group policyholder to the group policy members insured on the date the payment or refund is made to the group policyholder net of reasonable expenses incurred by the group policyholder in paying or refunding the dividend to such group policy members.

(4) For the purposes of this subsection, "dividend" means a return by an insurer to a group policyholder of excess premiums paid by that group policyholder in light of its favorable loss experience, including retrospective premium credits or retrospective premium refunds. The term "dividend" does not include reimbursements or fees received by a group policyholder in connection with the operation or administration of a group policy, including administrative reimbursements, fees for services provided by the group policyholder, or transactional service fees.

(f) The insurer shall treat in like manner all eligible group policy members of the same class and status.

(g) Each policy written pursuant to this section shall provide per occurrence limits of coverage for each group policy member in an amount not less than that required by article forty of the general business law, and may provide coverage for limits higher than the minimum limits required under the law.

(h)(1) The insurer shall be responsible for the mailing or delivery of a certificate of insurance to each group policy member, provided, however, that the insurer may delegate the mailing or delivery to the administrator. The insurer also shall be responsible for mailing or delivery to each group policy member an amended certificate of insurance, or endorsement to the certificate, whenever there is a change of limits; change in type of coverage; addition, reduction, or elimination of coverage; or addition of exclusion, under the group policy or certificate.

(2) The certificate shall contain in substance all material terms and conditions of coverage afforded to the group policy member, unless the

group policy is incorporated by reference and a copy of the group policy accompanies the certificate.

(3) If coverage afforded to the group policy member is in excess of other applicable insurance coverage, then the certificate shall contain a notice advising the group policy member that if the group policy member has other insurance coverage, specified coverages under the group policy will be excess over the other insurance.

(i) A group policyholder shall comply with the provisions of section two thousand one hundred twenty-two of this chapter, in the same manner as an insurance agent or insurance broker, in any advertisement, sign, pamphlet, circular, card, or other public announcement referring to coverage under a group policy or certificate.

(j) A group policy or certificate shall not be subject to section three thousand four hundred twenty-five or section three thousand four hundred twenty-six of this article, provided that the following requirements shall apply with regard to termination of coverage:

(1)(A) An insurer may terminate a group policy or certificate only if cancellation is based on one or more of the reasons set forth in subparagraphs (A) through (D) or (F) through (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article; provided, however, that an act or omission by a group member that would constitute the basis for cancellation of an individual certificate shall not constitute the basis for cancellation of the group policy.

(B) Where the premium is derived wholly from funds contributed by the group policyholder, an insurer may cancel an individual certificate only if cancellation is based on one or more of the reasons set forth in subparagraphs (B), (C), or (H) of paragraph one of subsection (c) of section three thousand four hundred twenty-six of this article.

(2)(A) An insurer's cancellation of a group policy, including all certificates, shall not become effective until thirty days after the insurer mails or delivers written notice of cancellation to the group policyholder at the mailing address shown in the policy or to an electronic mail address at which the group policyholder has consented to receive such notice.

(i) Where all or part of the premium is derived from funds contributed by the group policy member specifically for the coverage, the insurer

also shall mail or deliver written notice of cancellation of the group policy to the group policy member at the group policy member's mailing address or to an electronic mail address at which the group policy member has consented to receive such notice. Such cancellation shall not become effective until thirty days after the insurer mails or delivers the written notice to the group policy member.

(ii) Where none of the premium is derived from funds contributed by a group policy member specifically for the coverage, the group policyholder shall mail or deliver written notice to the group policy member advising the group policy member of the cancellation of the group policy and the effective date of cancellation. The group policyholder shall mail or deliver the written notice within ninety days after receiving notice of cancellation from the insurer.

(B) An insurer's cancellation of an individual certificate shall not become effective until thirty days after the insurer mails or delivers written notice of cancellation to the group policy member at the group policy member's mailing address, or to an electronic mail address at which the group policy member has consented to receive such notice, and to the group policyholder at the mailing address shown in the group policy or to an electronic mail address at which the group policyholder has consented to receive such notice.

(3)(A) A group policyholder may cancel a group policy, including all certificates, or any individual certificate, for any reason upon thirty days' written notice to the insurer and each group policy member; and

(B) The group policyholder shall mail or deliver written notice to each affected group policy member of the group policyholder's cancellation of the group policy or certificate and the effective date of cancellation. The group policyholder shall mail or deliver the written notice to the group policy member's mailing address, or to an electronic mail address at which the group policy member has consented to receive such notice, at least thirty days prior to the effective date of cancellation.

(4) A group policy member may cancel optional coverage upon providing notice to the group policyholder. For the purposes of this subsection, "optional coverage" means coverage other than financial responsibility coverage that an individual group policy member purchases on an optional basis. "Optional coverage" does not mean optional vehicle protection as

defined in article forty of the general business law.

(5)(A) A group policy and all certificates shall be issued or renewed for a one-year policy period unless the group policy provides for a longer policy period.

(B) The group policyholder shall be entitled to renew the group policy and all certificates upon timely payment of the premium billed to the group policyholder for the renewal, unless the insurer mails or delivers to the group policyholder and all group policy members written notice of nonrenewal, or conditional renewal, at least thirty but not more than one hundred twenty days prior to the expiration date specified in the group policy or, if no date is specified, then the next anniversary date of the group policy.

(6) Where the group policyholder nonrenews the group policy, the group policyholder shall mail or deliver written notice to each group member advising the group policy member of nonrenewal of the group policy and the effective date of nonrenewal. The group policyholder shall mail or deliver written notice at least thirty days prior to the nonrenewal.

(7) Every notice of cancellation, nonrenewal, or conditional renewal from an insurer shall set forth the specific reason or reasons for cancellation, nonrenewal, or conditional renewal.

(8)(A) An insurer shall not be required under this subsection to give notice to a group policy member if the insurer has been advised by either the group policyholder or another insurer that substantially similar coverage has been obtained from the other insurer without lapse of coverage.

(B) A group policyholder shall not be required under this subsection to give notice to a group policy member if substantially similar coverage has been obtained from another insurer without lapse of coverage.

(9)(A) If, prior to the effective date of cancellation, nonrenewal, or conditional renewal of the group policy, or a certificate, whether initiated by the insurer, group policyholder or by the group policy member in regard to the group policy member's certificate, coverage attaches pursuant to the terms of a group policy, then the coverage shall be effective until expiration of the applicable period of coverage provided in the group policy notwithstanding the cancellation, nonrenewal or conditional nonrenewal of the group policy.

(B) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate coverage under an individual certificate on the effective date of cancellation, if the certificate is cancelled in accordance with the provisions of subparagraph (B) of paragraph one of this subsection.

(k) Any mailing or delivery to a group policy member required or permitted under this section may be made by electronic mail if affirmative verifiable consent to such method of delivery has been previously received from such group policy member.

(l) An insurer may issue a group policy to an administrator notwithstanding that it may be a condition of using or operating a motor vehicle through the administrator's program for the shared vehicle owner to participate in such group policy.

(m) An insurer shall not include a mandatory arbitration clause in a policy that provides financial responsibility coverage under this section except as permitted in section five thousand one hundred five of this chapter.

(n) Coverage under a group policy, as provided for in this section, shall not be dependent on an insurer that issued a shared vehicle owner's policy of liability insurance or other motor vehicle insurance, nor shall an insurer be required to first deny a claim before the group policy shall afford coverage pursuant to this section.

* NB There are 2 § 3458's

§ 3459. Car share exclusions for motor vehicle insurance policies. (a) The definitions set forth in section three thousand four hundred fifty-eight of this article shall apply to this section.

(b) Notwithstanding any other provision of law to the contrary, the shared vehicle owner's policy of liability insurance or other motor vehicle insurance may exclude any and all coverage afforded under the policy issued to the shared vehicle owner for any loss, death, or injury that occurs during the car sharing period including:

(1) liability coverage for bodily injury and property damage;

(2) coverage provided pursuant to article fifty-one of this chapter;

(3) uninsured motorist coverage;

(4) supplementary uninsured/underinsured motorist coverage; and

(5) motor vehicle physical damage coverage as described in paragraph

nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter.

(c) The shared vehicle owner's motor vehicle insurer shall notify the shared vehicle owner that there is no duty to defend or indemnify any person or entity for the liability for any loss, death, or injury that shall occur during the peer-to-peer car sharing period.

(d) Nothing in this article shall invalidate or limit an exclusion contained in a motor vehicle insurance policy, including any insurance policy in use or approved for use that shall exclude coverage for motor vehicles made available for rent, sharing, hire or any business use.

§ 3460. Prohibition against cancellation of policy when motor vehicle is used or operated through a peer-to-peer car sharing program. (a) An insurer shall not cancel an existing motor vehicle insurance policy solely on the basis that the motor vehicle covered by the insurance policy has been made available pursuant to a peer-to-peer car sharing program in compliance with article forty of the general business law.

(b) The definitions set forth in section three thousand four hundred fifty-eight of this article shall apply to this section.

§ 3461. Notice of claim. (a) For purposes of article fifty-one of this chapter, 11 NYCRR Part 65 and general liability claims, notice of claim to the shared vehicle owner, shared vehicle driver, peer-to-peer car sharing program administrator, or any insurer of the shared vehicle owner, shared vehicle driver, or peer-to-peer car sharing program administrator shall be deemed notice to all appropriate parties and insurers.

(b) Any shared vehicle owner, shared vehicle driver, peer-to-peer car sharing program administrator, or any insurer of the shared vehicle owner, shared vehicle driver, or peer-to-peer car sharing program administrator receiving such notice shall provide such notice to all appropriate parties.

(c) The definitions set forth in section three thousand four hundred fifty-eight of this article shall apply to this section.

§ 3462. Affordable housing underwriting and rating. (a) An insurer that issues or delivers in this state a policy of insurance covering loss of or damage to real property containing units for residential purposes or legal liability of an owner of such real property, shall not inquire about on an application, nor shall an insurer cancel, refuse to issue, refuse to renew or increase the premium of a policy, or exclude, limit, restrict, or reduce coverage under a policy based on, the following:

(1) The residential building contains dwelling units that shall be affordable to residents at a specific income level pursuant to a statute, regulation, restrictive declaration, or regulatory agreement with a local, state, or federal government entity;

(2) The real property owner or tenants of such residential building or the shareholders of a cooperative housing corporation receive rental assistance provided by a local, state, or federal government entity, including, but not limited to, the receipt of federal vouchers issued under section eight of the United States Housing Act of 1937(42 U.S.C. § 1437f);

(3) The level or source of income of the tenants of the residential building or the shareholders of a cooperative housing corporation; or

(4) Whether such residential building is owned by a limited-equity cooperative; owned by a public housing authority; or owned by a cooperative housing corporation subject to the provisions of article two, article four, article five or article eleven of the private housing finance law.

(b) Nothing in this section shall prohibit an insurer from canceling, refusing to issue, refusing to renew, or increasing the premium of, an insurance policy, or excluding, limiting, restricting, or reducing coverage under such policy, due to other factors that are permitted or not prohibited by any other section of this chapter.

ARTICLE 41

PROPERTY/CASUALTY INSURANCE COMPANIES

Section 4101. Definitions.
4102. Powers.

4103. Stock companies; financial requirements.
4104. Deposits.
4105. Domestic stock companies; declaration and payment of dividends.
4106. Stock companies; participating policies.
4107. Domestic mutual companies; financial and other requirements.
4108. Foreign and alien mutual companies; licensing.
4109. Mutual companies; special contingent surplus.
4110. Domestic mutual companies; expense limits.
4111. Mutual companies; assessments.
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4116. Domestic mutual companies; voting rights of members.
4117. Loss and loss expense reserves.
4118. Limitation of risks; fidelity and surety; fire; hospital mutuals.
4119. Foreign and alien companies; license qualification.
4121. Security may be required from banking officers and employees.

§ 4101. Definitions. In this article: (a) "Basic kinds of insurance" means the kinds of insurance described in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter numbered therein as set forth in parentheses below:

fire (4);

burglary and theft (7);

glass (8);

boiler and machinery (9);

elevator (10);

animal (11);

personal injury liability (13);

property damage liability (14) - basic as to stock companies only;

workers' compensation and employers' liability (15);

fidelity and surety (16);

credit (17);

marine and inland marine (20);

marine protection and indemnity (21) - basic as to mutual companies only;

business interruption insurance (34).

(b) "Non-basic kinds of insurance" means the kinds of insurance described in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter numbered therein as set forth in parentheses below:

accident and health (item (i) of (3));

non-cancellable disability (item (ii) of (3));

miscellaneous property (5);

water damage (6);

collision (12);

property damage liability (14) - non-basic as to mutual companies

only;

motor vehicle and aircraft physical damage (19);

inland marine as specified in marine and inland marine (20);

marine protection and indemnity (21) - non-basic as to stock companies only;

residual value (22);

credit unemployment (24);

gap (26);

prize indemnification (27);

service contract reimbursement (28);

legal services insurance (29);

involuntary unemployment insurance (30);

salary protection insurance (31);

donor medical expense insurance (32);

excess business disability insurance (33);

parametric insurance (34).

*** § 4102. Powers.** (a) A property/casualty insurance company may be organized and licensed to write any one or more basic kinds of insurance.

(b) A property/casualty insurance company organized and licensed to write any one or more basic kinds of insurance, may be licensed to write

non-basic kinds of insurance, subject to the following requirements (references are to paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter describing kinds of insurance):

(1) If licensed to write burglary and theft (7), glass (8), boiler and machinery (9), elevator (10), animal (11), personal injury liability (13), property damage liability (14), workers' compensation and employers' liability (15), fidelity and surety (16) or credit (17), it may be licensed to write accident and health (item (i) of (3)), non-cancellable disability (item (ii) of (3)), water damage (6), collision (12), residual value (22), credit unemployment (24), gap (26), prize indemnification (27), service contract reimbursement (28) and involuntary unemployment (30);

(2) If licensed to write fire (4), it may be licensed to write miscellaneous property (5), water damage (6), collision (12), motor vehicle and aircraft physical damage (19), inland marine as specified in marine and inland marine (20) and parametric (34);

(3) If licensed to write marine and inland marine (20), it may be licensed to write collision (12), motor vehicle and aircraft physical damage (19), and marine protection and indemnity (21);

(4) If licensed to write personal injury liability (13) and property damage liability (14), it may be licensed to write motor vehicle and aircraft physical damage (19) and legal services insurance (29); and

(5) In the case of a mutual company licensed to write burglary and theft (7), glass (8), boiler and machinery (9), elevator (10), animal (11), personal injury liability (13), workers' compensation and employers' liability (15), fidelity and surety (16), or credit (17), it may be licensed to write property damage liability (14).

(c) A property/casualty insurance company organized and licensed to write any basic kind of insurance, may be licensed, except with respect to the kinds of insurance defined respectively in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter: life insurance (1), annuities (2) and title insurance (18), to (i) reinsure risks of every kind or description and (ii) insure property or risks of every kind or description located or resident outside of the United States, its territories and possessions.

(d) A property/casualty insurance company complying with the provisions of this section shall meet all other applicable requirements

of this article.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

*** § 4103. Stock companies; financial requirements.** (a) (1) A stock property/casualty insurance company organized in the manner prescribed in subsection (a) of section one thousand two hundred one of this chapter may be licensed under subsection (e) of section one thousand one hundred two of this chapter to write one or more kinds of insurance as specified in TABLE ONE upon meeting the applicable paid-in capital and an additional amount of paid-in surplus for each kind of insurance licensed, in the aggregate at least equal to the requirements specified in TABLE ONE and every such company shall thereafter maintain a minimum capital at least equal to the amount specified in this section and a surplus to policyholders at least equal to the aggregate paid-in capital specified in TABLE ONE for the kind or kinds of insurance licensed.

TABLE ONE

Kind of insurance specified in the following numbered paragraphs of subsection (a) of § 1113:	Paid-in Capital	Paid-in Surplus
Group A:		
7	$300,000	$150,000
8, 9, 10, 11, or 14 - for each such kind	$100,000	$ 50,000
13 or 15 - for each such kind	$500,000	$250,000
16	$900,000	$450,000
17	$400,000	$200,000
Basic additional amount required for any one or more of the above kinds of insurance	$100,000	$ 50,000

3(i), 3(ii), 6{1} or 12{2} - for each such kind	$100,000	$ 50,000
22	$2,000,000	$1,000,000
24	$400,000	$200,000
26(B)	$200,000	$100,000
26(A), 26(C) or 26(D) - for each such kind	$600,000	$300,000
27	$300,000	$150,000
28	$2,000,000	$1,000,000
30	$400,000	$200,000
31	$100,000	$ 50,000
32	$100,000	$ 50,000
33	$100,000	$ 50,000
34	$2,000,000	$1,000,0000
Group B:		
4{3} or 20{4} - for each such kind	$500,000	$500,000

Notes to TABLE ONE

{1} If licensed to write paragraph 4, no additional paid-in capital and surplus is required.

{2} If licensed to write paragraph 4 or 20, no additional paid-in capital and surplus is required.

{3} If licensed to write paragraph 4, no additional paid-in capital and surplus is required for a license to write paragraphs 5, 6, 12, 19, 20, (inland marine only) and 34.

{4} If licensed to write paragraph 20, no additional paid-in capital and surplus is required for a license to write paragraphs 12, 19 and 21.

(2) A stock property/casualty insurance company licensed to write one or more of the kinds of insurance as specified in TABLE ONE, Group A, and having a minimum capital of one million dollars, may be licensed to write any other kind of insurance specified in TABLE ONE, Group A, upon at least having an initial surplus to policyholders equal to the aggregate of the paid-in capital and paid-in surplus specified in TABLE ONE for the kinds of insurance for which it is to be licensed, and shall thereafter maintain a surplus to policyholders at least equal to the aggregate paid-in capital prescribed in TABLE ONE for the kinds of insurance licensed or one million dollars, whichever is greater.

(3) A stock property/casualty insurance company licensed to write any kind of insurance specified in TABLE ONE, Group A, must have a minimum capital of one million dollars and a surplus to policyholders as specified in this paragraph before being licensed to write either kind of insurance specified in Group B. If licensed to write the kind or kinds of insurance specified in TABLE ONE, Group B, it may, in addition write any one or more kinds of insurance specified in TABLE ONE, Group A, provided it has a minimum capital of one million dollars and a surplus to policyholders as specified in this paragraph before being licensed to write any other kind or kinds of insurance specified in TABLE ONE, Group A. Every such company shall have an initial surplus to policyholders at least equal to the aggregate of the paid-in capital and paid-in surplus specified in TABLE ONE for the kinds of insurance for which it is to be licensed and shall thereafter maintain a surplus to policyholders at least equal to the aggregate paid-in capital prescribed in TABLE ONE for the kinds of insurance licensed or one million dollars whichever is greater.

(4) A stock property/casualty insurance company licensed under subsection (c) of section four thousand one hundred two of this article to reinsure risks or write insurance on risks outside the United States, its territories and possessions, must maintain a surplus to policyholders of at least thirty-five million dollars.

(5) The dollar amounts set forth in paragraphs one (except the dollar amounts set forth for paragraphs (22), (24) and (26)), two and three of this subsection shall be reduced by fifty percent for a domestic stock property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two.

(b) No foreign stock property/casualty insurance company shall be granted a license to do business in this state unless it has a paid-in capital and surplus at least equal, respectively, to the amounts required by subsection (a) hereof for the organization of a domestic company to write the same kind or kinds of insurance which such foreign company is to be licensed to write in this state, and every such company shall thereafter maintain a minimum capital and a surplus to policyholders at least equal to the amount required of a domestic company licensed for the same kind or kinds of insurance.

(c) No alien stock property/casualty insurance company shall be

granted a license to write any kind of insurance specified in TABLE ONE, Group A, except as permitted by the provisions of notes {1} and {2} to TABLE ONE, unless it has a trusteed surplus, as defined in section one thousand three hundred twelve of this chapter, at least equal in amount to one hundred fifty percent of the paid-in capital set forth in TABLE ONE for such kind or kinds of insurance, nor to write any kind of insurance specified in TABLE ONE, Group B, unless it has such a trusteed surplus at least equal in amount to two hundred percent of the paid-in capital set forth in TABLE ONE for such kind or kinds of insurance. Every such insurer shall thereafter maintain a trusteed surplus at least equal to the paid-in capital set forth in TABLE ONE for such kind or kinds of insurance.

(d) The financial requirements specified in subsections (b) and (c) hereof shall be reduced by fifty percent for a foreign or alien stock property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two, but such reduction shall not apply to such a foreign or alien insurer licensed under subsection (c) of section four thousand one hundred two of this article to reinsure risks or write insurance on risks outside the United States, its territories and possessions. Such reduction shall also not apply to the financial requirements specified in subsection (a) of this section in order to write paragraph twenty-two, twenty-four or twenty-six.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

*** § 4104. Deposits.** (a) Before being licensed to write one or more of the kinds of insurance defined respectively in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter: burglary and theft (7), glass (8), boiler and machinery (9), elevator (10), animal (11), personal injury liability (13), property

damage liability (14), workers' compensation and employers' liability (15), fidelity and surety (16), or credit (17), a domestic property/casualty insurance company shall have made a deposit with the superintendent of eligible securities in an amount of at least five hundred thousand dollars or the amount required as paid-in capital or minimum surplus for the kind or kinds of insurance which such company is to be licensed to write, whichever is the lesser, but in no event shall the amount of the deposit be less than four hundred thousand dollars for any stock company writing any two kinds of insurance designated in this subsection.

(b) Before being licensed pursuant to subsection (c) of section four thousand one hundred two of this article to reinsure risks or to write insurance on risks outside of the United States, its territories and possessions, a domestic property/casualty insurance company shall have made a deposit with the superintendent of eligible securities in an amount of at least three million dollars. Such deposit shall be inclusive of any deposit required by subsection (a) or (c) hereof.

(c) Before being authorized to issue non-assessable policies pursuant to section four thousand one hundred thirteen of this article, a domestic mutual property/casualty insurance company shall have made a deposit with the superintendent of eligible securities in an amount of at least five hundred thousand dollars. Such deposit shall be inclusive of any deposit required by subsection (a) or (b) hereof.

(d) Before being granted any license or renewal license, every foreign property/casualty insurance company shall have made a deposit with the superintendent of eligible securities in an amount not less than the amount required for a similar domestic property/casualty insurance company. The superintendent shall accept in lieu of such deposit a certificate of the proper state officer of the state under whose laws such company is organized showing that such company has deposited with the proper officer of such state, in trust for the benefit and protection of, or for the security of, all of its policyholders, or of all of its policyholders and creditors, securities valued at an amount not less than the amount hereinbefore specified. Such certificate and deposit shall be governed by the provisions of sections one thousand three hundred eighteen and one thousand three hundred nineteen of this chapter.

(e) The dollar amounts of the deposits specified in subsections (a) and (c) hereof shall be reduced by fifty percent for any property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

§ 4105. Domestic stock companies; declaration and payment of dividends. (a) Except as provided in subsection (c) of this section no domestic stock property/casualty insurance company shall declare or distribute any dividend to shareholders except out of earned surplus. Notwithstanding the foregoing, the superintendent may permit a domestic stock property/casualty insurance company to restate its earned surplus under a plan of quasi-reorganization in accordance with regulations as may be promulgated by the superintendent. No domestic stock property/casualty insurance company shall declare or distribute any dividend to shareholders which, together with all dividends declared or distributed by it during the next preceding twelve months, exceeds the lesser of ten percent of its surplus to policyholders as shown by its last statement on file with the superintendent, or one hundred percent of adjusted net investment income during such period unless, upon prior application therefor, the superintendent approves a greater dividend distribution based upon his finding that the insurer will retain sufficient surplus to support its obligations and writings.

In this section, (1) "earned surplus" means the portion of the surplus that represents the net earnings, gains or profits, after deduction of all losses, that have not been distributed to the shareholders as dividends, or transferred to stated capital or capital surplus or applied to other purposes permitted by law but does not include unrealized appreciation of assets;

(2) "adjusted net investment income" means net investment income for the twelve months immediately preceding the declaration or distribution of the current dividend increased by the excess, if any, of net investment income over dividends declared or distributed during the period commencing thirty-six months prior to the declaration or distribution of the current dividend and ending twelve months prior thereto; and

(3) "surplus" means the amount of the insurer's admitted assets in excess of its capital and liabilities, and both "surplus" and "surplus to policyholders" include any voluntary reserves, or any part thereof, which are not required by law.

(b) If the superintendent finds, after notice and hearing, that any such company has distributed any dividend in violation of this section, he may order the company to cease doing any new business until the amount of the dividend has been restored to the company. The directors of any such company who vote in favor of the declaration and distribution of any dividend in violation of this section shall, in addition to all other liabilities or penalties prescribed by law, be jointly and severally liable to the creditors, including policyholder creditors, of the company to the extent of the dividend so declared and distributed, and every shareholder receiving any such dividend shall be liable to the creditors of the company to the extent of the dividend received by such shareholder.

(c) Such company may declare and distribute a stock dividend to its shareholders whenever it shall have a surplus, as defined in subsection (a) hereof, in an amount at least equal to the sum of the dividend and thirty percent of its unearned premium liability as shown by its last statement on file with the superintendent and, for such purpose, the company may increase its capital stock from such surplus in the manner prescribed in section one thousand two hundred six of this chapter, and it shall distribute the additional or increased stock to its shareholders in proportion to the stock held by each, respectively.

§ 4106. Stock companies; participating policies. A stock property/casualty insurance company authorized to do business in this state may include in its charter a provision authorizing the board of

directors to permit its policyholders from time to time to participate in the profits of its operations through the payment of dividends to policyholders. For the purpose of carrying into effect this provision, the board of directors may from time to time make reasonable classifications of policies. Every such classification of risks shall be filed with the superintendent and shall not be effective as to policies issued or delivered in this state unless approved by the superintendent as fair and equitable and not unfairly discriminatory. Any classification approved by the superintendent shall remain in effect in this state until disapproved by him or until withdrawn or modified with his approval by the company filing the same. No dividends to policyholders shall be declared or paid by any such company except out of its earned surplus as defined in subsection (a) of section four thousand one hundred five of this article.

*** § 4107. Domestic mutual companies; financial and other requirements.** (a) (1) A mutual property/casualty insurance company organized in the manner prescribed in subsection (a) of section one thousand two hundred one of this chapter may be licensed pursuant to subsection (e) of section one thousand one hundred two of this chapter to write any one kind (but only one kind except as hereinafter in this section provided) of insurance as specified in TABLE TWO upon at least meeting the requirements set forth therein. In this section, "initial surplus" means the paid-in initial surplus required pursuant to subparagraph (A) of paragraph nine of subsection (a) of section one thousand two hundred one and subparagraph (B) of paragraph one of subsection (e) of section one thousand one hundred two of this chapter, and "minimum surplus" means the surplus required to be maintained unimpaired after a company is licensed to do business.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

TABLE TWO

Kind of insurance specified in the following numbered paragraphs of subsection (a) of § 1113	Number of Members	Number of Applications	Number of Separate Risks	Number of Insurance Policies	Initial Surplus	Minimum Surplus to be Maintained	Other Requirements
4	50	300	300	--	$ 300,000{1}	$ 200,000{1}	see note{2}
7	20	20	200	20	$ 300,000	$ 200,000	see note{3}
8	20	20	300	20	$ 150,000	$ 100,000	see note{3}
9	20	20	200	20	$ 300,000	$ 200,000	see note{3}
10	20	20	300	20	$ 150,000	$ 100,000	see note{3}
11	20	20	300	20	$ 150,000	$ 100,000	see note{3}
13	100	100	500{4}	--	$ 500,000{5}	$ 400,000{5}	see note{6}
15	40{7}	40	2,500{7}	--	$ 500,000	$ 400,000	see note{6}
	30{7}	30	5,000{7}	--	$ 500,000	$ 400,000	see note{6}
	20{7}	20	7,500{7}	--	$ 500,000	$ 400,000	see note{6}
	10{7}	10	10,000{7}	--	$ 500,000	$ 400,000	see note{6}
16	--	--	---	--	$1,500,000	$1,000,000	
17	20	20	2,000	20	$ 750,000	$ 500,000	see note{3}
20	50	300	300	--	$1,000,000{8}	$ 500,000{8}	see note{9}
21	20	20{10}	200{11}	--	$ 500,000	$ 500,000	see note{12}
34	20	20	200	20	$2,000,000	$1,000,000	see note {3}

Notes to TABLE TWO

{1} If licensed to write paragraph 4, no additional surplus is required for a license to write paragraphs 5, 6, 12, 19, 20, (inland marine only) and 34.

{2} The aggregate premiums in respect to the separate risks shall be at least $100,000 and each applicant shall have paid one-half of the premium payable with the balance due upon the issuance of the policy.

{3} Shall have received cash from each applicant at least equal to 1/2 of the annual premium on the policy.

{4} Not more than 5 risks from any one member.

{5} If licensed to write paragraph 13, no additional surplus is required for a license to write paragraphs 6, 12 and 14.

{6} The aggregate annual premium cost of such insurance shall be at least $50,000.

{7} Substitute "employers" for "members" and "employees" for "separate risks"

{8} If licensed to write paragraph 20, no additional surplus is required for a license to write paragraphs 12, 19, and 21.

{9} The aggregate amount of cash received for the premiums on the policies applied for shall be at least $150,000.

{10} The 20 applications shall be from persons, firms, corporations, associations or joint stock companies, each owning, operating or chartering one or more vessels.

{11} Applicants shall take insurance covering in the aggregate at least 200 vessels having an aggregate gross tonnage of at least 500,000 tons.

{12} Shall have received cash, from such applicants, on account of the premiums on the respective policies applied for, a sum at least equal to 20 cents per ton upon such aggregate gross tonnage.

(2) A mutual property/casualty insurance company whose membership is limited to hospitals may be organized in the manner prescribed in subsection (a) of section one thousand two hundred one of this chapter and may be licensed pursuant to subsection (e) of section one thousand one hundred two of this chapter to write the kinds of insurance specified in paragraph thirteen or fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter provided (i) it shall have applications from at least forty members on at least forty separate risks, (ii) the total annual premium cost shall be at least seven hundred fifty thousand dollars, (iii) it shall have an initial surplus of at least five hundred thousand dollars and shall maintain a surplus of at least four hundred thousand dollars and (iv) it shall receive from its members advances pursuant to the requirements of section one thousand three hundred seven of this chapter averaging not less than one-third of the average annual indicated premium, but the total thereof shall not be less than the initial minimum surplus.

(b) If licensed to write any kind of insurance specified in TABLE TWO,

a mutual property/casualty insurance company may in addition write any one or more of the kinds of insurance specified in Group A and/or Group B of TABLE THREE, and if licensed to write any kind of insurance specified in Group A, it may in addition write any one or more of the kinds of insurance specified in Group C of TABLE THREE, in either case, upon at least meeting the initial surplus requirement prescribed in TABLE THREE for the kinds of insurance for which it is to be licensed. It shall thereafter maintain the minimum surplus prescribed in TABLE THREE for the kinds of insurance licensed.

TABLE THREE

Kind of insurance specified in the following numbered Paragraphs of subsection (a) of § 1113:	Initial{1} Surplus	Minimum Surplus{1} to be Maintained
Group A:		
7 or 9 - for each such kind	$100,000	$100,000
8, 10 or 11 - for each such kind	$ 50,000	$ 50,000
13,{2} 15 or 17 - for each such kind	$300,000	$300,000
16	$900,000	$900,000
Group B:		
4{3}	$ 300,000	$200,000
20{4}	$1,000,000	$500,000
Group C:		
3(i) or 3(ii) - for each such kind	$ 100,000	$ 100,000
22	$3,000,000	$2,000,000
24	$ 300,000	$ 300,000
26 (B)	$ 300,000	$ 200,000
26(A), 26(C) or 26(D) - for each such kind	$ 900,000	$ 600,000
28	$3,000,000	$2,000,000
6{5}, 12{6} or 14{2} - for each such kind	$ 50,000	$ 50,000
27	$ 300,000	$ 150,000
30	$ 300,000	$ 300,000
31	$ 100,000	$ 100,000
32	$ 100,000	$ 100,000
33	$ 100,000	$ 100,000

Notes to TABLE THREE

{1} The amounts shown in TABLE THREE are added to the initial and minimum surplus for the kind of insurance for which the mutual was organized as set forth in TABLE TWO. In addition, if organized to write paragraphs 4, 20 or 21 the initial and minimum surplus required for paragraphs 7, 8, 9, 10, 11, 13, 15, 16 or 17 shall be determined from TABLE TWO for the kind of insurance with the highest initial surplus requirement as indicated in TABLE TWO. After such determination use TABLE THREE to derive the initial and minimum surplus requirements for all other kinds of insurance.

{2} If licensed to write paragraph 13, no additional surplus is required for a license to write paragraphs 6, 12, and 14.

{3} If licensed to write paragraph 4, no additional surplus is required for a license to write paragraphs 5, 6, 12, 19, 20, (inland marine only) and 34.

{4} If licensed to write paragraph 20, no additional surplus is required for a license to write paragraphs 12, 19, and 21.

{5} If licensed to write paragraph 4 or 13, no additional initial and minimum surplus is required.

{6} If licensed to write paragraphs 4, 13 or 20, no additional initial and minimum surplus is required.

(c) A mutual property/casualty insurance company licensed pursuant to paragraph four of subsection (b) of section four thousand one hundred two of this article to write the kind of insurance specified in paragraph nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter must maintain a minimum surplus of at least six hundred thousand dollars.

(d) A mutual property/casualty insurance company licensed pursuant to subsection (c) of section four thousand one hundred two of this article to reinsure risks or write insurance on risks outside the United States, its territories and possessions, must maintain a surplus to policyholders of at least thirty-five million dollars.

(e) The dollar amounts of initial surplus, minimum surplus and surplus to policyholders set forth in subsections (a), (b) and (c) of this section shall be reduced by fifty percent for any mutual property/ casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two. Such reduction

shall not apply to the financial requirements specified in subsection (b) of this section in order to write paragraph twenty-two, twenty-four or twenty-six.

(f) Notwithstanding any provision of this section to the contrary, if licensed to write the kind of insurance specified in paragraph fifteen of subsection (a) of section one thousand one hundred thirteen of this chapter, a mutual property/casualty insurance company may be licensed for the purposes of article nine of the workers' compensation law to write the kind of insurance specified in item (i) of paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter without having any additional surplus.

§ 4108. Foreign and alien mutual companies; licensing. (a) No foreign or alien mutual property/casualty insurance company shall be granted a license to do business in this state unless it substantially complies with all of the requirements set forth in this chapter for a domestic mutual property/casualty insurance company licensed to write the same kind or kinds of insurance.

(b) No alien mutual property/casualty insurance company shall be authorized to do business in this state unless it maintains a trusteed surplus, as required by section one thousand three hundred twelve of this chapter, at least equal to the surplus to policyholders required to be maintained by a domestic stock property/casualty insurance company licensed to write the same kind or kinds of insurance.

(c) The financial requirements specified in subsections (a) and (b) hereof shall be reduced by fifty percent for a foreign or alien mutual property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two, but such reduction shall not apply to such a foreign or alien insurer licensed under subsection (c) of section four thousand one hundred two of this article to reinsure risks or write insurance on risks outside the United States, its territories and possessions. Such reduction shall also not apply to the amounts required in order to write paragraph twenty-two, twenty-four or twenty-six of subsection (a) of section one thousand one hundred thirteen of this chapter.

§ 4109. Mutual companies; special contingent surplus. (a) A domestic mutual property/casualty insurance company licensed to write any of the kinds of insurance defined respectively in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter: accident and health (item (i) of (3)), non-cancellable disability (item (ii) of (3)), burglary and theft (7), glass (8), boiler and machinery (9), elevator (10), animal (11), personal injury liability (13), property damage liability (14), workers' compensation and employers' liability (15), fidelity and surety (16) or credit (17), shall establish on its general ledger a special contingent surplus and shall thereafter maintain the same unimpaired so long as it is licensed to write one or more of the foregoing kinds of insurance. An impairment exists in the surplus of any such company at any time when the aggregate value of its admitted assets is less than the amount of all of its liabilities and the special contingent surplus which it is required to maintain at such time.

(b) During each full calendar year except the first two full calendar years next following the calendar year in which such company was licensed to write any kind of insurance specified in subsection (a) hereof, the amount of such contingent surplus shall exceed the required amount thereof at last year-end, by an amount at least equal to one and one-half percent of the net premium income received for the kinds of insurance referred to in subsection (a) hereof during such whole calendar year, until the amount of such contingent surplus shall be at least equal to the amount of surplus to policyholders required under section four thousand one hundred three of this article to be maintained by a similar domestic stock property/casualty insurance company licensed to do any one or more of the kinds of insurance specified in subsection (a) hereof. Such special contingent surplus, by whatever name called, shall be inclusive of the minimum surplus required by the provisions of this chapter and shall be exclusive of any divisible surplus available for the payment of dividends.

(c) No domestic mutual property/casualty insurance company shall declare or pay any dividend to policyholders if, after the payment of such dividend, its special contingent surplus as herein required will be impaired. The declaration and payment of dividends by any such company

shall be subject to the provisions of section one thousand two hundred eleven of this chapter.

(d) Any domestic mutual property/casualty insurance company shall be authorized in any year to further increase its special contingent surplus by an amount in excess of the annual accumulation required by this section, and any such excess shall be credited upon the amount which otherwise it would have been required to accumulate by the provisions of this section in any subsequent year or years.

(e) The superintendent may refuse to issue a license or renewal license to do an insurance business in this state to any foreign or alien mutual property/casualty insurance company which does not comply in substance with this section applicable to a similar domestic mutual property/casualty insurance company licensed to write the same kind or kinds of insurance.

§ 4110. Domestic mutual companies; expense limits. (a) No domestic mutual property/casualty insurance company licensed to write a kind of insurance specified in paragraph seven, eight, nine, ten, eleven, thirteen, fourteen, fifteen, sixteen or seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter shall expend in any one calendar year for management expenses a greater amount than thirty percent of the sum of its net premium income and seventy-five percent of its investment income for such year; provided that any insurer whose principal line of business is medical malpractice liability insurance or any insurer who is the subject of a proceeding pursuant to article seventy-four of this chapter shall not expend in any one calendar year for management expenses, a greater amount than thirty percent of its net premium income for such year. Management expenses shall be held to include all expenses of the company except expenses incurred in the investigation, adjustment and settlement of claims, taxes, fees and expenses of examination, and taxes, repairs and expenses on real estate. In applying the provisions of this section the net premium income of, and expenses of, boiler and machinery insurance or elevator insurance shall not be included. In the event expenses incurred in making a new system upgrade result in this subsection's management expenses limit being exceeded, then the insurer shall inform the

superintendent sixty days in advance of the expense limit being exceeded. Subject to approval by the superintendent, the limit shall be temporarily raised to the amount necessary to encompass the aforestated new system upgrade, provided that in no event shall the limit be raised more than five percentage points and shall not be in effect for more than three years, and provided further that an insurer may submit to the superintendent, for the superintendent's prior approval, a written request to temporarily raise the limit for up to an additional three years, for a total of no more than six years. An insurer shall submit such written request to the superintendent at least sixty days but not more than one hundred twenty days before the expiration of the initial period during which the limit was raised. The insurer shall not increase premiums solely as a result of the management expenses cap limit being exceeded. For purposes of this subsection, a new system upgrade is defined as the acquisition of electronic data processing apparatus and related equipment constituting a data processing, record keeping or accounting system and operating and non-operating software.

(b) Subsection (a) hereof shall not apply to a mutual company organized before the effective date of this chapter as a domestic mutual fire or marine or marine protection and indemnity company.

§ 4111. Mutual companies; assessments. (a) Except as provided in section four thousand one hundred thirteen of this article, every domestic mutual property/casualty insurance company shall in its by-laws and policies prescribe the contingent mutual liability of its members for the payment of assessments, in such a way that each member shall be liable to pay the member's proportionate share, subject to the limitations hereinafter specified, of the amount of any assessment or assessments permitted for any purpose under any provisions of this chapter or necessary to make good an impairment of the minimum surplus of such company. The contingent liability of a member may be limited to an amount not less than one additional annual premium on each policy held by a member. The aggregate amount of all assessments whether levied by the board of directors of such insurer or by the superintendent as liquidator or rehabilitator of the insurer, or otherwise, shall be no greater amount than that specified in the by-laws and policies. Except

as provided in section four thousand one hundred thirteen of this article, no such insurance company shall make, issue or deliver any policy of insurance, which does not prescribe the contingent liability of the policyholder in clear and explicit language printed in type not smaller than eight point.

(b) If any domestic mutual property/casualty insurance company does not have admitted assets at least equal in amount to the aggregate of its liabilities and its minimum surplus as required by the provisions of this chapter, and if such impairment is not otherwise made good, the board of directors of the company may, with the approval of the superintendent and within such time as he prescribes, order an assessment in the manner specified in the by-laws for an amount which will provide sufficient funds to make good the impairment, except that no member shall be liable for an assessment exceeding the limit specified in his policy in accordance with subsection (a) hereof. All orders of assessment made by the board of directors shall be filed with the superintendent and shall not take effect unless and until approved by him. The superintendent may refuse any such approval if, in his judgment, refusal will best promote the interests of the policyholders and creditors of the company, and of the insuring public. Every assessment shall be made upon all members liable to assessment therefor in the proportion hereinafter specified. Every person, firm or corporation who or which was a member of such company at any time during one year prior to the making of an order of assessment by the board of directors shall be liable to pay and shall pay the member's proportionate share of any assessment which may be made in accordance with law, if the member is notified of the assessment within one year after making of an order of assessment. A member's proportionate part of any assessment shall be determined by applying to the premium earned on the member's policy or policies in force during a period of one year next preceding the order of assessment the ratio of the total assessment to the total premiums earned during such period on all policies subject to assessment.

(c) Unless specifically authorized by the provisions of this chapter to issue non-assessable policies in this state, no foreign mutual property/casualty insurance company shall be or continue to be authorized to do business in this state unless its by-laws and policies

issued in this state contain provisions for the levying and collection of assessments upon members, at least for the payment of losses and expenses, which conform in substance to subsection (b) hereof.

(d) In the case of a mutual property/casualty insurance company subject to paragraph two of subsection (a) of section four thousand one hundred seven of this article, an assessment authorized by this section shall be made when, in addition to the grounds set forth in this section, if the ratio of net premium writings to surplus as regards policyholders is four to one or greater, based upon the last annual statement or any quarterly statement projected on an annual basis, subject to the approval of the superintendent, and if, at any time, upon examination, the superintendent determines that an assessment should be made pursuant to subsection (b) hereof or this subsection the superintendent shall make an appropriate order that the assessment be made.

§ 4112. Mutual companies; protection against assessments. No domestic mutual property/casualty insurance company and no officer or representative thereof shall make any contract whether on behalf of such company or of all or any of its policyholders, whereby the company or the policyholders are insured or indemnified against the imposition or payment of assessments which may be made upon members of the company, if the contract is cancellable or otherwise terminable by any party thereto upon the giving of notice of cancellation or termination within a period of less than one year before the effective date of the cancellation or termination.

*** § 4113. Mutual companies; non-assessable policies.** (a) Every mutual property/casualty insurance company licensed to do business in this state, if its charter or by-laws permit or are amended to permit the issuance of policies without contingent mutual liability of the policyholder for assessment, may with the permission of the superintendent issue non-assessable policies in this state upon compliance with the following requirements:

(1) It shall maintain a surplus, as determined from its latest filed

statement, which together with its unearned premium reserve from its latest filed statement is at least equal to the surplus to policyholders required to be maintained by a domestic stock property/casualty insurance company licensed to write the same kind or kinds of insurance.

(2) It shall have submitted a copy of its proposed non-assessable policy or policies for approval of the superintendent, and shall have obtained his approval.

(b) Every policy issued by any such company shall clearly state whether or not the holder of the policy is subject to a liability for assessment.

(c) Any surplus required for the purposes specified in this section shall be inclusive of any surplus required by any other sections of this chapter.

(d) A mutual property/casualty insurance company subject to paragraph two of subsection (a) of section four thousand one hundred seven of this article and subject to subsection (d) of section four thousand one hundred eleven of this article may with the prior approval of the superintendent amend its charter and by-laws to permit the issuance of policies without contingent mutual liability of the policyholder and may with the permission of the superintendent issue non-assessable policies in this state upon compliance with the requirements of this section.

(e) The financial requirement specified in paragraph one of subsection (a) hereof shall be reduced by fifty percent for a mutual property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

§ 4114. Mutual companies; dividends. The board of directors of a mutual property/casualty insurance company may from time to time fix and determine an amount to be declared and paid as a dividend or as a return

of unused or unabsorbed premiums or premium deposits on policies, retaining such sums as they may deem necessary to meet outstanding policy obligations and for the maintenance of reserves and surplus as herein provided. The determination, declaration and payment of such dividend shall be subject to section one thousand two hundred eleven of this chapter. In declaring any dividend to policyholders, the board of directors may make reasonable classifications of policies. Every such classification shall be filed with the superintendent and shall not become effective unless approved by the superintendent as fair, equitable, not impracticable in operation and not unfairly discriminatory. Any such classification approved by the superintendent shall remain in effect until disapproved by the superintendent or until withdrawn with the superintendent's approval by the company filing the same. The requirements as to filing and approval, as applied to any foreign or alien mutual property/casualty insurance company, shall apply only to risks located or resident in this state.

§ 4115. Certain mutual companies existing prior to January first, nineteen hundred forty. (a) Notwithstanding the provisions of sections four thousand one hundred eleven, four thousand one hundred thirteen and four thousand one hundred fourteen of this article, any domestic mutual property/casualty insurance company heretofore organized as a domestic mutual marine and fire insurance company under special act of this state and reincorporated pursuant to former section fifty-two of the insurance law in effect immediately before January first, nineteen hundred forty and doing business immediately prior to such date, may continue to issue non-assessable policies in accordance with its charter powers, without making any deposit, if and so long as it maintains a surplus of not less than one million dollars.

(b) Notwithstanding the provisions of sections one thousand two hundred nine and one thousand two hundred eleven of this chapter and section four thousand one hundred fourteen of this article, any such domestic mutual insurance company of the kind specified in subsection (a) hereof, may continue to issue both participating and non-participating policies or contracts of insurance, in accordance with its charter, and may continue to exercise its existing charter powers as

to the qualification of its members and trustees and as to the election and powers of its board of trustees.

§ 4116. Domestic mutual companies; voting rights of members. The charter or by-laws of any domestic mutual property/casualty insurance company may, with the approval of the superintendent pursuant to section one thousand two hundred nine of this chapter, provide for the distribution of voting power, at all meetings of the corporation, among the members on the basis of the amount of insurance held, the number of policies held, or the amount of premiums paid, by the member or on any other basis which the superintendent finds to be fair and equitable; but in any event every member whose insurance is in force at the time of the election shall be entitled to at least one vote, and no member shall be entitled to more than ten votes.

§ 4117. Loss and loss expense reserves. (a) In determining the financial condition of any property/casualty insurance company for the purpose of applying the provisions of this chapter, and in any financial statement or report of any such company, there shall be included in the liabilities of such company loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section, and the amount of such reserves shall be diminished by allowance or credit for reinsurance recoverable from assuming insurers in accordance with paragraph nine of subsection (a) of section one thousand three hundred one of this chapter. The date as of which such determination, statement or report is made is hereinafter referred to as the date of determination.

(b) For all outstanding losses and loss expenses, the reserves shall include the following:

(1) the aggregate estimated amounts due or to become due on account of all known losses and claims and loss expenses incurred but not paid, including the estimated liability on any notice received by the company of the occurrence of any event which may result in a loss;

(2) the aggregate amounts of liability for all losses and loss expenses incurred but on which no notice has been received, estimated in

accordance with the company's prior experience, if any, otherwise in accordance with the experience of similar companies under similar contracts of insurance. The estimated liabilities for such losses under all its bonds, policies or contracts of fidelity insurance, shall be not less than ten percent of the net premiums in force thereon, and the estimated liabilities for all such losses under all its surety contracts shall be not less than five percent of the net premiums in force thereon.

(c) Except as provided in subsection (e) hereof the minimum reserves for outstanding losses and loss expenses under policies of personal injury liability insurance and under policies of employers' liability insurance, where the losses were incurred during the three years immediately preceding the date of determination, shall be calculated in accordance with any method adopted or approved by the National Association of Insurance Commissioners and shall be not less than the aggregate of the estimated unpaid losses and loss expenses for claims incurred computed in accordance with subsection (b) hereof.

(d) The minimum reserves for outstanding losses and loss expenses under policies of workers' compensation insurance, except as provided in subsection (e) hereof, shall be computed as follows:

(1) For all such compensation policies where losses were incurred more than three years prior to the date of determination, such reserves shall be the sum of the present values, at five percent interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) hereof.

(2) Where losses were incurred during the three years immediately preceding the date of determination, such reserves shall be the sum of the reserves for each year, which shall be calculated in accordance with any method adopted or approved by the National Association of Insurance Commissioners and shall be not less than the sum of the present values, at five percent interest per annum, of the determined and estimated unpaid losses computed on an individual case basis plus the estimated unpaid loss expenses computed in accordance with subsection (b) hereof.

(e) Whenever in the judgment of the superintendent, the loss and loss expense reserves of any property/casualty insurance company doing business in this state calculated in accordance with the foregoing

provisions are inadequate or excessive, he may prescribe any other basis which will produce adequate and reasonable reserves.

(f) Every property/casualty insurance company doing business in this state shall keep a complete and itemized record showing all losses and claims on which it has received notices including all notices received by it of the occurrence of any event which may result in a loss.

(g) (1) Effective with the nineteen hundred ninety annual statement, every licensed property/casualty insurer required to file such annual statement with the superintendent by the following April first, shall, unless exempted by the superintendent, engage a qualified independent loss reserve specialist for the following year to render an opinion as to the adequacy of its loss and loss adjustment expense reserves when two of three of such insurer's results of its loss and loss adjustment expense ratios as indicated below are outside of the indicated acceptable ranges:

(A) One Year Reserve Development to Surplus

Add the year-end estimate of the losses that were outstanding one year earlier to the payments on those losses made during that year. The difference between that sum and the reserves that were established at the end of the prior year is the one-year reserve development. The ratio of one-year reserve development to prior year's surplus is the deficiency or redundancy. The acceptable range is less than twenty-five percent deficiency. Any redundancy is acceptable.

(B) Two Year Reserve Development to Surplus

Add the year-end estimate of the losses that were outstanding two years earlier to the payments on those losses made during those two years. The difference between that sum and the reserves that were established at the end of the second prior year is the two-year reserve development. The ratio of two-year reserve development to the second prior year's surplus is the deficiency or redundancy. The acceptable range is less than twenty-five percent deficiency. Any redundancy is acceptable.

(C) Estimated Current Reserve Deficiency to Surplus

For the last two years the reserves as stated in those years are

adjusted by the one-year or two-year reserve development as calculated in the above two ratios. This total is then divided by the net premium earned in the appropriate year to obtain the developed reserve to premium ratio. The estimated reserves required is the current net premium earned multiplied by the average ratio between developed reserves and earned premium for the last two years. The estimated deficiency is the difference between the estimated reserves required by the company and the actual reserves maintained. The estimated current reserve deficiency or redundancy is taken as a percentage of surplus and the acceptable range is less than twenty-five percent deficiency. Any redundancy is acceptable.

(2) Such opinion shall be submitted by the qualified loss reserve specialist to the insurer and the superintendent, by such date established by the superintendent. For the purposes of this section, a "qualified independent loss reserve specialist" shall mean a person who is not an employee, principal or director or indirect owner of the insurer and is a member of the Casualty Actuarial Society, or has such other experience as is acceptable to the superintendent to assure a professional opinion on the adequacy of loss and loss adjustment expense ratios.

(3) Nothing in this subsection shall be construed to restrict or diminish any right or power of the superintendent under any other provision of this chapter.

(4) The superintendent shall keep the contents of each report made pursuant to this subsection and any information obtained in connection therewith confidential and shall not make the same public without the prior written consent of the insurer to which it pertains unless the superintendent after notice and an opportunity to be heard shall determine that the interests of policyholders, shareholders or the public will be served by the publication thereof.

§ 4118. Limitation of risks; fidelity and surety; fire; hospital mutuals. (a) (1) In applying the limitation of section one thousand one hundred fifteen of this chapter to fidelity and surety risks the net amount of exposure on any one fidelity or surety risk shall, except as provided in paragraph four hereof, be deemed within the limit of ten

percent if the company is protected in excess of that amount by:

(A) reinsurance in a company authorized to write such business in this state or reinsurance in an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter, which is in such form as to enable the obligee or beneficiary to maintain an action thereon against the ceding insurer jointly with the assuming insurer or, where the commencement or prosecution of actions against the ceding insurer has been enjoined by any court of competent jurisdiction or any justice or judge thereof, against the assuming insurer alone, and to have recovery against the assuming insurer for its share of the liability thereunder and in discharge thereof; or

(B) the co-suretyship of any other company authorized to do such business in this state; or

(C) a deposit of property with it in pledge or conveyance of property to it in trust for its protection; or

(D) a conveyance or mortgage of property for its protection; or

(E) in case a suretyship or guaranty obligation was made on behalf or on account of a fiduciary holding property in a trust capacity, by such a deposit or other disposition of a portion of the property so held in trust that no future sale, mortgage, pledge or other disposition can be made thereof except with the consent of the insurance company or by decree or order of a court of competent jurisdiction.

(2) Notwithstanding the provisions of paragraph one hereof, a company may execute bonds of the kind commonly known as transportation or warehousing bonds for United States internal revenue taxes in a net amount not exceeding twenty percent of its surplus to policyholders, determined as provided in paragraph one hereof.

(3) In determining the net amount of exposure on any one risk, the following rules shall be applicable to the kinds of obligations hereinafter described:

(A) When the penalty of a suretyship obligation exceeds the amount of a judgment prescribed therein as appealed from and thereby secured, or exceeds the amount of the subject matter in controversy or of the estate in the hands of the fiduciary for the performance of whose duties it is conditioned, the bond may be executed by such company if the actual amount of the judgment or the subject matter in controversy or estate not subject to supervision or control of the surety, is not in excess of

a limitation of ten percent.

(B) When the penalty of a suretyship obligation executed for the performance of a contract exceeds the contract price, the latter amount shall be taken as the basis for estimating the limit of risk within the meaning of this paragraph.

(4) In addition to any other limitation contained in this chapter, no authorized company shall at any one time be exposed to risks on suretyship obligations guaranteeing the deposits of any single financial institution in an aggregate net amount in excess of ten percent of the surplus to policyholders of such company, determined as provided in paragraph one hereof, unless it shall be protected in excess of that amount by security in accordance with the provisions of subparagraphs (A), (B), (C) and (D) of paragraph one hereof.

(b) No insurer authorized to write fire insurance in this state shall expose itself to any loss on any one fire risk, whether located in this state or elsewhere, in an amount exceeding ten percent of its surplus to policyholders, except that in the case of risks adequately protected by automatic sprinklers or risks principally of non-combustible construction and occupancy such insurer may expose itself to any loss on any one risk in an amount not exceeding twenty-five percent of the sum of its unearned premium reserve and its surplus to policyholders. Any risk or portion of any risk reinsured in an assuming insurer authorized to write such business in this state or in an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter, shall be deducted in determining the limitation of risk prescribed in this subsection.

(c) A mutual property/casualty insurance company subject to paragraph two of subsection (a) of section four thousand one hundred seven of this article may be permitted to write coverage on any one risk in excess of the limitation provided by section one thousand one hundred fifteen of this chapter, based upon criteria approved by the superintendent.

§ 4119. Foreign and alien companies; license qualification. No foreign or alien property/casualty insurance company shall be licensed to do business in this state unless it shall have continuously transacted an insurance business in the state or country of its incorporation for at

least three years immediately prior to the issuance of such license. The superintendent may waive or reduce the three year requirement, with respect to a license applicant, upon determination that the three year period is not necessary to safeguard the interests of the public or policyholders.

§ 4121. Security may be required from banking officers and employees. (a) The board of directors or trustees of each bank, trust company, savings bank or savings and loan associations in this state, may require from each officer and employee thereof an individual fidelity bond in favor of the institution in an amount and form approved by such board of directors or trustees.

(b) Such bond shall be accepted only from a corporation authorized to issue fidelity bonds and doing business in this state under the authority of the department.

(c) The premium for such bond may be paid as a necessary expense of any such banking institution.

ARTICLE 42

LIFE INSURANCE COMPANIES AND ACCIDENT AND HEALTH INSURANCE COMPANIES AND LEGAL SERVICES INSURANCE COMPANIES

Section 4202. Capital and surplus requirements of life insurance companies.

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4204. Financial requirements for the organization of stock accident and health insurance companies and stock legal services insurance companies.

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§ 4202. Capital and surplus requirements of life insurance companies. (a) (1) A stock company may be organized as prescribed in section one thousand two hundred one and subsection (e) of section one thousand one hundred two of this chapter and licensed to do the business of life insurance as specified in paragraph one of subsection (a) of section one thousand one hundred thirteen of this chapter with a paid-in capital of at least two million dollars and a paid-in initial surplus at least equal to the greater of four million dollars or two hundred percent of its capital, and it may in addition do any one or more of the kinds of insurance business specified in paragraphs two, three, twenty-nine and thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter, without having additional capital or surplus.

(2) Every such company shall at all times maintain a minimum capital of two million dollars, except that every such company

(A) if organized prior to April fourth, nineteen hundred sixty-two shall at all times maintain a minimum capital of at least three hundred thousand dollars and a surplus at least equal to fifty percent of such capital; and

(B) if organized on or after April fourth, nineteen hundred sixty-two and prior to September first, nineteen hundred sixty-six shall at all

times maintain a minimum capital of at least five hundred thousand dollars and a surplus at least equal to fifty percent of such capital; and

(C) if organized on or after September first, nineteen hundred sixty-six and prior to September first, nineteen hundred seventy-nine shall at all times maintain a minimum capital of at least one million dollars and a surplus at least equal to fifty percent of such capital.

(b) (1) The superintendent may permit the organization, in conformity with section one thousand two hundred one and subsection (e) of section one thousand one hundred two of this chapter, of a stock company to do on a restricted plan any one or more of the kinds of insurance business specified in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter, with a minimum paid-in capital and a minimum paid-in surplus in an amount prescribed by him, but not less than a paid-in capital of two hundred thousand dollars and a paid-in surplus at least equal to one hundred thousand dollars provided the superintendent, after investigation, finds that the restricted plan is sound, economical and practical and that there is a public demand for such insurance or annuity contracts.

(2) Every such company shall at all times maintain such prescribed minimum capital except that every such company organized prior to April fourth, nineteen hundred sixty-two shall at all times maintain a minimum paid-in capital and a minimum paid-in surplus in an amount prescribed by the superintendent, but not less than a paid-in capital of one hundred thousand dollars and a paid-in surplus at least equal to fifty thousand dollars.

§ 4203. Transfer of shares of domestic life insurance company. (a) No shareholder of a domestic life insurance company shall vote his shares until the earlier of (i) ten days after written notice of acquisition thereof has been filed with the superintendent, or (ii) one year after the date of acquisition thereof.

(b) This section shall apply only to shares acquired after such a company has been licensed under this chapter.

§ 4204. Financial requirements for the organization of stock accident and health insurance companies and stock legal services insurance companies. (a) (1) A stock company may be organized in the manner prescribed in section one thousand two hundred one and subsection (e) of section one thousand one hundred two of this chapter and licensed to do only the kind of insurance business specified in item (i) of paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter, with a paid-in capital of not less than one hundred thousand dollars, and a paid-in surplus at least equal to fifty percent of its capital. Every such company shall at all times thereafter maintain a minimum capital of one hundred thousand dollars.

(2) Notwithstanding the foregoing, any such stock company initially licensed on or after July first, nineteen hundred eighty-two shall have a paid-in capital of not less than two hundred thousand dollars and a paid-in surplus at least equal to fifty percent of its capital and shall at all times maintain a minimum capital of at least two hundred thousand dollars.

(b) (1) Any company organized under the provisions of subsection (a) of this section may be licensed to do the kind of insurance business specified in item (ii) of paragraph three, paragraph twenty-nine and paragraph thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter, if it has a paid-in capital of not less than one hundred fifty thousand dollars, and a paid-in initial surplus at least equal to fifty percent of its capital. Every such company shall at all times maintain a minimum capital of one hundred fifty thousand dollars.

(2) Notwithstanding the foregoing provisions of this subsection, any such company initially licensed on or after July first, nineteen hundred eighty-two shall have a paid-in capital of not less than three hundred thousand dollars and a paid-in surplus at least equal to fifty percent of its capital and shall at all times maintain a minimum capital of at least three hundred thousand dollars.

(c) A stock company may be organized to do only the kind of insurance specified in paragraph twenty-nine of subsection (a) of section one thousand one hundred thirteen of this chapter if it complies with the financial requirements of paragraph one of subsection (a) of this section.

§ 4205. Life, accident and health, and legal services insurance companies; engaging in other business. No life insurance company licensed to do a life insurance business in this state shall do any business other than the kinds of business specified in paragraphs one, two, three, twenty-nine and thirty-one of subsection (a) of section one thousand one hundred thirteen, sections one thousand one hundred fourteen, one thousand seven hundred fourteen and three thousand two hundred twenty-two of this chapter and such other business as is necessarily or properly incidental thereto. Except as stated in section one thousand one hundred six of this chapter, this section shall apply to the business within or without this state of such a foreign life insurance company and shall apply only to the business within the United States of such an alien life insurance company.

§ 4206. Deposits by life, accident and health, and legal services insurance companies. Before being licensed to do business, every domestic life insurance company, every domestic accident and health insurance company and every domestic legal services insurance company shall deposit with the superintendent at least one hundred thousand dollars in securities eligible for deposits, except that every such company initially licensed on or after July first, nineteen hundred eighty-two shall make a deposit with the superintendent at least equal to two hundred percent of the amount required hereinabove.

§ 4207. Dividends to shareholders of life, and accident and health insurance companies. (a)(1) For purposes of this subsection, "earned surplus" means an amount equal to an insurer's positive unassigned funds, excluding eighty-five percent of the change in net unrealized capital gains or losses less capital gains tax, for the immediately preceding calendar year as set forth in the insurer's most recent annual statutory financial statement filed with the superintendent pursuant to section three hundred seven of this chapter.

(2) Notwithstanding paragraph five of this subsection, any domestic

stock life insurance company may distribute a dividend to its shareholders out of earned surplus where the aggregate amount of such dividends in any calendar year does not exceed the greater of:

(A) ten percent of its surplus to policyholders as of the immediately preceding calendar year; or

(B) its net gain from operations for the immediately preceding calendar year, not including realized capital gains, not to exceed thirty percent of its surplus to policyholders as of the immediately preceding calendar year; provided, however, that, notwithstanding this paragraph, in no event may a dividend be distributed without approval of the superintendent, in accordance with paragraph five of this subsection, in the calendar year immediately following a calendar year for which its net gain from operations, not including realized capital gains, was negative.

(3) Notwithstanding paragraph five of this subsection, any domestic stock life insurance company may distribute a dividend to its shareholders where the aggregate amount of such dividends in any calendar year does not exceed the lesser of:

(A) ten percent of its surplus to policyholders as of the immediately preceding calendar year; or

(B) its net gain from operations for the immediately preceding calendar year, not including realized capital gains.

(4) An insurer shall not distribute a dividend pursuant to both paragraph two and paragraph three of this subsection.

(5) Except as provided in paragraphs two and three of this subsection, no domestic stock life insurance company shall distribute any dividend to its shareholders unless a notice of its intention to declare such dividend and the amount thereof shall have been filed with the superintendent not less than thirty days in advance of such proposed declaration. The superintendent may disapprove such distribution by giving written notice to such company within thirty days after such filing that the superintendent finds that the financial condition of the company does not warrant such distribution.

(6) With respect to dividends to shareholders distributed pursuant to paragraph two of this subsection, every domestic stock life insurance company shall report to the superintendent all such dividends within five business days following the declaration thereof and at least ten

days prior to the payment thereof.

(7) A domestic stock life insurance company's surplus to policyholders following any distribution of dividends to its shareholders under paragraph two of this subsection shall be reasonable in relation to the company's outstanding liabilities and adequate to meet its financial needs.

(8) With respect to dividends to shareholders distributed pursuant to paragraph two of this subsection, the superintendent may limit or disallow dividends if the superintendent determines that the:

(A) domestic stock life insurance company's surplus to policyholders is not reasonable in relation to the company's outstanding liabilities and not adequate to meet its financial needs; or

(B) domestic stock life insurance company is financially distressed or troubled.

(b) (1) Except as provided in paragraph three hereof, no domestic stock accident and health insurance company shall declare or distribute any dividend on its capital stock, except out of earned surplus, as defined in subsection (a) of section four thousand one hundred five of this chapter. Notwithstanding the forgoing, the superintendent may permit a domestic stock accident and health insurance company to restate its earned surplus under a plan of quasi-reorganization in accordance with regulations as may be promulgated by the superintendent. No domestic stock accident and health insurance company shall declare or distribute any dividend to shareholders which, together with all such dividends declared or distributed by it during the next preceding twelve months, exceeds the lesser of ten percent of its surplus to policyholders, as shown by its last statement on file with the superintendent, or one hundred percent of adjusted net investment income for such period unless, upon prior application therefor, the superintendent approves a greater dividend payment based upon his finding that the insurer will retain sufficient surplus to support its obligations and writings. Within the meaning of this section, "adjusted net investment income" means net investment income for the twelve months immediately preceding the declaration or distribution of the current dividend increased by the excess, if any, of net investment income over dividends declared or distributed during the period commencing thirty-six months prior to the declaration or distribution of the

current dividend and ending twelve months prior thereto; "surplus" means the amount of the insurer's admitted assets in excess of its capital and its liabilities; and both "surplus" and "surplus to policyholders" shall include any voluntary reserves, or any part thereof, which are not required by law.

(2) If the superintendent finds, after notice to and hearing of such company, that any such company has distributed any dividend in violation of this subsection, he may order such company to cease doing any new business until the amount of such dividend has been restored to such company. The directors of any such company who vote in favor of the declaration and distribution of any dividend in violation of this section shall, in addition to all other liabilities or penalties prescribed by law, be jointly and severally liable to the creditors, including policyholder creditors, of such company to the extent of the dividend so declared and paid, and every shareholder receiving any such dividend shall be liable to such creditors of such company to the extent of the dividend received by such shareholder.

(3) Any domestic stock accident and health insurance company may declare and distribute a stock dividend to its shareholders whenever it shall have a surplus as defined in paragraph one hereof, in an amount at least equal to the sum of such dividend and thirty percent of its unearned premium liability as shown by its last statement on file in the office of the superintendent and, for such purpose, such company may increase its capital stock from such surplus in the manner prescribed in section one thousand two hundred six of this chapter, and it shall distribute such additional or increased stock to its shareholders in proportion to the stock held by each, respectively.

(c) Any stock accident and health insurance company authorized to do business in this state may include in its charter a provision authorizing the board of directors to permit its policyholders from time to time to participate in the profits of its operations through the payment of dividends to policyholders. For the purpose of carrying into effect any such provision, the board of directors may from time to time make reasonable classifications of policies. Every such classification of risks shall be filed with the superintendent and shall not be effective as to policies issued or delivered in this state unless approved by the superintendent as fair and equitable and not unfairly

discriminatory. Any such classification approved by the superintendent shall remain in effect in this state until disapproved by him or until withdrawn or modified with his approval by the company filing the same. No dividends to policyholders shall be declared or paid by any such company except out of its earned surplus, as defined in subsection (a) of section four thousand one hundred five of this chapter.

§ 4208. Financial and additional requirements for the organization of mutual life, accident and health, and legal services insurance companies. (a) (1) A mutual insurance company may be incorporated and licensed exclusively to do one or more of the kinds of insurance business specified in paragraphs one, two, three, twenty-nine and thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter, upon compliance with the applicable requirements of section one thousand two hundred one and subsection (e) of section one thousand one hundred two of this chapter and subsection (b) of this section.

(2) In this section:

(A) "Initial surplus" means the paid-in initial surplus required pursuant to paragraph nine of subsection (a) of section one thousand two hundred one and paragraph one of subsection (e) of section one thousand one hundred two of this chapter.

(B) "Minimum surplus" means the amount of surplus which such company shall, after being licensed to do business, at all times maintain unimpaired.

(C) "Applications" means individual applications for policies of life insurance, except that in the case of volunteer firefighters, it shall also mean applications for enrollment for coverage to be issued under group life insurance policies applied for by not less than twenty-five associations or organizations of volunteer firefighters in accordance with the provisions of paragraph seven of subsection (b) of section four thousand two hundred sixteen of this article.

(b) (1) If organized to do only the kind of insurance business specified in paragraph one of subsection (a) of section one thousand one hundred thirteen of this chapter, such company shall:

(A) have not less than one thousand bona fide applications for life

insurance in an amount not less than one thousand dollars each;

(B) have received from each such applicant in cash the full amount of one annual premium on the policy applied for, which premiums in the aggregate at least equal twenty-five thousand dollars;

(C) have an initial surplus of one hundred fifty thousand dollars in cash; and

(D) have a minimum surplus of one hundred thousand dollars.

(2) If organized to do only the kind of business specified in item (i) of paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter, such company shall:

(A) have not less than five hundred bona fide applications for such insurance;

(B) have received from each such applicant in cash the full amount of one annual premium on the policy applied for, which premiums in the aggregate at least equal twenty thousand dollars;

(C) have an initial surplus of one hundred fifty thousand dollars in cash; and

(D) have a minimum surplus of one hundred thousand dollars, except that every such company initially licensed on or after July first, nineteen hundred eighty-two shall have an initial surplus and a minimum surplus in an amount which is at least equal to two hundred percent of that required of a like company licensed prior to July first, nineteen hundred eighty-two.

(3) If organized to do the kinds of insurance business specified in paragraph one and in item (i) of paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter, such company shall comply with both paragraph one and paragraph two of this subsection.

(4) To be organized to do the kind of insurance business specified in paragraph two of subsection (a) of section one thousand one hundred thirteen of this chapter, such company shall meet the organizational requirements of paragraph one hereof and shall have an initial surplus and a minimum surplus, each in an amount at least fifty thousand dollars in excess of the respective amounts otherwise required by paragraph one hereof.

(5) To be organized to do the kind of insurance business specified in item (ii) of paragraph three or paragraph twenty-nine of subsection (a)

of section one thousand one hundred thirteen of this chapter, such company shall meet the organizational requirements of one or more of paragraphs one through four hereof and shall have an initial surplus and a minimum surplus, each in an amount at least fifty thousand dollars in excess of the highest applicable respective amount required by such paragraph or paragraphs, except that any such company initially licensed on or after July first, nineteen hundred eighty-two shall have an initial surplus and a minimum surplus, each in an amount at least one hundred thousand dollars in excess of the highest applicable respective amount required by such paragraph or paragraphs.

§ 4209. Mutual life insurance companies, mutual accident and health insurance companies; assessments. (a) (1) No domestic mutual life insurance company shall issue any policy of life or accident and health insurance or any annuity contract providing for the payment of any assessment by any policyholder or member in addition to the regular premium or consideration charged therefor; nor shall any such company have power to levy or collect any such assessment.

(2) No foreign or alien life insurance company shall do business in this state if it does business anywhere on any assessment plan.

(b) (1) Except as provided in subsection (c) hereof, every domestic mutual accident and health insurance company shall provide in its policies that every member shall be liable for an assessment, in addition to the amount of premiums paid or payable, in an amount not exceeding the maximum named therein, which shall be not less than one annual premium on the policy; if the assessment liability is unlimited the policy shall so provide.

(2) If any domestic mutual accident and health insurance company does not have admitted assets at least equal to the aggregate of its liabilities, reserves and its minimum surplus as required by this chapter, and if such impairment is not otherwise rectified, the board of directors of such company may, with the approval of the superintendent and within such time as he prescribes, order an assessment as specified in its by-laws for an amount which will provide sufficient funds to rectify such impairment, except that no member of such company shall be liable for an assessment exceeding the limit specified in his policy.

(3) All such orders of assessment shall be filed with the superintendent and shall not take effect unless and until approved by him. The superintendent may refuse any such approval if, in his judgment, such refusal will best promote the interests of the policyholders and creditors of such company, and of the insuring public. Such assessment shall be made upon all members liable to assessment therefor in proportion to their several liabilities.

(4) Every person who was a member of such company at any time during two years prior to the making of an order of assessment by the board of directors shall pay his proportionate part of any such assessment if he is notified of such assessment within one year after the making of an order of assessment. A member's proportionate part of any assessment shall be determined by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment the ratio of the total assessment to the total premiums earned during such period on all policies subject to assessment.

(c) Every mutual accident and health insurance company licensed to do business in this state, if its charter or by-laws permit or are amended to permit the issuance of policies without contingent mutual liability of the policyholders for assessment, may with the permission of the superintendent issue non-assessable policies in this state. Every such company shall submit a copy of its proposed non-assessable policy or policies for approval of the superintendent, and shall have obtained his approval thereof. Every policy issued by any such company shall clearly state whether or not the holder of such policy is subject to a liability for assessment.

(d) (1) Any foreign mutual accident and health insurance company which complies with the requirements of subsection (c) hereof for the issuance of non-assessable policies may do an insurance business in this state without complying with the requirements of subsection (b) hereof.

(2) No such company which does not comply with the requirements of subsection (c) hereof shall do an insurance business in this state unless its by-laws and its policies issued in this state contain provisions for the levying and collection of assessments upon members, at least for the payment of losses and expenses, which conform in substance to the requirements of subsection (b) hereof.

§ 4210. Election of directors of domestic mutual life insurance companies. (a) (1) The directors of every domestic mutual life insurance company shall be elected in the manner and subject to the regulations prescribed in this section.

(2) Every such company shall, in accordance with its charter, either elect its entire board of directors biennially, or divide its board of directors into not more than three classes, as nearly equal as may be, in which case the members of one class only shall be elected annually.

(3) In this section:

(A) "Policyholder" means the person insured under an individual policy of life insurance or of accident and health insurance issued upon the application of such person, the person who effectuates any such policy upon the person of another pursuant to subsection (c) of section three thousand two hundred five of this chapter, the person to whom any annuity or pure endowment is presently or prospectively payable by the terms of an individual annuity or a pure endowment contract, except where the policy or contract declares some other person to be the owner or holder thereof, in which case such owner or policyholder shall be deemed the policyholder, and except in cases of assignment as hereinafter provided. In the case of any such individual policy or contract insuring two or more persons jointly the persons insured, or, if any such policy be issued upon the application of some third person or persons, the person or persons who effectuated any such policy pursuant to subsection (c) of section three thousand two hundred five of this chapter shall be deemed one policyholder within the meaning of this section. In case any such policy or contract shall have been assigned by an assignment absolute on its face, to an assignee other than the company which shall have issued such policy, and in case the signature of such assignee, either attested by the assignor or acknowledged by the assignee, shall have been more than six months prior to any election hereinafter referred to, filed at the principal office of such company, then such assignee shall be deemed a policyholder within the meaning of this section. In the case of every policy or contract of group insurance or group annuity contract, issued by such company, the employer, or other person, firm, corporation or association to whom or in whose name the master policy shall have been issued and held, shall be deemed one

policyholder within the meaning of this section. Whenever in this section reference is made to a policy of life insurance for one thousand dollars or more, such reference shall be deemed to include, as equivalent thereto, an annuity contract which at normal date of maturity requires the payment of one hundred dollars or more annually, and a pure endowment contract for the principal sum of one thousand dollars or more.

(B) "Acknowledged", when used in reference to any instrument or signature, shall have the same meaning which it has in reference to conveyances of real property eligible for recording under section two hundred ninety-one of the real property law.

(b) (1) Every participating policyholder of such company and every policyholder of such company whose policy or contract is a non-participating policy or contract described in the first sentence of paragraph one of subsection (e) of section four thousand two hundred thirty-one of this article, or a variable annuity contract subject to paragraph one of subsection (d) of section four thousand two hundred forty of this article and whose policy or contract shall be in force and shall have been in force for at least one year prior to any such election shall be entitled, without further qualification, to vote thereat, either in person or by mail or by proxy, as hereinafter provided, except that any company may adopt a resolution amending its charter or by-laws so as to provide that all voting by policyholders for directors shall be by ballot alone and not by proxy. In the event any company adopts such an amendment, all mention of proxy or proxies or of persons to receive proxies in this section, shall not apply to such company and such company shall conduct its elections only by means of ballots as long as such amendment is in effect. Any such company may, upon the approval of the superintendent, confer, upon all or any class of its non-participating policyholders holding a policy or contract issued pursuant to the special permit granted by the superintendent in accordance with paragraph one of subsection (e) of section four thousand two hundred thirty-one of this article, the same rights to vote for directors possessed by its participating policyholders. The superintendent may give such approval if he finds that the proposed change is in conformity with the requirements of law and that the representation of the policyholders therein conferred is equitable and

reasonable.

(2) Every other person having a right to vote in any such election by virtue of any contract which was made prior to April twenty-seventh, nineteen hundred six, and which shall be in force at the time of such election, shall be entitled to vote thereat in similar manner.

(3) In any election of directors of a domestic mutual life insurance company pursuant to the provisions of this section, every policyholder shall be entitled to one vote only, irrespective of the number of policies or contracts held by him and of the amount thereof.

(c) (1) Not less than five months nor more than eight months prior to any such election, on request of not less than twenty-five policyholders entitled to vote at the last prior election, which request must be subscribed and affirmed as true under the penalties of perjury by each of such policyholders and must be filed in duplicate with such company at least five days before any hearing thereon, the superintendent, after notice of not less than five days to such company and a hearing thereon, may in his discretion order such company within a period of not more than forty-five days and not less than thirty days thereafter, to file in his office, or in some suitable place designated by him and under his custody, a full and correct copy of its list or card catalogue of the names and last known postoffice addresses of all policyholders who have been such for at least six months under a policy of life insurance for one thousand dollars or more, or to file any part of such list or card catalogue as the superintendent specifies.

(2) A list or any part thereof which may be so ordered filed pursuant to paragraph one hereof shall be arranged, classified and corrected as directed by the superintendent; and if one or more independent nominations are made, as specified in subsection (h) hereof, then such election shall be deemed a contested election and a complete list or card catalogue of names of all policyholders who are eligible to vote, as defined in this section, under a policy of life insurance for one thousand dollars or more shall be so filed within forty-five days after the copy of the certificate of such nominations, certified by the superintendent shall have been filed at the home office of such company, and such list or card catalogue shall be corrected from the records of such home office so that a list or card catalogue, as nearly correct as may be, shall be on file as aforesaid down to within three months of

such election.

(d) (1) Such list or card catalogue or any part thereof so filed, while in the custody of the superintendent, shall be subject to inspection, under regulations prescribed by him, at any time during business hours by any policyholder of such company or by his authorized representative, and in case of a contested election, under regulations to be prescribed by the superintendent, may be used in the canvass of the policyholders of the company.

(2) After such election, or, if no independent nomination has been made, then after the time for such independent nominations has expired, such list or card catalogue shall be returned to the company filing the same.

(e) If all or any class of the policyholders of any domestic stock life insurance company shall be entitled to vote at any election of the directors of such company, such policyholders, subject to the provisions of the company's charter, shall be entitled to vote in person, by proxy or by mail, as herein provided, and under the conditions stated in subsection (c) hereof, a similar list or card catalogue of policyholders, qualified to vote, in accordance with the charter or by-laws of such corporation, except the holders of industrial policies, shall be filed and maintained in the office of the superintendent, or in some suitable place designated by him and under his custody, and at the home office of such company, respectively, similarly arranged and similarly subject to inspection and copy and withdrawal as in the case of mutual life insurance companies as above provided.

(f) Where policyholders in any company shall have made nominations as hereinafter prescribed, they or a committee representing them, shall upon demand, and with the approval of the superintendent and the payment to the company of the actual cost of making such copies, be furnished by such company with a copy of such list of policyholders or with a copy therefrom of the policyholders residing in a designated territory. A copy of a list so taken, or of any part thereof, shall be held by persons receiving the same inviolate and solely for the purposes of said nominators in a pending election and shall not be transmitted to other persons for any other use whatever. At the close of the canvass of the votes all copies of such lists shall be returned to the company.

(g) At least seven months prior to the date of any election of

directors in any such company, the board of directors shall nominate candidates for every vacancy to be filled at such election and shall also appoint three persons, jointly or severally, to receive proxies to be voted for said nominees, and shall also file in duplicate with the superintendent and at its home office a certificate of the names of the candidates so nominated and of the persons so designated to receive said proxies, which shall be described as the "administration ticket."

(h) (1) (A) In every such company which had over one hundred thousand policies or contracts of the kind or kinds specified in subsection (a) hereof, in force at its last preceding election, each in the amount of one thousand dollars or more, of life insurance or an equivalent thereto as hereinbefore provided, any policyholders, prospectively qualified as voters at the next ensuing election of directors, equal in number to one-tenth of one per centum of such total policies in force or five hundred, whichever number is greater, and in every other such company, any five hundred or more of such prospectively qualified voters, may make other nominations for one or more vacancies in the board of directors to be filled at any such election by filing with the superintendent, at least five months before the election, a certificate, subscribed and affirmed as true under the penalties of perjury by each of such policyholders, giving the names and addresses of the candidates nominated, the names and addresses of three persons jointly or severally, designated to receive proxies to be voted for said nominees, and an appropriate name or title designated by the superintendent to distinguish such ticket from the administration ticket and other nominations.

(B) If the superintendent finds after investigation or hearing that such other nominations have been made as specified in this subsection, he may certify to such certificate.

(C) Such nominators shall also file a copy of said certificate, certified by the superintendent, at the home office of the company at least five months before such election.

(D) Any policyholder who will be qualified to vote at such ensuing election if he continues his policy or contract in force at the time of such election, shall be deemed prospectively qualified to vote thereat.

(2) (A) All certificates of nomination shall be accompanied by a written acceptance of such nomination by each nominee thereon.

(B) The supreme court in the judicial district in which such company has its home office may for cause shown direct the name of any candidate to be stricken from a ticket on file.

(C) The provisions of subsection (k) hereof shall apply to any vacancy so created.

(3) If no independent nomination shall have been made as provided in subsection (h) hereof, then the provisions of subsections (i) to (k), hereof inclusive, of this section, shall not be applicable, and such election of directors shall be conducted in accordance with such reasonable rules and regulations as the superintendent may prescribe; but no votes shall be cast or counted except by ballot signed by the policyholder and for candidates nominated by the board of directors, in accordance with subsection (g) of this section or for such candidate as the board of directors may have nominated to fill vacancies among said candidates caused by the death, disability or refusal to stand as candidates of any one or more of those so nominated.

(i) (1) (A) At least three months prior to any such contested election the company shall cause to be mailed, in a sealed envelope with postage prepaid, to each policyholder whose name shall be upon said complete list or card catalogue and whose policy shall still be in force, at his last known post-office address, a serially numbered official ballot in a form approved by the superintendent and containing the respective tickets nominated as hereinbefore provided and the names and addresses of the persons so appointed to receive proxies. A corresponding serially numbered stub or card containing the name and address of the policyholder to whom each ballot is sent shall be retained at the home office of the company for the purpose of identifying said ballot when returned.

(B) Such official ballot shall be conveniently arranged under the names or titles by which the nominations have been designated and shall have printed upon it the name of the company, the post-office address of its home office, the number of directors to be elected and the names of those whose terms expire, the date of the election and instructions as herein provided for executing such official ballot or for the use of a proxy as herein provided and a designated space for the signature of the policyholder, the number of one of his policies and the signature of a subscribing witness.

(C) No other or different ballot shall be used, except that a duplicate ballot or ballots may be supplied to any policyholder and voter or to the holder of his proxy, for his own use, pursuant to rules and regulations prescribed by the superintendent.

(D) There shall be inclosed in such sealed envelope with such official ballot a suitable return gummed envelope having inscribed thereon the name and post-office address of the home office of the company, the corresponding serial number, and the words "ballot for directors". There shall also be inclosed in such sealed envelope or printed on the back of such ballot, a suitable blank proxy together with a statement of the right of the policyholder to vote either by mail or by proxy as herein provided or in person.

(E) No other papers or written or printed matter shall be inclosed in such sealed envelope. Specimen copies of such sealed envelope, ballot and proxy shall be submitted to the superintendent for his approval, and no such envelope and inclosures shall be mailed unless the same shall have been approved by him.

(2) A policyholder desiring to vote directly by mail must indicate the name of the nominee or nominees for whom he desires to vote or strike out the name or names of those for whom he does not desire to vote upon the official ballot so provided or must otherwise suitably indicate in the blank spaces thereon the nominee or nominees for whom he desires to vote, and must sign the said official ballot in his own handwriting in the presence of a subscribing witness, and place or cause to be placed thereon the number of at least one policy held by him. Failure to state or to correctly state such policy number shall not render a ballot void or subject the policyholder to any penalty.

(3) Such policyholder desiring to vote directly by mail must inclose the official ballot so marked in such return envelope or in a similarly inscribed envelope. Such envelope containing the ballot sealed and postpaid shall be mailed by the policyholder to the home office of the company. No policyholder may vote for more than the number of directors so to be elected and all ballots upon which the intent of the policyholder does not fairly appear shall be void.

(j) (1) A policyholder may vote by proxy executed to one or more of the persons designated in the certificates filed as provided in subsections (g) and (h) of this section. The execution of a proxy shall

be attested by a subscribing witness and the proxy shall set forth the number of at least one policy held by the person giving it. A proxy shall not be valid unless executed within three months prior to the election and shall be used only at such election or any adjournment thereof and may not be revoked by the policyholder giving the same unless it appears that the policyholder was induced by fraud or misrepresentation to execute the proxy.

(2) In exercising such proxy the holder or holders thereof shall vote only upon the official ballot, or the duplicate thereof, furnished to such policyholder as hereinbefore provided, to which such proxy shall be attached. In so voting the proxy holder shall sign said ballot in the name of the policyholder, and shall also sign his own name as proxy.

(3) Ballots voted by proxy holders shall be mailed to the home office, or voted in person by said proxy holder, in the same manner as herein prescribed for ballots voted directly by policyholders.

(k) (1) The votes at such contested election shall be limited to the candidates nominated as aforesaid and to substituted nominees chosen as follows:

(A) In case any vacancy occurs more than five months prior to the day set for such election, the board of directors, if such vacancy occurs on the administration ticket, or a majority of the nominators, if such vacancy occurs on any independent ticket, shall nominate another candidate to fill such vacancy by filing at least one month prior to the date of such election a certificate of said nomination with the superintendent and a certified copy thereof at the home office of the company, and the name of the candidate so selected shall be set forth in the official ballot sent out by the company.

(B) If such vacancy occurs within five months of such election then the board of directors, including those elected at such election, shall have power to fill such vacancy.

(2) All ballots by mail shall be received, at the home office of the company holding such contested election, by two or more persons, one-half of whom shall be appointed for that purpose by the superintendent and one-half by the directors of the company. The compensation of the custodians so appointed shall be paid by the company. Such custodians shall keep a daily record of the envelopes marked as containing ballots for directors which are received at the

home office, and shall securely retain them in their joint custody in safety vaults or compartments accessible only to such custodians and not to either of them separately, under regulations prescribed by the superintendent. Prior to the closing of the polls on election day said custodians shall deliver all ballots so received by them to the inspectors of election.

(3) The election shall be held at the home office of the company. The polls shall be opened at ten o'clock in the forenoon and remain open until four o'clock in the afternoon of the day of the election, at which time they shall be closed. All votes cast at such election shall be by ballot as hereinbefore provided.

(4) The superintendent shall appoint an adequate number of competent and disinterested inspectors of election and may appoint if necessary, expert accountants and other assistants and may authorize the procurement of stationery and supplies necessary for conducting the election and canvassing the votes. The reasonable compensation of such inspectors, expert accountants and other assistants prescribed by the superintendent, and other necessary disbursements approved by him, shall be paid by the company. Such inspectors shall have power to determine all questions concerning the verification of the ballots, the ascertainment of the validity thereof, the qualifications of the voters and the canvass of the vote, and with respect thereto shall act under such rules and regulations as are prescribed by the superintendent.

(5) All envelopes marked substantially as hereinbefore prescribed received by mail at the office of the company at any time prior to the day of election or on that day before the polls are closed shall be forthwith delivered intact without opening to the custodians appointed as hereinbefore provided and before the polls are closed shall be delivered to the inspectors of election.

(6) No person shall conceal or withhold or aid or abet any other person in concealing or withholding from the custodians or inspectors any such envelope; nor shall any person, other than an inspector, or an authorized assistant, open or aid or abet any person to open any such envelope.

(7) No ballots received by mail at the office of the company or offered personally or by proxy after the polls are closed shall be counted. All ballots offered personally or under proxies and all ballots

received by mail at the office of the company as aforesaid before the polls are closed shall be received by the inspectors subject to verification and ascertainment of the validity thereof and of the qualifications of the voters.

(8) Immediately upon the closing of the polls the inspectors shall proceed to the examination of the ballots and shall canvass the votes lawfully cast. The canvass shall proceed from day to day and the inspectors, or a majority thereof, shall certify the result to the company and to the superintendent as soon as it is completed. Such certificate shall be subscribed and affirmed by such inspectors as true under the penalties of perjury. Unless contested by the superintendent or other qualified person pursuant to paragraph twelve hereof, the results so certified shall be decisive. The superintendent may require the inspectors to report for determination by him any questions upon which they may disagree.

(9) Representatives designated by a majority of each three persons who shall have been appointed as aforesaid to receive proxies to be voted for tickets nominated for such contested election, in such number as shall be approved by the superintendent, may be present during the casting, verification and canvass of the votes. The compensation of such representatives shall not be a charge upon or paid from the funds of the company.

(10) All ballots and proxies received by the inspectors of election shall immediately upon the completion of the canvass be placed in sealed packages and shall be preserved by the said inspectors for a period of four months, subject to the order of any court having jurisdiction of any proceedings relating thereto. The necessary expenses of preserving such ballots and proxies shall be paid by the company as a part of the expenses of such election.

(11) The superintendent shall have power to supervise and direct the methods and procedure of any such contested election and to make all further needful rules and regulations concerning the same. The superintendent shall prescribe the method of distribution of ballots and proxies to policyholders, qualified to vote at such election, who are not included in such list or card catalogue, and shall prescribe reasonable rules and regulations for the casting of such ballots and the exercise of such proxies. All bills for or on account of the custodians

of ballots and inspectors of election, their employees, assistants and other necessary expenses or disbursements, during the conduct of such contested election, and the canvass of the votes, shall be approved by the superintendent before payment by the company.

(12) Any such contested election and the conduct thereof shall at all times, on petition of the superintendent or of any person or persons qualified with respect to any procedure or right therein which is in question, be subject to the supervision and control of the supreme court in the judicial district in which such company has its home office, in like manner as elections for state, county and municipal officers, so far as analogous thereto.

(l) The inclusion by any such company of the name of any person in any list of policyholders required by this section shall not be construed as an admission by the company of the validity of any policy or contract and no such list shall be competent evidence against the corporation in any action or proceeding in which the question of the validity of any policy or contract or of any claim under it is involved.

(m) (1) No insurance company, and no officer, agent or employee thereof shall knowingly omit, from any list or card catalogue herein required to be filed, the name of any policyholder required to be included therein, or shall knowingly omit to give the correct name and address of such policyholder, or shall knowingly give a wrong address, or shall expend, advance or lend any money of the company contrary to the provisions of this section.

(2) Except where such expenditure is otherwise authorized or required by this section, no money of the company shall be expended in connection with any such election or in canvassing therefor, and no officer or agent of the company shall directly or indirectly make any advance or loan of such moneys to any person in connection with or for the purpose of such election or canvass unless the expenditure or loan is in a contested election and shall be limited to reasonable amounts authorized by the board of directors of the company and approved in advance by the superintendent.

(3) No officer, salaried agent or employee of any such company shall, within the period between the filing of the nominations and the election, during business hours, devote any of his time to soliciting votes in support of or in opposition to any candidate or list of

candidates in connection with any such election of directors. No officer, agent or employee of any such company shall compel or coerce any other such officer, agent or employee to support, work for, or oppose any candidate or any list of candidates. Neither the stationery or supplies of any such company nor office space devoted to the conduct of its business shall be used for furthering the interest of any ticket or candidate at any election of directors. Notwithstanding the above, the company may utilize the time of officers, employees and agents, office space, stationery and supplies in circumstances where money of the company may be expended pursuant to paragraph two of this subsection, but no officer, employee or agent shall in connection with any election be coerced to undertake activity outside the scope of the duties of the position of such officer, employee or agent.

(4) No person, firm or corporation, whether connected with such company or otherwise, shall issue or cause to be issued any circular or other written or printed communication, either in behalf of or in opposition to any ticket or any candidate for election as director of such company which contains any false statement.

(5) No policyholder shall sell or offer to sell any vote or proxy for any sum of money or anything of value. No agent shall be paid or receive any sum of money or anything of value in connection with the voting of a ballot or obtaining of a proxy.

(n) In addition to the procedures described in this section, a domestic mutual life insurance company may, upon approval of the superintendent, offer policyholders alternate methods of voting in an uncontested election and receiving materials related thereto, including via electronic means. The superintendent may approve such methods if he or she finds that they are consistent with the requirements of law and equitable and reasonable for the company's policyholders. The superintendent may issue such rules and regulations as he or she deems necessary to implement the provisions of this subsection.

§ 4211. Election of directors of domestic stock life insurance companies. (a) No election of directors of a domestic stock life insurance company shall be valid unless a copy of the notice of election shall have been filed in the office of the superintendent at least ten

days before the day of such election in addition to the service thereof, as required by section six hundred five of the business corporation law.

(b) Whenever any directors of such a company shall have resigned and successors shall have been chosen pursuant to the provisions of the by-laws, such successors shall not take office nor exercise their duties until ten days after written notice of their election shall have been filed in the office of the superintendent.

(c) Policyholders of such an insurance company shall be eligible for election as directors or officers, whether or not they are shareholders.

§ 4212. Stock life insurance companies; voting power of policyholders. (a) (1) Any domestic stock life insurance company may, by amendment to its charter, confer upon its policyholders, or upon such of its policyholders as shall have a specified amount of insurance on their lives, the right to vote for all or any less number of directors of such company in a manner not inconsistent with this chapter.

(2) Such amendment shall take effect upon approval by the superintendent. The superintendent may give such approval if he finds that the proposed change is in conformity with the requirements of law and that the representation of policyholders therein conferred is equitable and reasonable.

(3) If the right to vote for all of the directors of such company is conferred upon such policyholders, then the election of directors shall thereafter be governed by the provisions of subsection (e) of section four thousand two hundred ten of this article.

(b) This section shall not apply to any such company which has conferred voting power upon policyholders pursuant to any previous law effective before January first, nineteen hundred forty, but the voting rights of such policyholders shall continue to be governed by such previous law.

§ 4213. Industrial life insurance. (a) In this chapter "industrial life insurance" means that form of life insurance, either:

(1) under which the premiums are payable weekly, or

(2) under which the premiums are payable monthly or oftener, but less

often than weekly, if the face amount of insurance provided in any such policy is less than one thousand dollars and if the words "industrial policy" are printed upon the policy as a part of the descriptive matter.

(b) (1) No insurer or fraternal benefit society doing in this state the business of industrial life insurance shall deliver or issue for delivery in this state, and no agent or representative of any such company or society shall aid in so issuing or delivering, any policy of weekly premium industrial life insurance on the life of a person of the age, as determined by next birthday, of ten years or more, with knowledge that the amount of such policy, together with the amount of all other policies of weekly premium industrial life insurance then in force as premium paying insurance on the life of such person, exceeds one thousand dollars but nothing contained in this section shall affect the validity or enforceability, in accordance with its terms, of any such policy.

(2) The amounts of weekly premium industrial life insurance referred to in this subsection shall not include dividend additions nor additional amounts payable under provisions for accidental death benefits.

(3) Any rules or regulations of any such insurer or fraternal benefit society, which are designed to limit the amount of insurance, as herein provided, shall be filed with the superintendent.

(c) No authorized life insurance company, including a cooperative life and accident insurance company and no authorized fraternal benefit society, shall deliver or issue for delivery in this state any policy or contract of industrial life insurance in the form of endowment insurance.

(d) Notwithstanding the provisions of subsection (c) hereof, any domestic life insurance company or fraternal benefit society may issue in this state for delivery outside of this state through its agent or like representative in another state or foreign country any policy of industrial life insurance, in the form of endowment insurance, which insures the life of a non-resident of this state and which is not prohibited by the laws of such other state or foreign country.

(e) Notwithstanding the foregoing provisions, on and after June first, nineteen hundred eighty, no policy of industrial life insurance shall be delivered or issued for delivery in this state.

§ 4214. Industrial accident and industrial health insurance. (a) In this chapter:

(1) "Industrial accident insurance" means that form of accident insurance wherein the premium is payable in the manner prescribed in subsection (a) of section four thousand two hundred thirteen of this article, covering such risks as death, dismemberment, loss of eyesight, or loss of time, as a result of accidental means.

(2) "Industrial health insurance" means that form of health insurance wherein the premium is payable in the manner prescribed in subsection (a) of section four thousand two hundred thirteen of this article, covering such risk as loss of time caused by illness or sickness.

(b) Notwithstanding the foregoing provisions, on and after June first, nineteen hundred eighty, no policy designated or sold as an industrial accident insurance or industrial health insurance policy shall be delivered or issued for delivery in this state; provided, however, that this prohibition shall not prevent the delivery or issuance for delivery of a policy approved by the superintendent where the premium is payable weekly or monthly and such policy is approvable under other provisions of this chapter.

§ 4215. Contracts with industrial life insurance agents; prohibitions. (a) No life insurance company licensed to do business in this state shall make any contract with any agent, superintendent or other representative employed in this state which provides:

(1) That the company shall charge against the past, present or future compensation of the agent, superintendent or other representative, either salary or commission, any sum of money as a result of the surrender for cash of any industrial policy by any policyholder;

(2) That the company shall charge against the past, present or future compensation of the agent, superintendent or other representative, either salary or commission, any sum of money as a result of the lapse of any industrial policy that has been in force for three years or longer.

(b) The provisions of subsection (a) hereof shall not prohibit the

company from contracting with its agents, superintendents or other representatives, to charge any agent, superintendent or other representative, a sum not exceeding the commission on any policy written by the agent, superintendent or other representative on the life of any person, or any relative sharing the home with the person, who has terminated a policy of the company not more than three months before or who terminates such a policy within three months after the policy was written.

§ 4216. Group life insurance; premium requirements; notice of conversion; filing of compensation. (a) (1) In this chapter:

(A) "Group life insurance" means that form of life insurance covering any one of the groups specified in subsection (b) hereof, which is written under a policy issued to the policyholder as hereinafter defined, and which in all other respects conforms to the requirements of subsection (b) hereof.

(B) "Certificate holder," as used in relation to a group life insurance policy, means the person to whom a certificate evidencing such insurance is issued under any such policy, as hereinafter provided.

(2) In this section, for the purposes of insurance hereunder: "employees" may be deemed to include (i) 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 employer through stock ownership, contract or otherwise; (ii) the individual proprietor or partner if the employer is an individual proprietor or a partnership; (iii) as used in paragraph one of subsection (b) hereof, the directors of the employer and of subsidiary or affiliated corporations of a corporate employer; and (iv) as used in paragraphs four and five of subsection (b) hereof, the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(b) Any life insurance company authorized to do business in this state may deliver in this state policies of group life insurance only as follows:

(1) A policy issued to an employer or to a trustee or trustees of a

fund established by an employer, which employer or trustees shall be deemed the policyholder, insuring with or without evidence of individual 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 by a combination of such conditions and conditions pertaining to the family status of the employee, for amounts of insurance 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 a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable. The premium for the policy shall be paid by the policyholder, either wholly 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, such policy must insure a minimum of fifty percent or five of such eligible employees whichever is fewer. Except as provided in subsection (b) of section four thousand two hundred thirty-one of this article and in paragraph five of subsection (a) of section three thousand two hundred twenty of this chapter, such policy shall provide for payment of all benefits thereunder, to the person insured or to some beneficiary or beneficiaries other than the employer, and shall provide for the issuance of a certificate to the policyholder for delivery to the person insured or to such beneficiary, as evidence of such insurance.

(2) A policy issued to a labor union, which shall be deemed the policyholder insuring, with or without evidence of individual insurability satisfactory to the insurer, not less than twenty-five members of such union, and insuring, except as hereinafter provided all of the members of such union or all of any class or classes thereof determined by conditions pertaining to their employment or membership in the union, or both, and who are actively engaged in their occupations, for amounts of insurance 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 members if the selections offered utilize a consistent pattern of grading the amounts of insurance

for individual group members so that the resulting pattern of coverage is reasonable. The premium on such policy may be paid by the union, by the members, or by the union and its members jointly. If the premium is paid by the members or by the union and its members jointly such policy must insure not less than fifty percent of such eligible members or, if less, fifty or more of such members. Except as provided in paragraph five of subsection (a) of section three thousand two hundred twenty of this chapter, such policy shall provide for the payment of benefits to the person insured or to some beneficiary or beneficiaries, other than the union or any of its officials, representatives or agents, and shall provide for the issuance of a certificate to the union for delivery to the person insured or to such beneficiary, as evidence of such insurance. Any such policy may vary from the foregoing requirements, as follows:

(A) if the policy is cancellable at the option of the insurer at the end of any policy year and if the basis of premium rates may be changed by the insurer at the beginning of any policy year, all members of such labor union may be insured thereunder;

(B) if and when members of such union apply for and pay for additional amounts of insurance, a smaller percentage of such members than fifty percent may, with evidence of individual insurability satisfactory to the insurer, be insured thereunder for such additional amounts.

(3) (A) A policy issued to a creditor or vendor, or to a trustee or agent designated by two or more creditors or vendors, which creditor, vendor, trustee, or agent shall be deemed the policyholder, except as hereinafter provided.

(B) The policy shall insure all of the members, but may exclude any as to whom evidence of individual insurability is not satisfactory to the insurer, of a group of debtors or vendees, defined as follows:

(i) all of the borrowers, or borrowers and guarantors of borrowers, or intended borrowers (under 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, which program includes provision for immediate periodic payments by the parent or guardian of such student and a loan commitment to such parent and guardian by a financial institution, or by or on behalf of a college or university or such an elementary or secondary school to defray the cost of attendance

at such college or university or elementary or secondary school in excess of the accumulated periodic payments by the parent or guardian) from one financial institution and its subsidiary or affiliated companies, or from two or more creditors or vendors so designating such trustee, trustees or agent, or

(ii) all of the purchasers of securities, merchandise or other property from one vendor, or from two or more vendors so designating such trustee or agent, or

(iii) all of any class or classes of such debtors or purchasers determined by conditions pertaining to the type of indebtedness or purchase.

(C) The policy may specify the ages to which the insurance provided shall be limited, provided however that if the insurance terminates at a particular age, the age at which it terminates shall be prominently displayed on the application for insurance.

(D) If the agreement provides for repayment in instalments, the insurance may be continued for the duration of the debt over a period of not more than thirty-five years from the date the debt is first incurred; otherwise the insurance may be continued for a period not in excess of eighteen months except that such insurance may be continued for an additional period not exceeding six months in the case of default, extension or recasting of the loan.

(E) Notwithstanding anything in this paragraph to the contrary,

(i) the insurance of borrowers, who incur indebtedness arising from the granting of policy loans pursuant to policy provisions therefor, provided under a policy issued to the insurance company granting the policy loan, may be continued for the duration of the indebtedness,

(ii) under a plan approved by the superintendent the insurance of debtors with respect to an agreement which does not provide for repayment in instalments may be continued for the duration of the indebtedness but not more than seven years from the date the indebtedness is incurred, and

(iii) the insurance of persons who are tenants or shareholders of a mutual or other housing corporation (organized pursuant to the provisions of the private housing finance law and regulated by such statute as to rent, dividends and profits) under a policy issued with identifiable charges or fixed amounts of premiums to such corporation or

to a trustee or trustees or agent designated by one or more such corporations may be continued for the term of the tenant's lease with such corporation or thirty-six months or whichever is the greater period, and the amount of insurance with respect to any person insured under such policy may be a fixed amount not greater than the lesser of fifty-five thousand dollars or an amount equal to thirty-six times the monthly instalments due under such lease.

(F) The benefits of any policy authorized under this paragraph shall be payable to the policyholder; but the amount of any benefit received by the policyholder thereunder not in excess of the actual indebtedness shall be applied by the policyholder to the discharge of any obligation of the person insured, or his personal representative, to the policyholder, creditor or his assignee and the amount of any benefit received by the policyholder thereunder in excess of the actual indebtedness shall be payable to a beneficiary named by the debtor or, if none, then either to the estate of the debtor or under the provision of a facility of payment clause.

(G) No such group shall be eligible for insurance hereunder unless the new entrants to such group number at least twenty-five persons yearly.

(H) The premium for the policy shall be paid by the policyholder, either from the creditor's or vendor's funds, or from charges collected from the insured debtors or purchasers, or from both. A policy on which all or part of the premium to be derived from the collection from the insured debtors or purchasers of identifiable charges not required of uninsured debtors or purchasers may be issued only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent of the new entrants in any year become insured and provided that such policy shall not include, in the class or classes of debtors or purchasers eligible for insurance, debtors or purchasers under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent of the then eligible debtors or purchasers elect to pay the required charges.

(I) The policy may be issued to an assignee to whom such creditor or vendor has transferred all of its right, title and interest to the unpaid indebtedness, or to the unpaid purchase price, under all such agreements made by it.

(J) The amount of insurance on any person insured under a policy shall not at any time exceed:

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

(ii) in the case of a loan commitment pursuant to the hereinabove program for defraying the cost of attendance of a student at a college or university or at such an elementary or secondary school, the lesser of fifty-five 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 two hundred twenty thousand dollars and the amount of the indebtedness so secured.

(iv) in the case of indebtedness arising from a credit card account where there is no specific charge for insurance, the lesser of the sum of one hundred thousand dollars or the amount of unpaid indebtedness.

(K) (i) With respect to loans made by production credit associations organized pursuant to the federal Farm Credit Act of 1933, 12 U.S.C. §§ 1131c - 1138c, and with respect to loans made by a bank, trust company or industrial bank to a borrower engaged in the business of farming, crop production or the raising, breeding, fattening or marketing of livestock for the purposes of such business and other requirements of the borrower, the amount of insurance may exceed the unpaid indebtedness and shall not be limited as to amount except that the insurance shall not exceed the greater of the loan commitment or the outstanding balance of the loan at the inception of the period for which the borrower is insured.

(ii) With respect to loans made by Federal Land Banks established pursuant to an Act of Congress of the United States entitled the "Federal Farm Loan Act", approved July seventeenth, nineteen hundred sixteen, as amended, the amount of insurance on any person insured under the policy shall not at any time exceed the amount of the unpaid indebtedness at the inception of the period for which premiums are paid, but shall not otherwise be limited as to amount.

(L) The superintendent shall prescribe from time to time regulations determining the procedures, terms and conditions applicable to a policy

issued pursuant to this paragraph to the trustee or agent designated by two or more creditors or vendors.

(M) Each insurer shall file with the superintendent its forms of policies, certificate statements and applications pertaining to credit insurance together with its premium rates for such insurance and the same shall be subject to his approval. The superintendent shall not approve any such forms if the premium charged is unreasonable in relation to the benefits provided.

(N) For the purposes of this paragraph: (i) "creditor" includes a lessor of real or personal property, (ii) "borrower" includes a lessee of real or personal property, and (iii) "indebtedness" includes rentals payable under the lease of real or personal property.

(4) 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:

(A) 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.

(B) The premium for the policy shall be paid by the trustees either wholly from funds contributed by the employer or employers of the insured persons or by the union or unions, or by both, or from funds contributed by the insured persons, or jointly from such funds and funds contributed by the insured persons specifically for their insurance. 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.

(C) The policy shall insure at least fifty persons at date of issue.

(D) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions. However, such a plan may permit a limited number of selections by employees or members if the selections offered utilize a consistent pattern of grading the amounts of insurance

for individual group members so that the resulting pattern of coverage is reasonable.

(E) 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.

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

(A) 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 covered for group life insurance;

(B) 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.

(C) The premium for the policy shall be paid by the trustee or trustees either wholly 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, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer;

(D) The policy must cover at least fifty employees at date of issue;

(E) The amounts of insurance 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 limited number of selections by employees if the selections offered utilize a consistent pattern of grading the amount of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(6) A policy issued to a duly organized association of civil service employees which shall include in its membership not less than five thousand civil service employees having a common employer, or to a duly organized association of teachers having a membership of not less than five thousand, which association, in either event, shall be deemed the policyholder, and which shall have been formed and is maintained for purposes other than to effect group life insurance on its members. Such policy shall insure only members of such association, with or without evidence of individual insurability satisfactory to the insurer, based upon a plan which will preclude individual selection. However, such a plan may permit a limited number of selections by members if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable. The premium on such policy may be paid by the association or by the association and the insured members jointly or by the insured members alone. Every member of such association in good standing shall have opportunity to apply for such insurance and not less than sixty percent of the eligible members in good standing may be so insured. Such policy shall provide for the payment of benefits, except policy dividends, to the person insured or to some beneficiary or beneficiaries, other than the association or any of its officers or directors, as such, and shall also provide for the issuance of a certificate to the association for delivery to the person insured or to such beneficiary, as evidence of such insurance.

(7) A policy insuring the members of one or more troops or units of the state troopers or state police of any state, issued to the commanding officer of the state troopers or state police, who shall be deemed the policyholder, the premium on which is to be paid by the members insured; or a policy covering the members of one or more duly incorporated police officers' benevolent associations or of one or more

associations or organizations of uniformed firefighters or volunteer firefighters or volunteer ambulance workers which association or organization shall have been in existence for at least two years prior to the issuance of such policy and which shall have twenty-five members at the time of the issuance of such policy, which shall be issued to such association or to a trustee or trustees of a fund established, or participated in, by one or more of such associations or organizations as the policyholder. If the opportunity to take such insurance is offered to all eligible members of a unit of such state troopers or state police, or to all eligible members of such incorporated police officers' benevolent association or of an association or organization of uniformed firefighters, volunteer firefighters, then not less than fifty percent of such members or, if less, fifty or more of such members may be so insured. If the insurance is limited to those eligible members who are employed as state troopers, police officers, firefighters or volunteer ambulance workers, then not less than sixty percent or five hundred of such members, whichever is less, may be so insured. Such policy shall provide for the payment of benefits, except policy dividends, to the person insured or to some beneficiary or beneficiaries, other than such commanding officer or such association or any of its officials, as such, and shall also provide for the issuance of a certificate to the policyholder for delivery to the person insured or to such beneficiary, as evidence of such insurance. For the purposes of this paragraph any association currently holding premium dividends as a result of policies issued under this section shall be permitted to maintain said dividends for the general purposes of the entire membership. For the purposes of this paragraph the term "eligible members of an association of volunteer firefighters or volunteer ambulance workers" means members who perform services in fire-fighting duties or members of a volunteer exempt fire benevolent association who are entitled to benefits from the expenditures of foreign fire insurance tax moneys, including, inactive exempt volunteer firefighters as defined by section two hundred of the general municipal law or in ambulance-related duties, respectively. The amounts of insurance may be based upon a plan which permits a limited number of selections by the members if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(8) (A) A policy issued to a municipal corporation or a public housing authority, which corporation or authority shall be deemed the policyholder, insuring, with or without evidence of individual insurability satisfactory to the insurer, not less than twenty-five employees of such corporation or authority, except that in each of the villages of Croton-on-Hudson and Lloyd Harbor not less than ten such employees, and insuring all of such employees or all of any class or classes thereof determined by conditions pertaining to the employment, for amounts of insurance 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 a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(B) The premium for the policy may be paid either by the policyholder or by the insured employees, or both, in the manner provided in section ninety-three of the general municipal law. If a part of the premium is to be derived from funds contributed by insured employees, the policy must insure not less than seventy-five percent of all eligible employees. Such policy shall provide for the payment of benefits to the person insured or to some beneficiary or beneficiaries other than the municipal corporation or the public housing authority, and shall also provide for the issuance of a certificate to the policyholder for delivery to the person insured or to such beneficiary, as evidence of such insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured employees specifically for their insurance must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(C) Subject to the constitution and general laws of this state, every municipal corporation or public housing authority is empowered to contract by its fiscal or disbursing officer with an authorized life insurance company for group life insurance on the lives of its employees.

(9) A policy issued to the state covering, 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 or subscription charges may be derived from funds contributed entirely by insured employees and retired employees or by insured employees and retired employees and the employer jointly or entirely by the employer. If the premiums or subscription charges are derived from funds contributed wholly by the employer, all eligible employees are to be covered. If all or part of the premiums or subscription charges are to be derived from funds contributed by insured employees and if the opportunity to take such insurance is offered to all eligible employees of an employer, then such policy must cover not less than forty percent of such employees, the calculation being with respect to each employer individually. The amounts of insurance may be based upon a plan which permits a limited number of selections by the employees if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(10) 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, and except as provided in paragraph five of subsection (a) of section three thousand two hundred twenty of this chapter, such policy shall provide for the payment of benefits to the person insured or some beneficiary or beneficiaries 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 who have not attained any limiting age specified in the policy, or all such 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 premium for the policy shall be paid by the association or trustee or trustees either from funds contributed by the association or by the insured individuals, or from funds contributed jointly by the association and insured individuals specifically for their insurance. 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 insure all eligible individuals, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer. The policy must insure at least one hundred individuals at date of issue. The amounts of insurance on employees or members insured under the policy shall be based upon some plan precluding individual selection. However, such a plan may permit a limited number of selections by employees or members if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is 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.

(11) A policy, covering persons employed pursuant to 32 U.S.C. § 709, members of the national guard on full-time training duty under provisions of such title 32, or on active duty or active duty for training under provisions of 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 trustee or trustees or the adjutant general. The policy shall also provide for the issuance of a certificate to the policyholder for delivery to the individual insured or to such beneficiary, as evidence of such insurance. The amounts of insurance may be based upon a plan which permits a limited number of selections by the members provided the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(12) 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:

(A) 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:

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

(II) The association collects dues or solicits contributions from members; and

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

(B) The premium for the policy shall be paid by the association or 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.

(C) The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the insured persons or by

an association. However, such a plan may permit a number of selections by the association, if the selections offered utilize a consistent pattern of grading the amounts of insurance so that the resulting pattern of coverage is reasonable. Furthermore, such plan may permit a limited number of selections by members if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(D) Except as provided in paragraph five of subsection (a) of section three thousand two hundred twenty of this chapter, 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 persons insured or such beneficiary, as evidence of such insurance.

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

(13) 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:

(A) 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.

(B) 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.

(C) 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.

(D) 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, such plan may permit a number of selections by the organization if the selections offered utilize a consistent pattern of grading the amounts of insurance so that the resulting pattern of coverage is reasonable. Furthermore, such a plan may permit a limited number of selections by members if the selections offered utilize a consistent pattern of grading the amounts of insurance for individual group members so that the resulting pattern of coverage is reasonable.

(E) Except as provided in paragraph five of subsection (a) of section three thousand two hundred twenty of this chapter, such policy shall provide for the payment of benefits to the persons insured or to some beneficiary or beneficiaries other than the organization, or any official, 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.

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

(14) A policy issued to insure any other group approved by the superintendent upon a finding that:

(A) There is a common enterprise or economic or social affinity or relationship;

(B) The premiums charged are reasonable in relation to the benefits provided; and

(C) 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 paragraph.

(c) (1) No domestic, foreign or alien life insurance company shall be permitted to do business in this state if it hereafter issues, within or without this state, any policy of group life insurance which on its issuance does not appear to be self-supporting on reasonable assumptions

as to interest, mortality and expense.

(2) Anything in this chapter to the contrary notwithstanding, any group life insurance policy issued or delivered in this state 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. Any such rate readjustment shall be computed on a basis which is equitable to all group life insurance policies.

(d) In the event a group life insurance policy hereafter issued for delivery in this state permits a certificate holder to convert to another type of life insurance within a specified time after the happening of an event, such certificate holder shall be notified of such privilege and its duration within fifteen days before or after the happening of the event, provided that if such notice be given more than fifteen days, but less than ninety days after the happening of such event, 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 happening of the event, the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days. Written notice by the policyholder given to the certificate holder or mailed to the certificate holder at his last known address, or written notice by the insurer mailed 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.

(e) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedule of rates of commissions, compensation and other fees or allowances to agents and brokers pertaining to the solicitation or sale of group life insurance and of fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer other than as agent, to any individuals, firms or corporations pertaining to the service or administration of group life insurance, whether transacted within or without this state. An insurer may revise such schedules from time to time, and shall file such revised schedules with the superintendent. No insurer shall pay to an agent, agents, broker or brokers or any combination of licensees for the solicitation or sale of

a policy of group life insurance or for any other purpose related to such group insurance 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 except such as are rendered in behalf of such insurer, provided, however, nothing contained herein shall apply to or affect the computation of dividends or experience rating credits.

(f) Any policy of group life insurance may include provisions for the payment by the insurer of life insurance benefits upon the death of the spouse of the insured employee or member or his or her child dependent upon him or her for support and maintenance or any other person dependent upon the insured employee or member, provided that insurance upon the life of the spouse or other person shall not exceed the amount of insurance for which the employee or member is eligible, nor shall the insurance upon the life of each dependent child so insured exceed twenty-five thousand dollars. A policy of insurance issued in accordance with paragraph three of subsection (b) of this section, while it may provide coverage for a spouse of the insured employee or member, it shall not, however, provide coverage for a dependent child of the insured employee or member. An insurer providing group life insurance for a spouse or dependent children shall require evidence of insurability sufficient to protect against substantial adverse selection.

(g) An insurer authorized or licensed to do business in this state may solicit or make available credit life insurance coverage in this state as provided for in paragraph three of subsection (b) of this section under a policy of group life insurance only if the policy is delivered to policyholders described in and conforming to the definition in paragraph three of subsection (b) of this section, and with respect to all credit transactions entered into in this state, the policy fully complies with the requirements of paragraph twelve of subsection (a) of section three thousand two hundred twenty of this chapter.

(h)(1) 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 paragraph twelve, thirteen or fourteen of subsection (b) of this section, 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.

(2) The provisions of paragraph one of this subsection 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 paragraphs one through eleven of subsection (b) of this section.

(i) (1) The provisions of subsections (d), (f) and (h) of this section shall not apply to policies issued under the authority of subsection (d) of section three thousand two hundred five of this chapter, provided such policies are issued in compliance with the requirements of subsection (d) and subsection (e) of section three thousand two hundred five of this chapter.

(2) Any life insurance company authorized to do business in this state may deliver in this state policies of group insurance issued to an employer or to the trustee of a fund established by one or more employers, or one or more employers and one or more labor unions without complying with the provisions of paragraphs one and four of subsection (b) of this section where group insurance is issued under the authority of subsection (d) or subparagraph (B) of paragraph (1) of subsection (a) of section three thousand two hundred five of this chapter, provided that, prior to or at the commencement of coverage on any person under a policy issued under the authority of such subparagraph:

(A) the employer providing such insurance coverage or causing such

coverage to be issued notifies the prospective insured in writing: (i) of the intent to insure the employee's life, specifying in such notice the maximum face amount for which the employee could be insured at the time the contract is issued; and (ii) that the employer or policyholder will be a beneficiary of any proceeds payable upon the death of the employee; and

(B) the prospective insured employee consents in writing to such coverage.

§ 4217. Valuation of insurance policies and contracts. (a) (1) The superintendent shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding insurance policies and contracts of every life insurance company doing business in this state, except that, in the case of an alien company, such valuation shall be limited to its United States business, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest and methods (net level premium method or other) used in the calculation of such reserves. In calculating such reserves, the superintendent may use group methods and approximate averages for fractions of a year or otherwise.

(2) In lieu of the valuation of the reserves herein required of any foreign or alien company, the superintendent may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the superintendent when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(3) (A) The superintendent may, in his discretion, vary the standards of mortality applicable to policies of insurance on substandard lives and other extra-hazardous lives issued by any life insurance company doing business in this state.

(B) He may also, in his discretion, vary the standards of interest and

mortality applicable to contracts issued by an alien insurer in countries other than the United States, if such alien insurer maintains the trusteed surplus prescribed by section one thousand three hundred twelve of this chapter.

(4) (A) Any life insurance company doing business in this state which has adopted as a basis for the valuation of its insurance policies and contracts standards producing greater reserves in the aggregate than the minimum standards herein prescribed may continue to use such higher standards as a basis of valuation.

(B) After January first, nineteen hundred forty, any life insurance company doing business in this state may, subject to the provisions of paragraph eight of subsection (c) of this section, adopt as the basis for the valuation of its insurance policies and contracts standards producing greater reserves in the aggregate than the minimum standards herein prescribed; and any such company which shall have at any time adopted such higher standards of valuation may, with the approval of the superintendent, adopt lower standards of valuation, but in no case lower than the minimum standards herein prescribed, provided, however, that, for the purposes of this paragraph, the holding of additional reserves determined by a qualified actuary to be necessary to render the opinion required by subsection (e) of this section shall not be deemed to be the adoption of a higher standard of valuation.

(C) The superintendent may approve any such change if he finds that the proposed standards are for the best interests of the holders of the policies and contracts and annuitants of such company.

(D) Nothing contained herein shall be deemed to affect the contractual rights or obligations of the holder of any such policy or contract.

(b) (1) This subsection shall apply only to those policies and contracts issued prior to the operative date of section four thousand two hundred twenty-one of this article.

(2) Except as provided in paragraph six hereof the legal minimum standards for the valuation of life insurance contracts shall be as follows:

(A) For the valuation of all such contracts issued before the first day of January, nineteen hundred one, it shall be the Actuaries' or Combined Experience Table of Mortality with interest at four percent per annum.

(B) For the valuation of such contracts issued on or after said day, except as provided in subparagraphs (C) and (D) hereof, it shall be the American Experience Table of Mortality with Craig's extension for ages under ten years and with interest at three and one-half percent per annum.

(C) For the valuation of group term insurance policies under which premium rates are not guaranteed for a period in excess of five years, it shall be the American Men Ultimate Table of Mortality with interest at three and one-half percent per annum.

(D) Any life insurance company may, at its option, value its life insurance contracts issued on or after the first day of January, nineteen hundred thirty, in accordance with their terms on the basis of the American Men Ultimate Table of Mortality, supplemented by such extension and modification for ages under twenty years, as may be approved by the superintendent, with interest at three and one-half percent per annum by the level net premium method or by the modified preliminary term method prescribed in paragraph four hereof.

(3) Life insurance policies issued on or after the first day of January, nineteen hundred seven, may, at the option of the insurer, be valued in accordance with their terms by the modified preliminary term method prescribed in paragraph four hereof, or in accordance with the select and ultimate method on the basis that the rate of mortality during the first five years after the issuance of said contracts respectively shall be calculated according to the following percentages of the rates shown by the American Experience Table of Mortality:

For the first insurance year, fifty percent thereof; for the second insurance year, sixty-five percent thereof; for the third insurance year, seventy-five percent thereof; for the fourth insurance year, eighty-five percent thereof; and for the fifth insurance year, ninety-five percent thereof.

(4) (A) Life insurance policies may provide for not more than one year of preliminary term insurance by incorporating in the provisions thereof specifying the premium consideration to be received by the insurer, a clause plainly showing that the first year's insurance under such policies is term insurance, purchased by the whole or a part of the premium to be received during the first policy year.

(B) Such policies may, in accordance with their terms, be valued on the basis of the mortality tables and interest rates prescribed in paragraph two hereof, by the modified preliminary term plan described as follows: If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than twenty years from the date of the policy, or under an endowment preliminary term policy, exceeds that charged for like insurance under twenty payment life preliminary term policies of the same company, the reserve thereon at the end of any year, including the first, shall be not less than the reserve on a twenty payment life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a level net premium sufficient to provide for a pure endowment at the end of the premium paying period equal to the difference between items (i) and (ii) hereof as follows: (i) the value at the end of such period of such a twenty payment life preliminary term policy and (ii) the full level net premium reserve at such time of such a limited payment life or endowment policy.

(C) The premium paying period referred to above is the period during which premiums are concurrently payable under such twenty payment life preliminary term policy and such limited payment life or endowment policy.

(5) (A) The legal minimum standard for the valuation of all individual annuity contracts issued on or after January first, nineteen hundred forty (including life annuities provided or available under optional modes of settlement in insurance contracts issued on or after such date) shall be the Combined Annuity Tables with age set back one year, with interest at three and one-half percent per annum.

(B) The legal minimum standard for the valuation of all individual annuity contracts issued prior to January first, nineteen hundred forty (including annuities provided or available under optional modes of settlement in insurance contracts issued prior to such date) shall be in accordance with the provisions of law applicable thereto as of the date of issuance.

(C) Except as otherwise provided in paragraphs three and four of subsection (c) hereof for group annuity and pure endowment contracts, the legal minimum standard for the valuation of all group annuity

contracts shall be the 1971 Group Annuity Mortality Table, or any modification of this table approved by the superintendent, and five percent interest.

(D) Annuities, annuity benefits and guaranteed interest contracts to which this subsection applies shall be subject to item (vi) of subparagraph (B) of paragraph four of subsection (c) of this section.

(6) (A) The legal minimum standard for the valuation of all industrial life insurance policies issued on or after January first, nineteen hundred forty shall, at the option of the company, be either (i) the 1941 Standard Industrial Mortality Table or the 1941 Substandard Industrial Mortality Table, with interest at three and one-half percent per annum by the net level premium method, or (ii) either of the tables specified in item (i) hereof, by the modified preliminary term method prescribed in paragraph four hereof, in accordance with the terms of the policy, or (iii) in the case of policies issued on the monthly premium plan, the New York Standard Intermediate Table of Mortality (1907 Table) with interest at three and one-half percent per annum. In lieu of such tables, at the option of the company, the Standard Industrial Mortality Table (1907) or the Substandard Industrial Mortality Table (1907) may be used with respect to such policies issued prior to January first, nineteen hundred forty-two.

(B) The legal minimum standard for the valuation of all industrial life insurance policies issued prior to January first, nineteen hundred forty shall be the minimum standard required by the law of this state in force at the date of issuance.

(7) The legal minimum standard for the valuation of all accidental death benefits and disability benefits, provided in connection with or supplemental to life insurance policies or annuity contracts shall be such tables as the superintendent may prescribe.

(c) (1) This subsection shall apply only to policies and contracts issued on or after the operative date of section four thousand two hundred twenty-one of this article, except as otherwise provided in paragraphs three and four of this subsection for group annuity and pure endowment contracts issued prior to such operative date.

(2) Except as otherwise provided in paragraphs three, four and ten of this subsection, the minimum standard for the valuation of all such policies and contracts shall be the commissioners reserve valuation

method defined in paragraph six of this subsection and in section four thousand two hundred eighteen of this article, three percent interest for all life insurance policies issued prior to January first, nineteen hundred sixty-six and for all individual annuity and pure endowment contracts issued prior to January first, nineteen hundred sixty, or three and one-half percent interest for all life insurance policies issued on or after January first, nineteen hundred sixty-six and prior to June thirteenth, nineteen hundred seventy-four and for all individual annuity and pure endowment contracts issued on or after January first, nineteen hundred sixty, and prior to the operative date of paragraph three of this subsection, or four percent interest for all life insurance policies issued on or after June thirteenth, nineteen hundred seventy-four and prior to January first, nineteen hundred seventy-nine, or four and one-half percent interest for all life insurance policies, issued on or after January first, nineteen hundred seventy-nine, or five percent interest for all annuities purchased or to be purchased under group annuity contracts, and the following tables:

(A) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of subsection (h) of section four thousand two hundred twenty-one of this article, the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after such operative date and prior to the operative date of subsection (k) of such section; provided that for any category of such policies issued on female risks all modified net premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured, and for such policies issued on or after the operative date of such subsection, and, at the option of the company, for such policies not providing for nonforfeiture benefits which are issued on or after nineteen hundred eighty-one and prior to the operative date of such subsection, (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after nineteen hundred eighty by the National Association of Insurance

Commissioners, that is approved by the superintendent for use in determining the minimum standard of valuation for such policies, or (iv) any other ordinary mortality table, or any modification of any of the foregoing tables, approved by the superintendent for any specified class or classes of risks.

(B) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of subsection (i) of section four thousand two hundred twenty-one of this article, and for such policies issued on or after such operative date (i) the Commissioners 1961 Standard Industrial Mortality Table, or (ii) any industrial mortality table, adopted after nineteen hundred eighty by the National Association of Insurance Commissioners, that is approved by the superintendent for use in determining the minimum standard of valuation for such policies, or (iii) any other industrial mortality table, or any modification of any of the foregoing tables, approved by the superintendent for any specified class or classes of risks.

(C) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such contracts,--the 1937 Standard Annuity Mortality Table or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the superintendent.

(D) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such contracts,--the 1971 Group Annuity Mortality Table or any modification of this table approved by the superintendent.

(E) For total and permanent disability benefits in or supplementary to ordinary policies or contracts--for policies or contracts issued on or after January first, nineteen hundred sixty-six, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefits or any tables of disablement rates and termination rates, adopted after nineteen hundred eighty by the National Association of Insurance Commissioners, that are approved by the superintendent for use in determining the minimum standard of valuation for such policies or any other tables of disablement rates and termination rates, or any

modification of any of the foregoing tables, approved by the superintendent for any specified class or classes of risks; for policies or contracts issued prior to January first, nineteen hundred sixty-six, either such tables or, at the option of the company, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(F) For accidental death benefits in or supplementary to policies--for policies issued on or after January first, nineteen hundred sixty-six, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after nineteen hundred eighty by the National Association of Insurance Commissioners, that is approved by the superintendent for use in determining the minimum standard of valuation for such policies or any other accidental death benefits table, or any modification of any of the foregoing tables, approved by the superintendent for any specified class or classes of risks; for policies issued prior to January first, nineteen hundred sixty-six, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table. Any such table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(G) For group life insurance, life insurance issued on the substandard basis, annuities involving life contingencies provided or available under optional modes of settlement in life insurance policies or annuity contracts and other special benefits--such tables as may be approved by the superintendent.

(3) Except as provided in paragraph four hereof, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph, as defined herein, and for all annuities and pure endowments purchased or to be purchased on or after the operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation method defined in paragraph six hereof and the following tables and interest rates:

(A) For individual annuity and pure endowment contracts issued prior to January first, nineteen hundred seventy-nine, excluding any disability and accidental death benefits in such contracts and excluding

any annuities, purchased under individual deferred annuity contracts, to which the company has elected to have subparagraph (B) hereof apply--the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the superintendent, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts, or such higher rate or rates of interest for any of such contracts as may be approved from time to time by the superintendent.

(B) For individual annuity and pure endowment contracts issued on or after January first, nineteen hundred seventy-nine, excluding any disability and accidental death benefits in such contracts, and, at the election of the company, for annuities purchased on or after such date under individual deferred annuity contracts--the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after nineteen hundred eighty by the National Association of Insurance Commissioners, that is approved by the superintendent for use in determining the minimum standard of valuation for such contracts, or any other individual annuity mortality table, or any modification of any of the foregoing tables, approved by the superintendent, and seven and one-half percent interest for all single premium individual immediate annuity contracts and all annuities, purchased under individual deferred annuity contracts, to which the company has elected to have this subparagraph apply and five and one-half percent interest for all other individual annuity and pure endowment contracts, excluding any annuities, purchased under deferred annuity contracts, for which the interest rate is seven and one-half percent or such higher rate or rates of interest for any of such contracts or annuities purchased under deferred annuity contracts as may be approved from time to time by the superintendent.

(C) For all annuities and pure endowments purchased or to be purchased prior to January first, nineteen hundred seventy-seven under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts,--the 1971 Group Annuity Mortality Table, or any modification of this table approved by the superintendent, and six percent interest, or such higher rate or rates of interest for any of such annuities and pure endowments as may be approved from time to time by the superintendent.

(D) For all annuities and pure endowments purchased or to be purchased on or after January first, nineteen hundred seventy-seven under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts--the 1971 Group Annuity Mortality Table, or any group annuity mortality table, adopted after nineteen hundred eighty by the National Association of Insurance Commissioners, that is approved by the superintendent for use in determining the minimum standard of valuation for such annuities and pure endowments, or any other group annuity mortality table, or any modification of any of the foregoing tables, approved by the superintendent, and seven and one-half percent interest, or such higher rate or rates of interest for any such annuities and pure endowments as may be approved from time to time by the superintendent.

(E) After June thirteenth, nineteen hundred seventy-four, any company may file with the superintendent a written notice of its election to comply with the provisions of this paragraph after a specified date before January first, nineteen hundred seventy-nine, which shall be the operative date of this paragraph for such company, provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this paragraph for such company shall be January first, nineteen hundred seventy-nine.

(F) Annuities, annuity benefits and guaranteed interest contracts to which this subsection applies shall be subject to item (vi) of subparagraph (B) of paragraph four of this subsection.

(4) (A) The interest rates used in determining the minimum standard for the valuation of:

(i) all life insurance policies issued in a particular calendar year, on or after January first, nineteen hundred eighty-two,

(ii) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January first, nineteen hundred eighty-two, and, at the option of the company, all annuities purchased in a particular calendar year on or after such date under individual deferred annuity contracts issued prior thereto,

(iii) all annuities and pure endowments purchased in a particular calendar year on or after January first, nineteen hundred eighty-two

under group annuity and pure endowment contracts, and

(iv) the net increase, if any, in a particular calendar year after January first, nineteen hundred eighty-two, in amounts held under guaranteed interest contracts,

shall be the calendar year statutory valuation interest rates as defined in this subsection, or such higher rate or rates of interest for any of such policies, contracts or annuities as may be approved from time to time by the superintendent.

(B) The calendar year statutory valuation interest rates ("I") shall be determined in accordance with the following formulae (where R is the reference interest rate, and W is the weighting factor, defined in this paragraph) and the results rounded to the nearer one-quarter of one percent:

(i) For life insurance, except as otherwise provided in this subparagraph,

$$I = .03 + W(R1 - .03) + W/2 (R2 - .09);$$

where R1 is the lesser of R and .09,

R2 is the greater of R and .09,

(ii) For single premium immediate annuities and for annuity benefits arising from life insurance policies and annuity and guaranteed interest contracts with cash settlement options,

$$I = .03 + W(R - .03)$$

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in item (ii), the formula for life insurance stated in item (i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in item (ii) shall apply to annuities and guaranteed interest contracts with guarantee durations of ten years or less, and to single premium life insurance policies of the kind referred to in item (vi) valued on a year of issue basis with guarantee durations of ten years or less,

(iv) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in item (ii) shall apply,

(v) For other annuities with cash settlement options and guaranteed

interest contracts with cash settlement options, and for single premium life insurance policies of the kind referred to in item (vi), valued on a change in fund basis, the formula for single premium immediate annuities stated in item (ii) shall apply,

(vi) Single premium life insurance policies of the kind referred to in this item are all single premium life insurance policies, issued on or after January first, nineteen hundred eighty-two, which provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this article and under which interest rates provided in, or declared pursuant to, the policy are, for some period, guaranteed to exceed the greater of (I) six percent per annum and (II) the calendar year statutory valuation interest rate for other life insurance policies with guarantee durations in excess of twenty years.

(C) If the calendar year statutory valuation interest rate for any life insurance policies, other than single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for nineteen hundred eighty, (using the reference interest rate defined for nineteen hundred seventy-nine) and shall be determined for each subsequent calendar year regardless of when subsection (k) of section four thousand two hundred twenty-one of this article becomes operative.

(D) The weighting factors referred to in the formulas stated above are given in the following tables:

(i) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

except that the factors shown above shall be increased for single premium policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph valued on an issue year basis by .05 and for single premium policies of such kind valued on a change in fund basis by ..10.

For life insurance, other than single premium policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy; for such single premium policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, the guarantee duration is the number of years for which interest rates provided in, or declared pursuant to, the policy are guaranteed to exceed the greater of (I) six percent per annum and (II) the calendar year statutory valuation interest rate for life insurance policies, other than such single premium policies, with guarantee durations in excess of twenty years;

(ii) Weighting factor for single premium immediate annuities, and for annuity benefits arising from life insurance policies and annuity and guaranteed interest contracts with cash settlement options: .80

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in item (ii), shall be as specified in tables (I), (II), (III), according to the rules and definitions in tables (IV) and (V):

	Weighting Factor for Plan Type		
Guarantee Duration (Years)	A	B	C
(I) For annuities and guaranteed interest contracts valued on an issue year basis:			
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35
(II) For annuities and guaranteed interest contracts valued on a change in			

fund basis, the factor shown in table (I) above increased by: .15 .25 .05

(III) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in table (I) or derived in table (II) increased by: .05 .05 .05

(IV) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the interest rates provided in, or declared pursuant to, the contract are guaranteed to exceed the calendar year statutory valuation interest rate for life insurance policies other than single premium policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, with guarantee durations in excess of twenty years.

For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(V) Plan type as used in the above tables is defined as follows:

Plan Type A: The policyholder may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (ii) without such adjustment but in installments over five years or more, or (iii) as an immediate life annuity.

Plan Type B: The policyholder may not withdraw funds before the expiration of the interest rate guarantee or, if withdrawals are permitted before the expiration of such guarantee, may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (ii) without such adjustment but in installments over five years or more. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: The policyholder may withdraw funds before the expiration of the interest rate guarantee in a single sum or installments over less than five years either (i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(E) A company may elect to value single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, guaranteed interest contracts with cash settlement options or other annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this paragraph, and except as otherwise permitted by the superintendent, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the life insurance policy, annuity contract or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the policy or contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the policy or contract is the calendar year valuation interest rate for the year of the change in the fund.

(F) The reference interest rate referred to above shall be defined as follows:

(i) For all life insurance, except single premium policies of the kind

referred to in item (vi) of subparagraph (B) of this paragraph, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(ii) For single premium immediate annuities and for annuity benefits arising from life insurance policies and annuity and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, and for single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, valued on a year of issue basis, except as stated in item (ii) hereof, with guarantee durations in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months ending on June thirtieth of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average - Monthly Corporates, as published by Moody's Investors Service, Inc.

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, and for single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, valued on a year of issue basis, except as stated in item (ii) hereof, with guarantee durations of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(v) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(vi) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, and for single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of this paragraph, valued on a change in fund basis, except as stated in item (ii) hereof, the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(G) In the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by the superintendent, may be substituted.

(H) The provisions of this subparagraph shall apply to any life insurance company which has life insurance policies or annuity or pure endowment contracts in effect which were issued in a foreign country and under which premiums and benefits, and the assets supporting reserves in respect thereof, are denominated in the currency of a foreign country which is rated in one of the two highest rating categories by an independent, nationally recognized United States rating agency. For the purpose of determining the reference interest rate to be used in valuing such policies and contracts, the superintendent may permit any such company, or may by regulation require all such companies (except as exempted pursuant to such regulation), to adjust the yield average of the applicable index published by Moody's Investors Service, Inc. (or the yield average determined on the basis of any substitute method applicable to such policies or contracts and approved by the superintendent in accordance with subparagraph (G) of this paragraph) in accordance with a method approved by the superintendent, or to substitute an alternative method approved by the superintendent in place of the applicable index published by Moody's Investors Service, provided that any such substitute or alternative method shall produce

year-to-year consistency in reserving methods and shall appropriately reflect the difference between the yield average on corporate bonds issued in the United States and the yield average on corporate bonds issued in such foreign country. Any company which adjusts yield averages in accordance with a method approved by the superintendent pursuant to this subparagraph shall continue to use such method with respect to the valuation of such policies and contracts until the superintendent permits or requires such company to cease using such method.

(6) (A) Except as otherwise provided in section four thousand two hundred eighteen of this article, reserves according to the commissioners reserve valuation method for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of item (i) over item (ii), as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(ii) A net one year term premium for such benefits provided for in the first policy year.

(B) Provided that for any life insurance policy issued on or after January first, nineteen hundred eighty-six for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender

value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in section four thousand two hundred eighteen of this article, be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in item (i) of subparagraph (A) hereof being reduced by fifteen percent of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in paragraphs two and four shall be used.

(C) Reserves according to the commissioners reserve valuation method for (i) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, (ii) disability and accidental death benefits in all policies and contracts, and (iii) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits in annuity, pure endowment and guaranteed interest contracts, shall be calculated by a method consistent with the principles of this paragraph, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

(D) The superintendent may, by regulation, issue guidelines for the application of the reserve valuation provisions of this section to such policies and contracts as the superintendent deems appropriate. Such guidelines may provide that the minimum standard for the valuation of single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of paragraph four of this subsection may be based on interest rates determined in accordance with paragraph four of subsection (c) of this section for the first ten years following the

date of valuation and thereafter on interest rates determined in accordance with the formula stated in item (i) of subparagraph (B) of paragraph four of this subsection. Such guidelines may permit recognition of surrender charges in determining reserves to the extent and under the conditions specified in the regulation. With respect to annuity, pure endowment, or guaranteed interest contracts providing allocation of assets to a separate account which qualifies under item (iii) of paragraph five of subsection (a) of section four thousand two hundred forty of this article and in which the assets are valued at their market value in accordance with the terms of such contracts, such guidelines may provide for the valuation of the reserves for such contracts in a consistent manner.

(7) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in paragraphs six and nine hereof and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies, nor less than the aggregate reserves calculated in accordance with section four thousand two hundred eighteen of this article. This paragraph shall not apply to single premium life insurance policies of the kind referred to in item (vi) of subparagraph (B) of paragraph four of this subsection nor to life insurance policies that provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this article if the aggregate reserves for all such policies are at least equal to the greatest of present values, at the date of valuation, of the future guaranteed cash surrender values at any time under all such policies, assuming no future premiums and the mortality tables and interest rates prescribed under paragraphs two and four of this subsection.

(8) Notwithstanding the provisions of subsection (a) hereof and notwithstanding the provisions of subsection (g) of section four thousand two hundred twenty-one of this article, after a life insurance company has established reserves for participating life insurance policies in accordance with a method consistent with the provisions of this chapter, it may calculate such reserves according to a rate of interest lower than the rate of interest previously used in calculating

reserves for the same policies only with the consent of the superintendent, subject to such conditions, if any, as he may impose.

(9) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in paragraph six hereof and section four thousand two hundred eighteen of this article, the reserves which are held under any such plan must:

(A) be appropriate in relation to the benefits and the pattern of premiums for that plan, and

(B) be computed by a method which is consistent with the principles of such paragraph and such section as determined by the superintendent.

(10) (A) The superintendent shall, by regulation, issue guidelines for the determination of the minimum reserve value required by this section for any plan or plans of life insurance policies under which cash surrender values and policy loan values are adjusted in accordance with a market-value adjustment formula.

(B) The regulation may require any company issuing or delivering such policies in this state to submit to the superintendent with each annual report an opinion, in form and substance satisfactory to the superintendent, of a qualified actuary that the reserves for all such policies in force at the end of the year, and the assets held by the company in support of such reserves, make adequate provision for the liabilities of the company with respect thereto, such opinion to be accompanied by a memorandum, also in form and substance satisfactory to the superintendent, of the qualified actuary describing the calculations made in support of such opinion and the assumptions used in the calculations. The regulation may prescribe the calculations required to support such opinions and may provide that if the company has designated particular assets primarily to support reserves for a class or classes of policies, including reserves for policies determined in accordance with the regulation, the opinion of the company's qualified actuary may apply to the policies whose reserves are supported by such assets. For purposes hereof, "qualified actuary" has the meaning ascribed to it by subparagraph (E) of paragraph four of subsection (e) of this section.

(C) With respect to any policies covered by the regulation that provide for the allocation of assets to a separate account which qualifies under item (iii) of paragraph five of subsection (a) of section four thousand two hundred forty of this article and in which assets are valued at their market value in accordance with the terms of such policies, the regulation may provide for the valuation of the reserves for such policies in a consistent manner.

(d) The company shall maintain reserves for all individual and group accident and health insurance policies which reserves shall reflect a sound value placed on its liabilities under such policies and shall be not less than the reserves required by regulations which the superintendent shall promulgate.

(e) Actuarial opinion of reserves.

(1) General. Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The superintendent by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) (A) Actuarial analysis of reserves and assets supporting such reserves. Every life insurance company, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by paragraph one of this subsection, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(B) The superintendent may provide by regulation for a transition

period for establishing any additional reserves which the qualified actuary may deem necessary in order to render the opinion required by this paragraph.

(3) Requirement for actuarial memorandum. (A) Except as exempted by or pursuant to regulation, a memorandum, in form and substance acceptable to the superintendent as specified by regulation, shall be prepared to support each actuarial opinion submitted pursuant to subparagraph (A) of paragraph two of this subsection. Each company required to prepare such memorandum shall submit such memorandum to the superintendent as part of its submission of the opinion of the qualified actuary pursuant to such subparagraph (A), except as otherwise provided in subparagraph (B) of this paragraph and except that if a foreign or alien company has submitted a memorandum in support of an opinion of a qualified actuary for the prior year to the commissioner of a state accredited by the National Association of Insurance Commissioners and if that memorandum was in form and substance acceptable to the commissioner and was in support of an opinion of a qualified actuary that was required by laws or regulations of that state to meet standards adopted from time to time by the Actuarial Standards Board and such additional standards as the superintendent has prescribed, the foreign or alien company need submit the memorandum required by this subparagraph only at the request of the superintendent or as the superintendent may by regulation require.

(B) In lieu of preparing a memorandum as required by subparagraph (A) of this paragraph, a company may increase its reserves in the manner provided by the superintendent by regulation. If a company that has not so increased its reserves fails to file a supporting memorandum as required by subparagraph (A) of this paragraph or fails to provide a supporting memorandum at the request of the superintendent within a period specified by regulation or the superintendent determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the superintendent.

(4) Requirement for all opinions. Every opinion shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December thirty-first, nineteen hundred ninety-four.

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the superintendent as specified by regulation.

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the superintendent may by regulation prescribe.

(D) In the case of an opinion required to be submitted by a foreign or alien company, the superintendent may accept the opinion submitted by that company to the commissioner of a state accredited by the National Association of Insurance Commissioners if the superintendent determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(E) For the purposes of this subsection, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements prescribed by the superintendent by regulation.

(F) Except in cases of fraud, willful misconduct or gross negligence, the qualified actuary shall not be liable for damages to any person (other than the insurance company or the superintendent) for any act, error, omission, decision or conduct with respect to the actuary's opinion and memorandum. The provisions of this subparagraph shall not operate to remove, condition or limit any rights, remedies or actions at law or equity which the insurance company or the superintendent may have or take against or with respect to the qualified actuary.

(G) Disciplinary action by the superintendent against the company or the qualified actuary shall be defined in regulations by the superintendent.

(H) Non-public information (meaning information not otherwise available from public documents or records) contained in any memorandum in support of the opinion, or in any other material provided by the company to the superintendent in connection therewith, shall at the written request of the company be kept confidential by the superintendent and shall not be made public, other than for the purpose of enabling any person to defend against an action seeking damages from such person by reason of any action required by this section or by

regulations promulgated hereunder; provided, however, that such non-public information may otherwise be released by the superintendent (i) with the written consent of the company or (ii) for the purpose of professional disciplinary proceedings conducted by the superintendent or by any professional body, provided that steps deemed appropriate by the superintendent are taken to preserve the confidentiality of such non-public information. Notwithstanding the foregoing, the superintendent shall release the non-public information to persons making demand therefor in a criminal proceeding pursuant to lawful subpoena, warrant or court order or in response to a subpoena from a grand jury served upon the superintendent. Any such request by the company for confidentiality shall designate with reasonable specificity the portion of such memorandum or other material with respect to which confidentiality is requested pursuant to this subparagraph. Once such memorandum or other material, or any portion thereof containing matters with respect to which confidentiality has been requested, is cited by the company in its marketing or is cited before any governmental agency (other than a state insurance department) or is released by the company to the news media, all portions of such memorandum or other material shall be no longer confidential.

(f) (1) An insurer shall be deemed to meet the minimum standard for the valuation of life insurance, if the amount of its aggregate reserves for group life insurance, for ordinary life insurance and for industrial life insurance, whether or not held in separate accounts pursuant to section four thousand two hundred forty of this article, is in each case at least equal to the aggregate minimum standard required by this section for the respective valuation thereof.

(2) An insurer shall be deemed to meet the minimum standard for the valuation of annuities and guaranteed interest contracts if the amount of its aggregate reserves therefor, whether or not held in separate accounts pursuant to such section forty-two hundred forty of this article, is at least equal to the aggregate minimum standard required by this section for the valuation thereof.

(3) An insurer shall be deemed to meet the minimum standard for the valuation of individual and group accident and health insurance policies if the amount of its aggregate reserves therefor is at least equal to the aggregate minimum standard required by this section for the

valuation thereof.

(4) Without the specific approval of the superintendent subject to such conditions as he may prescribe and as provided by regulation, an insurer shall not aggregate the reserves referred to in two or more of paragraph one, two or three of this subsection. Such regulation may prescribe the conditions under which the valuation of two or more classes of business of insurance or the valuation of all of its insurance business to which this section applies may be combined.

(5) For purposes of this subsection, the aggregate minimum standard required by this section for the valuation of any insurance policies or contracts shall be deemed to include such additional reserves as the qualified actuary deems necessary, taking into account any transition rules provided by regulation pursuant to subparagraph (B) of paragraph two of subsection (e) of this section, in order to render the opinion required by subsection (e) of this section and such additional reserves as may be necessary to comply with regulations promulgated by the superintendent pursuant to this section.

* (g)(1) This subsection shall apply only to individual and group life insurance policies and annuity contracts issued on or after the operative date of the valuation manual as prescribed by the superintendent by regulation, provided that the operative date shall be no sooner than January first, two thousand nineteen.

(2) For the purposes of this subsection, "NAIC" shall mean the National Association of Insurance Commissioners.

(3) For purposes of this subsection, "principle-based valuation" shall mean a reserve valuation that uses methods and assumptions required by paragraph eleven of this subsection as specified in the valuation manual.

(4) For purposes of this subsection, "qualified actuary" shall mean a member in good standing of the American Academy of Actuaries who meets the requirements prescribed by the superintendent by regulation.

(5) For purposes of this subsection, "valuation manual" shall mean the valuation manual adopted by the NAIC on December second, two thousand twelve, as subsequently amended, and as approved by the superintendent upon a finding that such manual is for the best interests of the holders of policies and contracts and annuitants of this state and which meets the requirements as set forth in this subsection.

(6) Notwithstanding subsection (c) of this section and section four thousand two hundred eighteen of this article, the minimum standard for the valuation of all such policies and contracts shall be the standard prescribed in the valuation manual.

(7) The valuation manual shall not become operative in this state unless and until the superintendent has approved of such manual and has adopted all necessary regulations to effectuate this subsection.

(8) (A) No amendment to the valuation manual shall take effect in this state unless the superintendent finds that such amendment is for the best interests of the holders of policies and contracts and annuitants of this state.

(B) The superintendent may deviate, through regulations, from the reserve standards, valuation methods, assumptions, and related requirements in the valuation manual, including for individual companies, provided, however, that such deviation shall not result in reserve valuations that are lower than the minimum standards prescribed in the valuation manual and may be based on a percentage of the reserves being held for the policies and contracts subject to this subsection prior to the operative date of such manual.

(9) The valuation manual shall specify all of the following:

(A) Minimum valuation standards for and definitions of the policies and contracts subject to this subsection as determined by the superintendent. Such minimum valuation standards shall be:

(i) The commissioners reserve valuation method for life insurance policies subject to this subsection; and

(ii) The commissioners annuity reserve valuation method for annuity contracts subject to this subsection.

(B) Requirements for the format of reports to the superintendent under item (iii) of subparagraph (B) of paragraph eleven of this subsection and which shall include information necessary to determine if the valuation is appropriate and in compliance with this subsection;

(C) Assumptions for risks over which a company does not have significant control or influence;

(D) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(E) Other requirements, including, but not limited to, those relating

to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(F) The data and form of the data required under paragraph twelve of this subsection, with whom the data shall be submitted, and other requirements including data analyses and reporting of analyses.

(10) The superintendent may engage a qualified actuary, at the expense of a company, to perform an actuarial examination of such company and opine on the appropriateness of any reserve assumption or method used by such company, or to review and opine on such company's compliance with any requirement set forth in this subsection.

(11) (A) A company that issues policies and contracts subject to this subsection shall establish reserves using a principle-based valuation that meets the following conditions for such policies and contracts as specified in the valuation manual:

(i) Quantify the benefits and guarantees, and the funding, associated with the policies or contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the policies and contracts. For policies and contracts with significant tail risk, reflect conditions appropriately adverse to quantify the tail risk.

(ii) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(iii) Incorporate assumptions that are derived in one of the following manners:

(I) The assumption is prescribed in the valuation manual.

(II) For assumptions that are not prescribed, the assumptions shall:

a. be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

b. to the extent that company experience is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(iv) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(B) A company that issues policies and contracts subject to this subsection shall:

(i) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(ii) Provide to the superintendent, annually on or before a date as determined by the superintendent, and the board of directors of the company an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(iii) Develop, and file with the superintendent upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(C) A principle-based valuation shall include a prescribed formulaic reserve component.

(12) A company that issues policies and contracts subject to this subsection shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual to the superintendent annually on or before a date as determined by the superintendent.

(13) (A) The superintendent may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of this subsection provided:

(i) The superintendent has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(ii) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any

requirements established by the superintendent and promulgated by regulation.

(B) For any company granted an exemption under this paragraph, subsections (c), (d), (e) and (f) of this section and section four thousand two hundred eighteen of this article shall be applicable. With respect to any company applying for this exemption, any reference to subsection (g) found in subsections (c), (d), (e) and (f) of this section and section four thousand two hundred eighteen of this article shall not be applicable.

* NB Repealed December 7, 2028

§ 4218. When actual premium is less than net premium; minimum reserve. (a) (1) When the actual premium or consideration charged for life insurance under any life insurance policy, issued by any life insurance company doing business in this state, is less than the modified net premium calculated on the basis of the commissioners reserve valuation method as defined in paragraph six of subsection (c) of section four thousand two hundred seventeen of this article and using the rate of interest and mortality tables contained in the minimum valuation standards in paragraphs two and four of such subsection, or in the case of future renewals under a renewable term insurance policy issued prior to the operative date of subsection (k) of section four thousand two hundred twenty-one of this article, the Modern CSO Mortality Table published in the Transactions of the Society of Actuaries, Vol. XXVII (1975), the minimum reserve required for such policy shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy, or the reserve calculated by the commissioners reserve valuation method as defined in paragraph six of subsection (c) of section four thousand two hundred seventeen of this article and using the mortality table and rate of interest prescribed in this section for calculating the commissioners reserve valuation method modified net premium and replacing such modified net premium by the actual premium charged for the policy in each contract year for which such modified net premium exceeds the actual premium.

(2) This section shall not authorize any such company to issue any

policy or contract in violation of any other provision of this chapter.

(b) (1) In the case of any life insurance policy issued on or after January first, nineteen hundred eighty-six, for which the actual premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of subsection (a) hereof shall be applied as if the method actually used in calculating the reserve for such policy were the method described in paragraph six of subsection (c) of section four thousand two hundred seventeen of this article, ignoring the proviso of such paragraph.

(2) The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with paragraph six of subsection (c) of section four thousand two hundred seventeen of this article, including the proviso of that paragraph, and the minimum reserve calculated in accordance with this section.

§ 4219. Limitation on accumulation of surplus of life insurance companies. (a) (1) Any domestic mutual life insurance company may maintain a surplus, above all of its reserves and liabilities required or specifically permitted by this chapter, not exceeding the greatest of (A) eight hundred fifty thousand dollars, or (B) ten percent of its policy reserves and policy liabilities, or (C) ten percent of its policy reserves and policy liabilities plus (i) the product of three and its authorized control level RBC as determined in accordance with section one thousand three hundred twenty-two of this chapter minus (ii) the asset valuation reserve as reported in its annual statement, or (D) the minimum amount of capital and surplus required by law of another state in which the company is authorized to do business.

(2) Any domestic stock life insurance company issuing participating policies only or both participating and non-participating policies or contracts in accordance with subsection (f) of section four thousand two hundred thirty-one of this article, may maintain a participating policyholders' surplus, above all of its reserves and liabilities

arising out of participating policies, required or specifically permitted by the provisions of this chapter, not exceeding the greatest of (A) two hundred fifty thousand dollars, or (B) ten percent of such policy reserves and such policy liabilities, or (C) ten percent of such policy reserves and policy liabilities plus the amount derived by prorating, based upon the ratio of participating assets to admitted assets, (i) the product of three and its authorized control level RBC as determined in accordance with section one thousand three hundred twenty-two of this chapter minus (ii) the asset valuation reserve as reported in its annual statement.

(3) In this section, "policy reserves and policy liabilities" includes reserves and liabilities on outstanding life insurance policies, accident and health insurance policies and annuity contracts, contracts supplemental thereto or in connection therewith or provisions included therein insuring against disability or against death by accident and including liabilities required under optional modes of settlement and for dividends left on deposit, after deducting the net value of its risks reinsured by other solvent assuming insurers. Policy reserves and liabilities shall also include the reserves and liabilities of the domestic life insurance company and the policy reserves and liabilities of any and all wholly-owned subsidiary life insurance companies of the domestic life insurance company, to the extent that the surpluses of such subsidiary life insurance companies are included in the surplus of the domestic life insurance company for purposes of determining the limit pursuant to this section.

(4) In the case of a mutual life insurance company that is reorganized into a stock life insurance company under section seven thousand three hundred twelve of this chapter, the limitation contained in paragraph one of this subsection shall not affect that part of the existing surplus of such reorganized company that is allocated to participating policies and contracts of the mutual life insurance company which is in excess of such limitation on the effective date of the reorganization, provided such excess, in addition to any further accretions occurring in the normal course of business, shall be equitably distributed to these participating policyholders and contractholders over a period not to exceed ten years.

(b) The superintendent may, for good cause shown, by order, permit any

such company to maintain a surplus in excess of the maximum prescribed by subsection (a) hereof, for a specified period, not exceeding one year under any one order. The superintendent shall state in such order his reasons therefor and shall cause a statement of such order and such reasons to be published in his next annual report to the legislature.

(c) This section shall not apply to any stock life insurance company doing exclusively a non-participating business.

§ 4220. Life insurance and annuities; nonforfeiture benefits under defaulted contracts. (a) (1) This section shall apply only to those policies and contracts issued prior to the operative date specified in section four thousand two hundred twenty-one of this article.

(2) Except as otherwise provided in this chapter, in the event of default in payment of a premium or a note therefor or any interest on such note, after three full years' premiums have been paid on a policy of life insurance issued by a domestic insurance company on or after January first, nineteen hundred forty, such company, upon surrender of such policy within the period of three months from the due date of the payment in default, shall pay to the person entitled thereto a cash surrender value not less than the excess, if any, of subparagraph (A) over subparagraph (B) as follows:

(A) The reserve on the policy at the due date of the premium in default (including the reserve for any paid-up additions thereto and excluding the reserve for any additional benefits in the event of death by accident or for benefits in the event of total and permanent disability or for any continuous instalment payments to the beneficiary or to the insured and the beneficiary incidental to the life insurance benefit), determined on the basis, in accordance with section four thousand two hundred seventeen of this article, specified in the policy, and in addition to such reserve, the amount of any dividends standing to the credit of the policy;

(B) the sum of any indebtedness to the company on the policy, including interest due or accrued, and a surrender charge equal to two and one-half per centum of the face amount of such policy and of any paid-up additions thereto, and if the policy be surrendered within the period above specified and after the expiration of the grace period, if

any, following the due date of the payment in default, then there may be added to the sum to be deducted the value of any extended term insurance granted (determined as hereinafter specified) during the period between the expiration of the grace period and the date of surrender of the policy.

(3) The person entitled to such cash surrender value may, upon demand therefor within three months after the due date of the payment in default, elect to receive in lieu of such cash surrender value either extended term insurance (including pure endowment benefits, if any) or reduced paid-up insurance under the policy, for a term, in the case of extended term insurance, and for an amount, in the case of reduced paid-up insurance, which, in either case, shall be not less than that provided by applying such cash surrender value at the date of default to provide such extended term or paid-up insurance, computed at net rates at the attained insurance age of the insured and on the same basis used for the computation of such cash surrender value, except that in the case of policies issued on a substandard basis or policies for which the reserves are computed upon the American Men Ultimate Table of Mortality, the term of such extended insurance may be computed upon rates of mortality not greater than one hundred thirty per centum of those shown by the table specified in the policy for the computation of the reserve. The period of extended term insurance shall date from the due date of the premium in default. Reduced paid-up insurance shall be participating if the policy be participating.

(4) The amount of the extended term insurance shall be not less than the amount of life insurance under the policy as expressed in the policy with the approval of the superintendent (including any paid-up additions thereto and excluding any additional benefits on account of death by accident or any continuous instalment payments to the beneficiary or to the insured and the beneficiary incidental to the life insurance benefit), decreased by the amount of any indebtedness to the company on the policy, including interest due or accrued. In the case of any endowment life insurance policy, if the sum used to provide extended term insurance shall be more than sufficient to continue the insurance to the end of the endowment period, the excess shall be used to provide a pure endowment benefit at the end of the endowment period.

(5) Extended term insurance and reduced paid-up insurance may exclude

additional benefits in the event of death by accident and benefits in the event of total and permanent disability, and extended term insurance may be without participation in surplus and without the right to loans.

(6) If no other option expressed in the policy be so selected by such person within three months after the due date of the premium in default, the amount of such nonforfeiture value shall be applied to continue the insurance in force from the due date of the premium in default as extended term insurance as hereinbefore provided.

(7) The policy shall specify the reserve basis used in determining nonforfeiture benefits and cash surrender values.

(8) This subsection shall not apply to any pure endowment, annuity, or reversionary annuity contract, nor to any term insurance of thirty years or less.

(9) In the case of ordinary or industrial life insurance policies issued on a substandard basis the company shall not be required to provide extended term insurance as a nonforfeiture benefit.

(10) That the company must provide, to any policyowner who so requests in writing, within twenty business days from the date the written request is received by the company, a statement of the cash surrender value of the policy.

(b) (1) Every contract issued after January first, nineteen hundred forty, by any domestic life insurance company which provides for a deferred annuity on the life of the insured or of the annuitant, or for a pure endowment contract, except a contract paid for by a single premium, shall provide that if the contract after having been in force for three full years, shall by its terms lapse or become defaulted because any stipulated payment to the company shall not have been made, the reserve on such contract, computed according to the standard adopted by such company pursuant to section four thousand two hundred seventeen of this article, shall, after deducting a surrender charge not to exceed the limits hereinafter specified, and after deducting the amount of the unpaid balance, including interest due or accrued, on any loans on such contract by the company, be applied as a net single premium according to such standard, for the purchase of a paid-up annuity or pure endowment contract, which shall be payable by the company under the same terms and conditions, except as to amount, as the original contract.

(2) The surrender charge to be deducted pursuant to paragraph one

hereof shall not exceed the greater of the following amounts:

(A) thirty-five percent of the gross annual stipulated payment required by the holder of such contract by the terms thereof; or

(B) twenty-five dollars per one hundred dollars a year income provided by the contract at the normal retirement age.

(3) If such contract provides for a cash surrender value at the option of the holder of such contract and in lieu of such paid-up annuity or pure endowment contract, such cash surrender value shall be an amount at least equal to such net single premium and shall be payable to the holder of such contract upon demand therefor and the surrender of such contract within ninety days after the date of lapse or default.

(4) The paid-up annuity or pure endowment contract prescribed by this section shall not include additional benefits in the event of accidental death or benefits in the event of total and permanent disability and, at the option of the insurer, may be without future participation in surplus and without the right to loans.

(c) The company may provide in any policy or contract that the payment of any cash surrender value may be deferred for not exceeding six months after demand therefor with surrender of the policy or contract as provided above, and the amount payable shall bear interest during any such deferred period of thirty days or more at the rate specified in the policy for the computation of the reserve.

(d) The surrender value and other nonforfeiture benefits of any lapsed or defaulted policy of life insurance or annuity contract issued by any domestic life insurance company before January first, nineteen hundred forty shall be determined in accordance with the law applicable at the date of issuance of such policy or contract.

(e) No foreign or alien life insurance company shall deliver or issue for delivery in this state any policy of life insurance or any annuity or pure endowment contract which does not contain the provisions required by subsection (a) or (b) hereof, as the case may be, or provisions which, in the opinion of the superintendent, are at least equally favorable to policyholders.

§ 4221. Standard nonforfeiture law. (a) In the case of policies issued on or after the operative date of this section as defined in subsection

(p) hereof, no policy of life insurance, except as stated in subsection (o) hereof, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the superintendent are at least as favorable to the defaulting or surrendering policyholder as are minimum requirements hereinafter specified and are essentially in compliance with subsection (n) hereof:

(1) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such value as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, a more favorable alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(3) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default.

(4) That, if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(5) In the case of policies which provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this article, under which cash surrender values are adjusted in accordance with a market-value adjustment

formula, which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and any paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and any paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(5-a) In the case of policies which provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this article and which provide for surrender charges in accordance with subsection (n-1) of this section, a statement as to any charges that will be imposed upon surrender of the policy.

(5-b) In the case of policies that provide for the adjustment of any cash surrender values in accordance with a market-value adjustment formula, a statement as to the times (which shall not be less frequently than once every ten years after issuance of the policy) on which cash surrender values will be determined without the use of such a formula.

(6) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by any statute of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit

available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(7) That the company shall deliver at issue to each holder of a policy under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two of this article, or under which cash surrender values and policy loan values are adjusted in accordance with a market-value adjustment formula, a statement containing such information as the superintendent prescribes, and shall mail to each such holder at least once each policy year or within sixty days after the end of a policy year a statement as of a date during such year as to the death benefit, cash surrender value and loan value under the policy (and any amount by which such cash surrender value and loan value were adjusted in accordance with a market-value adjustment formula) on such date as well as such further information as the superintendent requires. The statement shall be addressed to the last post-office address of the policyholder known to the company.

(8) Any of the foregoing provisions or portions of this subsection not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(b) (1) In the case of contracts issued on or after the operative date of this section as defined in subsection (p) hereof and prior to the operative date of section four thousand two hundred twenty-three of this article, no contract of annuity or pure endowment, except as stated in subsection (o) hereof, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the superintendent are at least as favorable to the defaulting or surrendering contract holder:

(A) That in the event of default in any stipulated payment the company will grant a paid-up nonforfeiture benefit on a plan stipulated in the contract, effective as of such due date, of such value as may be hereinafter specified.

(B) A statement of the mortality table, if any, and interest rate used

in calculating the paid-up nonforfeiture benefits available under the contract, together with a table showing either the cash surrender value or the paid-up nonforfeiture benefit, if any, available on each anniversary of the contract either during the first twenty contract years or during the term of stipulated payments, whichever is shorter, such benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the contract and that there is no indebtedness to the company on the contract.

(C) A statement that the paid-up nonforfeiture benefits available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered; an explanation of the manner in which the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the contract or any indebtedness to the company on the contract; if a detailed statement of the method of computation of the benefits shown in the contract is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the contract is delivered; and a statement of the method to be used in calculating the paid-up nonforfeiture benefit available under the contract on any contract anniversary beyond the last anniversary for which such benefits are consecutively shown in the contract.

If a company shall provide for the payment of a cash surrender value, it shall reserve the right to defer the payment of such value for a period of six months after demand therefor with surrender of the contract.

(2) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if the annuity allowed under any paid-up nonforfeiture benefit would be less than sixty dollars annually, the company may at its option grant a cash surrender value in lieu of such paid-up nonforfeiture benefit of such amount as may be required by subsection (f) hereof.

(c) (1) Any cash surrender value available under any policy referred to in subsection (a) hereof, in the event of default in a premium payment due on any policy anniversary, whether or not required by such subsection, shall be an amount not less than the excess, if any, of the

present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of (i) the then present value of the adjusted premiums as defined in subsections (g), (h), (i) and (k) hereof, corresponding to premiums which would have fallen due on and after such anniversary, and (ii) the amount of any indebtedness to the company on the policy, including interest due or accrued.

(2) In the case of any policy issued on or after the operative date of subsection (k) hereof, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph one of this subsection shall be in an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision, the cash surrender value as defined in such paragraph for a policy which provides only the supplemental life insurance benefits otherwise provided by such rider or supplemental policy provision, and the cash surrender value as defined in section four thousand two hundred twenty-three of this article for a contract which provides only the supplemental annuity benefits otherwise provided by such rider or supplemental policy provision.

(3) In the case of any family policy issued on or after the operative date of subsection (k) hereof as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in paragraph one of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within thirty days after any policy anniversary under any such policy paid up by completion of all premium payments or any such policy continued under any paid-up

nonforfeiture benefit, whether or not required by subsection (a) hereof, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy, including interest due or accrued.

(5) Every company must provide, to any policyowner who so requests in writing, within twenty business days from the date the written request is received by the company, a statement of the cash surrender value of the policy.

(d) Any paid-up nonforfeiture benefit available under any policy referred to in subsection (a) hereof, in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(e) (1) Any paid-up nonforfeiture benefit available under any annuity or pure endowment contract referred to in subsection (b) hereof, in the event of default in a stipulated payment due on any contract anniversary shall be such that its present value as of such anniversary shall be not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the contract, including any existing paid-up additions, if there had been no default, over the sum of (i) the then present value of the adjusted stipulated payments defined in subsection (g) hereof corresponding to stipulated payments which would have fallen due on and after such anniversary, and (ii) the amount of any indebtedness to the company on the contract, including interest due or accrued.

(2) In determining the benefits referred to in paragraph one hereof and in calculating the adjusted stipulated payments referred to in subsection (g) hereof, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional dates, the annuity payments shall be deemed to commence at a date which shall be the latest permitted by the contract for the commencement of such payments but not later than the contract anniversary nearest the annuitant's seventieth birthday or the tenth anniversary of the

contract, whichever is later; and the stipulated payments shall be deemed to be payable for the longest period during which they would be payable if election were made to have the annuity payments commence at such date.

(f) Any cash surrender value allowed by any annuity or pure endowment contract referred to in subsection (b) hereof and the present value, under any optional provision, of future benefits commencing on the due date of the stipulated payment in default shall each be at least equal to the then present value of the minimum paid-up nonforfeiture benefit required by subsection (e) hereof.

(g) (1) This subsection shall not apply to policies issued on or after the operative date of subsection (k) as defined herein.

(2) Except as provided in paragraph four hereof, the adjusted premiums for any policy referred to in subsection (a) hereof shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (iii) forty percent of the adjusted premium for the first policy year; (iv) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. Provided, however, that in applying the percentages specified in items (iii) and (iv) hereof, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(3) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount

of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided, however, that in the case of a policy providing a varying amount of insurance (including policies in which the death benefit prior to a date specified in the policy does not exceed the premiums paid with interest, or the cash value of the policy if greater) issued on the life of a child under age ten, the equivalent uniform amount of insurance shall be calculated as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(4) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (i) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (ii) the adjusted premiums for such term insurance, the foregoing items (i) and (ii) being calculated separately and as specified in paragraphs two and three hereof except that, for the purposes of items (ii), (iii) and (iv) of paragraph two hereof, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in item (ii) of this paragraph shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in item (i) of this paragraph.

(5) The adjusted stipulated payments for any annuity or pure endowment contract referred to in subsection (b) hereof shall be calculated on an annual basis and shall be such uniform percentage of the respective stipulated payments specified in the contract for each contract year that the present value, at the date of issue of the contract, of all such adjusted stipulated payments shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the contract; (ii) twenty percent of the adjusted stipulated payment for the first contract year; and (iii) two percent of the adjusted stipulated payment for the first contract year for each year not exceeding twenty

during which stipulated payments are payable.

(6) Except as otherwise provided in subsections (h), (i) and (j) hereof, all adjusted premiums, adjusted stipulated payments, and present values referred to in this section shall be calculated on the basis of (i) the rate of interest, not exceeding three and one-half percent per annum, specified in the policy or contract for calculating cash surrender values, if any, and paid-up nonforfeiture benefits; and (ii) a mortality table which shall be: for ordinary insurance, the Commissioners' 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured; for industrial insurance, the 1941 Standard Industrial Mortality Table; for annuity and pure endowment contracts, either the 1937 Standard Annuity Mortality Table, the Annuity Mortality Table for 1949 Ultimate, any modification of either of these tables approved by the superintendent or any other table approved by the superintendent. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred and thirty percent of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the superintendent.

(h) (1) This subsection shall not apply to ordinary policies issued on or after the operative date of subsection (k) hereof.

(2) In the case of ordinary policies issued on or after the operative date of this subsection, all adjusted premiums and present values shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits not exceeding three and one-half percent per annum except that four percent per annum may be used for policies issued on or after June thirteenth, nineteen hundred seventy-four and prior to January first, nineteen hundred seventy-nine, and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after

January first, nineteen hundred seventy-nine, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured; provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the superintendent.

(3) Any company may file with the superintendent a written notice of its election to comply with the provisions of this subsection after a specified date before January first, nineteen hundred sixty-six. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January first, nineteen hundred sixty-six.

(i) (1) In the case of industrial policies issued on or after the operative date of this subsection, all adjusted premiums and present values shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits not exceeding three and one-half percent per annum except that four percent per annum may be used for policies issued on or after June thirteenth, nineteen hundred seventy-four and prior to January first, nineteen hundred seventy-nine and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after January first, nineteen hundred seventy-nine; provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a

substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the superintendent.

(2) Any company may file with the superintendent a written notice of its election to comply with the provisions of this subsection after a specified date before January first, nineteen hundred and sixty-eight. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January first, nineteen hundred and sixty-eight.

(j) In the case of individual annuity and pure endowment contracts issued on or after the operative date of paragraph three of subsection (c) of section four thousand two hundred seventeen of this article, and prior to the operative date of section four thousand two hundred twenty-three of this article, all adjusted stipulated payments and present values referred to in this section shall be calculated on the basis of the Annuity Mortality Table for 1949, Ultimate, or any modification of this table approved by the superintendent, and the rate of interest not exceeding four percent per annum, specified in the contract for calculating cash surrender values, if any, and paid-up nonforfeiture benefits, except that, if such rate of interest exceeds three and one-half percent per annum, there shall be substituted for such mortality table the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the superintendent.

(k) (1) This subsection shall apply to all policies issued on or after the operative date as defined in this subsection.

(2) Except as provided in paragraph eight of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted

premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (iii) one hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(3) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(4) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(5) Except as otherwise provided in paragraph eight of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture

benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of

(A) the sum of

(i) the then present value of the then future guaranteed benefits provided for by the policy and

(ii) the additional expense allowance, if any, over

(B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(6) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

(7) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing subparagraph (A) by subparagraph (B) hereof where:

(A) equals the sum of

(i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and

(ii) the present value of the increase in future guaranteed benefits provided for by the policy, and

(B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(8) Notwithstanding any other provision of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher

uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(9) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of

(A) the Commissioners 1980 Standard Ordinary Mortality Table, or

(B) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. Provided, however, that:

(i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) hereof, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(iii) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table.

(v) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(vi) Any ordinary mortality tables, adopted after nineteen hundred

eighty by the National Association of Insurance Commissioners (or any modifications thereof for any specified class or classes of risks), that are approved by the superintendent for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

(10) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred and twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in section four thousand two hundred seventeen of this article rounded to the nearer one quarter of one percent, computed, with respect to a single premium life insurance policy of the kind referred to in item (vi) of subparagraph (B) of paragraph four of subsection (c) of such section, on a year of issue basis by using a reference interest rate defined for such policy in subparagraph (F) of such paragraph for the year immediately preceding the year of issue on the assumption that the company has submitted an opinion and memorandum, in form and substance satisfactory to the superintendent, of a qualified actuary with respect to such single premium life insurance policies in accordance with item (vi) of subparagraph (B) of such paragraph.

(11) Notwithstanding any other provision in this chapter to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(12) After May twenty-fourth, nineteen hundred eighty-two, any company may file with the superintendent a written notice of its election to comply, with respect to any plan of insurance, with the provisions of this subsection after a specified date before January first, nineteen hundred eighty-nine, which shall be the operative date of this subsection for that plan of insurance for such company; the operative dates of this subsection for other plans of insurance for such company shall be any dates not later than January first of the third subsequent calendar year, but in no event later than January first, nineteen

hundred eighty-nine. If a company makes no such election with respect to any plan of insurance, the operative date of this subsection for such company shall be January first, nineteen hundred eighty-nine.

(l) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsection (a), (c), (d), (g), (h), (i) or (k) of this section, then:

(1) the superintendent must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsection (a), (c), (d), (g), (h), (i) or (k) hereof;

(2) the superintendent must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by the superintendent.

(m) (1) Any cash surrender value and any paid-up nonforfeiture benefit, available under any such policy or contract in the event of default in the payment of any premium or stipulated payment due at any time other than on the policy or contract anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums or stipulated payments beyond the beginning of the policy or contract year in which the default occurs.

(2) All values referred to in subsections (c) through (k) hereof, may be calculated upon the assumption that any death benefit is payable at the end of the policy or contract year of death.

(3) Notwithstanding the provisions of subsections (c) and (e) hereof, additional benefits payable (i) in the event of death or dismemberment by accident, (ii) in the event of total and permanent disability, (iii) as reversionary annuity or deferred reversionary annuity benefits, (iv) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (v) as term insurance on the life of a child or on the lives

of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child and (vi) as other policy benefits additional to life insurance, endowment, and annuity benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(n) (1) This subsection, in addition to all other applicable provisions of this section, shall apply to all policies issued on or after January first, nineteen hundred eighty-six.

(2) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (i) the greater of zero and the basic cash value hereinafter specified and (ii) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(3) The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (c) or (g) hereof, whichever is applicable, shall be the same as are the effects specified in such subsection, whichever is applicable, on the cash surrender values defined in that subsection.

(4) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (g) or (k) hereof, whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such

percentage:

(A) must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(B) must be such that no percentage after the later of the two policy anniversaries specified in subparagraph (A) hereof may apply to fewer than five consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (g) or (k) hereof, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(5) All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section.

(6) (A) The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

(B) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (c), (d), (k) and (m) hereof.

(C) The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (i) through (vi) in paragraph three of subsection (m) hereof shall conform with the principles of this subsection.

(n-1) (1) Notwithstanding any other provision in this section, any policy that meets the requirements of this subsection shall be deemed to

provide the minimum nonforfeiture benefits and cash surrender values required by this section. Any policy which is issued by a company after the operative date of this subsection for the company and under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two of this article must meet the requirements of this subsection.

(2) In this subsection,

(A) "Policy value" means an amount equal to gross premiums paid under a policy (excluding separately identified premiums for riders or supplementary benefits that are not credited to the policy value) plus interest credited less the amount of any partial withdrawals and the following charges as specified in the policy: (i) expense charges, (ii) benefits charges, (iii) service charges, and (iv) partial surrender charges.

(B) "Benefit charges" means mortality charges made for life insurance on the insured person or persons and any charges made for riders or supplementary benefits.

(C) "Service charges" means charges for the cost of transactions requested by the policyowner such as partial withdrawals and benefit illustrations. Transactional charges made under mandatory policy provisions shall not be assessed unless specifically permitted by law or regulation for such transactions.

(D) "Expense charges" means charges (other than service charges) deducted from gross premiums before premiums are credited to the policy value or otherwise deducted from the policy value.

(E) "Excess first year expense charges" means the greatest amount by which (x) can exceed (y) based, for stipulated premium policies, on the premiums set forth in the policy and, for other policies, on the assumption that any premium (other than a single premium) payable in the first policy year is also payable during the entire premium paying period, where

(x) is the amount of the expense charges made in the first policy year and

(y) is the arithmetic average of the corresponding charges which the policy states would be imposed in policy years two through twenty or the premium paying period, if shorter.

(F) "Excess expense charges for a face amount increase" means the

greatest amount by which (x) can exceed (y) based, for stipulated premium policies, on the premiums set forth in the policy and, for other policies, on the assumption that the net level whole life annual premium for the increase applies throughout the remaining premium paying period, where

(x) is the amount of the expense charges attributable to an increase in face amount of insurance in the first policy year of the increase, and

(y) is the arithmetic average of the corresponding charges attributable to the increase which the policy states would be imposed in the nineteen policy years following the increase or the premium paying period, if shorter.

(G) "Interest credited" means the amount of interest credited to the policy value but, with respect to policies meeting the requirements of subparagraph (A) of paragraph three of this subsection, not less than three percent in any year.

(H) "Net level whole life annual premium at issue" means an annual premium based on face amounts of insurance set forth in the policy and on the assumption of level annual premiums for life, the mortality table rate used to calculate the maximum mortality charges (but not greater than that permitted under item (iv) of subparagraph (A) of paragraph three of this subsection) and an interest rate based on the rate specified in the policy but not less than the lesser of four percent and the nonforfeiture interest rate per annum pursuant to paragraph ten of subsection (k) of this section.

(I) "Net level whole life annual premium for an increase in the face amount of insurance" means an additional annual premium for an increase in the face amount of insurance determined as of the date of the increase in accordance with subparagraph (H) of this paragraph as though such increase were a separate policy.

(J) "Increase in face amount of insurance" means an increase in the schedule of face amounts of insurance provided for in the policy and made at the request of the policyholder and shall not include increases in face amount resulting from a change in the death benefit option or changes in death benefit pursuant to policy terms that do not affect the face amount.

(K) "Surrender charge" means a deferred charge made to the policy

value in the event of a full or partial surrender of the policy, reduction in the face amount of insurance or premium, or a default in a premium payment.

(L) "Cash surrender value" means an amount equal to the policy value less any surrender charge, before reduction for outstanding loans or other amounts due under the policy.

(M) "Deferred first year expense charge", at issue or for an increase in the face amount of insurance, means any portion of the allowable first year expense charge that is not deducted from premiums or charged to the policy value in the year of issue, or in the policy year of a face amount increase, but deferred and charged to the policy value in subsequent years.

(N) "Consumer price ratio" means the ratio (not to exceed two) of (x) the consumer price index (for all urban households) for the September preceding the policy year in which the ratio is being applied to (y) the consumer price index for September, nineteen hundred eighty-five.

(3) A policy that meets the requirements of this subsection must provide for cash surrender values that meet the requirements of either subparagraph (A) or subparagraph (B) and comply with the provisions of subparagraphs (C) and (D) of this paragraph.

(A) Cash surrender values shall be deemed to meet the requirements of this subparagraph, if the following conditions are met:

(i) Expense charges for any policy year shall not exceed the following:

(I) ninety percent of premiums received up to the net level whole life annual premium at issue (regardless of when received),

(II) ten percent of all other premiums received,

(III) ninety percent of any net level whole life annual premium for increases in the face amount of insurance (including increases offsetting previous decreases),

(IV) ten dollars per one thousand dollars of initial face amount in the first policy year,

(V) one dollar per one thousand dollars of the first one hundred thousand dollars of face amount in subsequent policy years,

(VI) ten dollars per one thousand dollars of any increase in the face amount of insurance in the year of increase (including increases offsetting previous decreases),

(VII) a charge per policy in the first policy year equal to the product of one hundred fifty dollars and the consumer price ratio, and

(VIII) in policy years after the first, a charge per policy per month equal to the product of five dollars and the consumer price ratio.

(ii) Any surrender charge provided in the policy shall be such that the initial surrender charge together with the expense charges made in the first policy year (and on premiums up to the net level whole life annual premium if received after the first year) do not exceed the sum of the amounts determined in accordance with clauses (I) and (II) (for premiums received in the first year) and clauses (IV) and (VII) of item (i) of this subparagraph. The surrender charge at any time shall not be greater than the difference between the maximum initial surrender charge permitted under this subparagraph and the sum of all the deferred expense charges made up to that time. Any additional surrender charges that are imposed in connection with an increase in face amount of the policy shall be such that such additional charges together with any expense charges made in connection with such increase do not exceed the sum of the amounts determined in accordance with clauses (III) and (VI) of item (i) of this subparagraph.

(iii) Deferred first year expense charges shall be such that: (I) the charge for any one year shall not exceed the maximum allowable surrender charge for that year, and (II) the total of all such charges at any time plus the surrender charge at that time shall not exceed the maximum initial surrender charge. Any deferred first year expense charge imposed with respect to an increase in the face amount of insurance shall be subject to comparable limitations.

(iv) A policy meeting the requirements of this subparagraph if issued before the operative date of subsection (k) of this section may not impose mortality charges in excess of those based on the commissioners 1958 standard ordinary mortality table in the case of a standard medically underwritten insured or the commissioners 1958 extended term insurance table in the case of any other standard insured, and if issued on or after such operative date may not impose mortality charges in excess of those based on the commissioners 1980 standard ordinary mortality table in the case of a standard medically underwritten insured or the commissioners 1980 extended term insurance table in the case of any other standard insured. At the option of the company, maximum

charges based on the commissioners 1980 standard ordinary mortality table may be computed using ten-year select mortality factors. Maximum charges may also be based on any other table (or modification thereof for the specified class of risk) approved by the superintendent pursuant to item (vi) of subparagraph (B) of paragraph nine of subsection (k) of this section. For insurance issued on a substandard basis, such charges may be based on appropriate modifications of such tables.

(B) Cash surrender values shall be deemed to meet the requirements of this subparagraph, if the following conditions are met:

(i) Policy values shall not be less than a minimum policy value which reflects the same transactions, the same interest credited and the same benefit charges that are reflected in the actual policy value, except that the excess first year expense charges shall not be greater than the initial expense allowance, and any excess expense charges for a face amount increase after issue shall not be greater than the increase expense allowance. For purposes of this item, the initial expense allowance shall be (I) the lesser of (aa) one hundred twenty-five percent of the net level whole life annual premium at issue and (bb) four percent of the average face amount of insurance provided under the policy during the first ten policy years plus (II) one percent of such average face amount, and the increase expense allowance shall be (I) the lesser of (aa) one hundred twenty-five percent of the net level whole life annual premium for an increase in the face amount of insurance and (bb) four percent of the average increase in face amount of insurance over a period of ten policy years (excluding any increases previously taken into account in determining an expense allowance under this item) plus (II) one percent of any such average increase.

(ii) Any surrender charge provided in the policy shall be such that the initial surrender charge together with any excess first year expense charges do not exceed the initial expense allowance. Any additional surrender charges that are imposed in connection with an increase in face amount shall be such that any such additional charge together with any excess expense charges made in connection with such increase do not exceed the increase expense allowance.

(iii) The policy shall provide that at least once each policy year the policyholder has the option to apply the portion of the cash surrender value necessary to provide an amount of guaranteed paid-up life

insurance at least as great as the lesser of (I) and (II), where (I) is the amount of paid-up life insurance provided by applying the cash surrender value to provide such paid-up insurance, computed on the basis of an interest rate (not less than the lesser of (aa) four percent and (bb) the nonforfeiture interest rate per annum pursuant to paragraph ten of subsection (k) of this section minus one percent) guaranteed in the policy for this purpose, and a mortality basis (not less favorable to the policyholder than the mortality basis specified for an insured not medically underwritten in item (iv) of subparagraph (A) of this paragraph) guaranteed in the policy for this purpose, and (II) is the amount of paid-up life insurance such that the amount at risk on the paid-up insurance is the same as the amount at risk under the policy. If the option is elected, the portion of the cash surrender value not applied to provide the paid-up life insurance shall be paid to the policyholder. The guaranteed paid-up life insurance benefit may be provided under the policy or by means of a separate single premium life insurance policy issued by the company or an affiliate or subsidiary thereof. For purposes of this item, the term "cash surrender value" is after reduction for outstanding loans or other amounts due under the policy.

(C) The surrender charge in policy years after the first shall not exceed the maximum initial surrender charge permitted under this subsection multiplied by the ratio of (i) the value of a life annuity due of one dollar per year for the balance of the amortization period to (ii) the corresponding annuity value at issue, based on the mortality table and interest rate used in calculating the net level whole life annual premiums. For all policies the maximum amortization period is twenty years.

(D) Any surrender charge that is imposed on an increase in premium payments under a policy meeting the requirements of this subsection that does not result in any increase in face amount of the policy shall not exceed the difference between (I) the maximum initial surrender charge computed on the assumption that premiums were paid at the increased rate from the date of issuance of the policy and (II) the maximum initial surrender charge permitted under this subsection.

(4) The superintendent may issue regulations to implement this subsection.

(5) The operative date of this subsection for a company shall be January first, nineteen hundred eighty-eight, or the operative date of this act for the company, whichever is earlier.

(n-2) Notwithstanding any other provision of this section, any policy that provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this article may provide for cash surrender benefits determined in accordance with a market-value adjustment formula, provided, however, that such policy provides for cash surrender benefits determined without adjustment in accordance with such a formula at specified times (which shall not be less frequent than once every ten years after issuance of the policy). For purposes hereof, "market-value adjustment formula" means a formula which is described in the policy for increasing and decreasing cash surrender values that would otherwise meet the minimum requirements of subsection (n-1) of this section and which takes into account (1) changes in interest rates on publicly-traded obligations or other investments or in interest rates provided in, or declared pursuant to, policies of the same class as the policy being surrendered and (2) the length of time between the date on which the policy is surrendered and the next date on which the policy would have provided cash surrender benefits determined without the use of any market-value adjustment formula. The superintendent may promulgate reasonable regulations to define permissible forms or market-value adjustment formulae.

(o) (1) This section shall not apply to any of the following:

(A) Reinsurance.

(B) Group insurance.

(C) Group annuity contract.

(D) A single premium pure endowment or annuity contract.

(E) A reversionary annuity contract.

(F) A term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of thirty years or less expiring before age eighty-one, for which uniform premiums are payable during the entire term of the policy.

(G) A term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (g), (h), (i) and (k) hereof, is less than the adjusted premium so calculated, on a term policy of

uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy.

(H) A policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (c), (d), (g), (h), (i) and (k) hereof, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year.

(I) A policy or contract delivered outside this state through an agent or other representative of the company issuing the policy or through a broker.

(2) For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(p) (1) Any company may file with the superintendent a written notice of its election to comply with the provisions of this section after a specified date before January first, nineteen hundred forty-eight.

(2) After the filing of such notice, then upon such specified date (which shall be the operative date for such company), this section shall become operative with respect to the policies and contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January first, nineteen hundred forty-eight.

(q) The provisions of this section shall not apply to any policy qualified for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code of 1986, as amended, to the extent such application would prevent such qualification.

§ 4222. Policy loans. The policy loan value referred to in paragraph eight of subsection (a) of section three thousand two hundred three of this chapter shall be the cash surrender value at the end of the current policy year calculated in accordance with the provisions of:

(a) Subsection (a) of section four thousand two hundred twenty of this

article, for policies issued before the operative date of section four thousand two hundred twenty-one of this article, except that any dividends credited to the policy need not be included and such policies may provide that the company may defer any such loan for not exceeding six months after receipt of the loan application;

(b) Section four thousand two hundred twenty-one of this article, for policies issued on or after the operative date of such section, except that the policy loan value for a policy under which any cash surrender value is adjusted in accordance with a market-value adjustment formula shall be a percentage (not less than seventy-five percent) of the sum of (1) the amount of any loan outstanding and (2) the remaining portion of the cash surrender value as so adjusted at the time the loan is applied for, but, if the policy so provides, not in excess of such cash surrender value before adjustment. The company shall reserve the right to defer any such loan, except when made to pay premiums, for six months after receipt of the loan application.

§ 4223. Standard nonforfeiture law for annuities. (a) (1) In the case of contracts issued on or after the operative date of this section, no contract of annuity, except as provided in subsection (b) of this section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions that in the opinion of the superintendent are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract.

(A) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (d), (f), (g) and (i) of this section.

(B) If a contract provides for a full or partial lump sum settlement at maturity, or at any other time, that upon full or partial surrender of the contract at the commencement of any annuity payments or prior thereto at times specified in the contract (which shall not be less frequently than once every ten years after the issuance of the contract), the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit (for the portion of the contract surrendered, if

the contract permits partial surrenders) in an amount meeting the requirements of paragraph one of subsection (e) of this section. The contract may provide for a cash surrender benefit on any other date or dates meeting the requirements of paragraph one or two of subsection (e) of this section. The company shall reserve the right to defer the payment of such cash surrender benefit for a period of six months after demand therefor with surrender of the contract. This subparagraph shall not apply to any contract qualified for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code to the extent such application would prevent such qualification.

(C) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity during the period it is guaranteed, and any cash surrender or death benefits that are guaranteed under the contract, and any times at which such guaranteed benefits are payable, together with sufficient information to determine the amounts of such benefits and, if the contract provides for the determination of any cash surrender value in accordance with a market-value adjustment formula authorized by paragraph two of subsection (e) of this section, a brief description of the formula and the circumstances in which it is applied, together with a statement that a detailed description has been filed with the superintendent.

(D) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(E) (i) Except as provided in item (ii) of this subparagraph, a statement that the annuity benefits at the time of their commencement will not be less than those that would be provided by the application of an amount, hereinafter defined, to purchase any single consideration immediate annuity contract offered by the company at the time to the same class of annuitants. For contracts that provide cash surrender benefits, such amount shall be the greater of the cash surrender benefit or ninety-five percent of what the cash surrender benefit would be if

there were no withdrawal charge. For contracts that do not provide cash surrender benefits, such amount shall be the present value of the paid-up annuity benefit provided under the contract in accordance with subsection (d) of this section.

(ii) For paid-up deferred annuity contracts in which each consideration paid into the contract purchases guaranteed paid-up annuity benefits determined at the time the consideration is paid, a statement that the annuity benefits at the time each consideration is paid will not be less than those that would be provided by the application of the consideration to current purchase rates for new sales of such contract or any comparable paid-up deferred annuity contract offered by the company at that time to the same class of annuitants. For purposes of this item, dividends applied to purchase paid-up additions to the contract shall be treated as considerations paid into the contract.

(iii) The statements set forth in items (i) and (ii) of this subparagraph shall not affect the amount of any benefits required to be provided under any other provision of this section.

(2) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of three full years and either (A) the actual accumulation amount as hereinafter defined would be less than five thousand dollars or the dollar limit established pursuant to subparagraph A of paragraph 11 of subsection (a) of section four hundred eleven of the internal revenue code of 1986, as amended, or (B) the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, calculated on the basis of the mortality table, if any, and the interest rate, if any, specified in the contract for determining the paid-up annuity benefits, the company may at its option terminate such contract by payment of the actual accumulation amount and by such payment shall be relieved of any further obligation under such contract.

(b) (1) This section shall not apply to any:

(A) Reinsurance.

(B) Group annuity contract purchased in connection with one or more retirement plans or plans of deferred compensation established or

maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combination thereof, except as otherwise provided in this subsection.

(C) Premium deposit fund.

(D) Variable annuity.

(E) Immediate annuity.

(F) Deferred annuity contract or group annuity certificate after annuity payments have commenced.

(G) Reversionary annuity.

(H) Contract delivered outside this state through an agent or other representative of the company issuing the contract or through a broker, except as otherwise provided in this subsection.

(2) This section shall apply to any certificate issued, or issued for delivery, under a group annuity contract (other than a group annuity contract issued to an employee benefit plan within the meaning of the federal employee retirement income security act of 1974, 29 U.S.C. §1001 et seq.) to a person solicited for the sale of such certificate in this state if:

(A) such certificate provides benefits under an individual retirement account or is issued as an individual retirement annuity, both as defined in section four hundred eight of the Internal Revenue Code, except for a simplified employee pension as defined in subsection (k) of section four hundred eight of such code; or

(B) such certificate is issued as an annuity contract in accordance with subsection (b) of section four hundred three of such code under a program for the purchase of such annuity contract where the payments are derived wholly from a salary reduction agreement or an agreement to forego an increase in salary; or

(C) the benefits provided under such group annuity contract are derived wholly from funds contributed by the persons covered thereunder.

(c) (1) Except as provided in paragraph four of this subsection, the minimum values as specified in subsections (d), (e), (f), (g) and (i) of this section of any paid-up annuity, cash surrender or death benefits attributable to any account subject to this section under an annuity contract shall be based (except as provided in subsection (e) of this section with respect to the use of a market-value adjustment formula) upon the actual accumulation amount computed as provided in this

subsection. For contracts that provide a cash surrender benefit prior to the commencement of annuity payments, the death benefit attributable to any account, other than an equity index account, shall not be less than the actual accumulation amount, as defined in paragraph two of this subsection, and the death benefit attributable to an equity index account shall not be less than the value of the equity index account, as defined in paragraph four of this subsection.

(2) The "actual accumulation amount" with respect to an account other than an equity index account at any time at or prior to the commencement of any annuity payments is:

(A) the net considerations credited to such account; minus

(B) premium taxes and premium charges attributable to the account; plus

(C) interest (which shall not be less in any year than the minimum annual effective rate of interest as specified in subparagraph (F) of this paragraph applied to the sum of the actual accumulation amount and the amount of any indebtedness to the company on the contract attributable to the account), additional amounts and dividends, credited by the company to the account; minus

(D) administrative charges (which shall not exceed fifty dollars per year per contract); minus

(E) the sum of (i) the amount appropriate according to the terms of the contract to reflect transfers to other accounts, any prior withdrawals from or partial surrenders of the account and (ii) the amount of any indebtedness to the company attributable to such account, including interest due and accrued.

(F) the minimum annual effective rate of interest shall be the lesser of three percent and the following:

(i) the five-year constant maturity treasury rate reported by the federal reserve as of a date, or average over a period, within the fifteen months prior to the contract issue or redetermination date rounded to the nearest one-twentieth of one percent;

(ii) reduced by one hundred twenty-five basis points; and

(iii) where the resulting minimum guaranteed interest rate is not less than one percent. The minimum annual effective rate of interest at issue shall be specified in the contract. The basis and calculation for setting the minimum annual effective rate of interest at issue of a

contract shall be filed with the superintendent. If the contract provides that the minimum annual effective rate of interest may be redetermined, the redetermination date, basis, calculation and period shall be stated in the contract. The basis is the date or average over a specified period that produces the values of the five-year constant maturity treasury rate to be used at each redetermination date or at issue.

(3)(A) "Net considerations" means the gross considerations credited to the account (including transfers from other accounts under the contract) less contract charges allocated to the account, but net considerations shall not, for any contract year for any account, be less than zero.

(B) "Contract charges" means the fixed dollar charges provided for in the contract (subject to any maximum limit based on the amount of annual considerations credited to the contract) but shall not exceed fifty dollars in any year.

(C) "Premium charge percentage" means a charge provided for in the contract based on a percentage of net considerations credited to the contract but shall not exceed (i) ten percent of any net consideration so credited if the contract does not contain a market-value adjustment formula or (ii) seven percent of any net consideration so credited if the contract contains a market-value adjustment formula.

(D) "Premium specific" when applied to a contract means that each net consideration credited to the contract is associated with a portion of the actual accumulation amount under the contract and of the amount of any indebtedness under the contract to the company and that a separate withdrawal charge percentage is applicable to each such portion.

(4)(A) The minimum values as specified in subsections (d), (e), (f), (g) and (i) of this section of any paid-up annuity, cash surrender or death benefits available under an equity index account in an annuity contract shall be based upon the greater of the minimum accumulation value and the equity index value, as defined in this paragraph, provided that:

(i) at least once every ten years the minimum accumulation value and the equity index value will be reset to equal the greater of the two values; and

(ii) the value of an equity index account during any contract year may not be less than the value of the equity index account at the start of

the contract year plus net considerations credited to the equity index account during the contract year less transfers, withdrawals and surrenders from the equity index account during the contract year.

(iii) if an amount is withdrawn from the equity index account, the greater of the minimum accumulation value and the equity index value shall not be reduced by more than the amount withdrawn. The lesser of the two values shall not be reduced by more than the amount withdrawn multiplied by the ratio of the lesser of the two values to the greater of the two values.

(B) The minimum accumulation value for an equity index account shall equal the actual accumulation amount, as defined in paragraph two of this subsection, with the following adjustments:

(i) the amounts added pursuant to subparagraph (C) of paragraph two of this subsection shall not include any additional amounts, but shall include the amounts, if any, credited to the minimum accumulation value when values are reset in accordance with item (i) of subparagraph (A) of this paragraph; and

(ii) the reduction described in item (ii) of subparagraph (F) of paragraph two of this subsection may be increased by not more than one percent upon demonstration satisfactory to the superintendent that the present value of the additional reduction does not exceed the market value of the benefit at the contract issue date, and, if applicable, at each date thereafter that the guaranteed interest rate, or equity index formula, can be changed.

(C) The equity index value shall equal the actual accumulation amount as defined in paragraph two of this subsection, with the following adjustments:

(i) the amounts added pursuant to subparagraph (C) of paragraph two of this subsection shall not include any interest; but shall include the amounts, if any, credited based on an equity index formula and the amounts, if any, credited to the equity index value when values are reset in accordance with item (i) of subparagraph (A) of this paragraph;

(ii) the amounts credited to the equity index value shall be based upon an equity index formula specified in the contract meeting the requirements of subparagraph (D) of this paragraph; and

(iii) the equity index value at the end of any contract year may not be less than the equity index value at the start of the contract year

plus net considerations credited to the equity index account during the contract year less transfers, withdrawals and surrenders from the equity index account during the contract year.

(D) The equity index formula shall be based on:

(i) a percentage change in an equity index;

(ii) guaranteed factors, such as participation rates, margins, caps and floors that adjust the percentage change in the equity index or where such factors are not guaranteed but subject to change after contract issue and:

(I) such changes occur not more frequently than annually;

(II) such changes are limited by guaranteed factors stated in the contract; and

(III) the use of factors other than the guaranteed factors stated in the contract are considered additional amounts within the meaning of subsection (a) of section four thousand two hundred thirty-two of this article.

(iii) be applied not more frequently than monthly nor less frequently than annually; and

(iv) use the equity index value as the base to which the percentage change in the equity index as modified by factors in the formula is applied.

(v) in the absence of withdrawals and net considerations, not result in a percentage change in the equity index value over a contract year of less than the percentage change in the equity index as adjusted and applied by the terms of the contract.

(E) The contract shall describe:

(i) the equity index used in the formula, including any alternative index should the equity index no longer be publicly available;

(ii) the period of time over which the percentage change in the index is calculated;

(iii) any initial participation rate, margin, cap, floor or other factor used to adjust the percentage change in the equity index, the period or periods of time for which such factor is applicable and if the factor is subject to change after the contract is issued, the maximum or minimum as applicable for such factor over the contract's lifetime and the procedures for determining and disclosing any change in such factor; and

(iv) the application of the equity index formula.

(d) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the actual accumulation amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate, if any, specified in the contract for determining any minimum paid-up annuity benefits guaranteed in the contract.

(e) (1) A cash surrender benefit that meets the requirements of this paragraph shall not be less than the excess of (i) the actual accumulation amount over (ii) the withdrawal charge percentage times the sum of (I) the actual accumulation amount and (II) the amount of any indebtedness under the contract to the company. Subject to the foregoing sentence and section four thousand two hundred thirty-two of this article, such benefit may be determined in any manner established pursuant to authority granted by the board of directors of the company or a committee thereof (including any formula that takes into account changes in interest rates of publicly-traded obligations or other investments).

(2) A cash surrender benefit that meets the requirements of this paragraph shall not be less than the excess of (i) the actual accumulation amount, as adjusted by a market-value adjustment formula, over, if the contract is not premium specific, (ii) the withdrawal charge percentage times the sum of (I) the actual accumulation amount, as adjusted by such market-value adjustment formula and (II) the amount of any indebtedness under the contract to the company or, if the contract is premium specific, (iii) the aggregate of such withdrawal charge percentage under the contract times the sum of (I) the corresponding portion of the actual accumulation amount, as adjusted by such market-value adjustment formula, and (II) the corresponding portion of the amount of any indebtedness under the contract to the company.

(3) (A) If the cash surrender benefit is computed on the basis of the actual accumulation amount without adjustment by a market-value adjustment formula and the contract does not include an equity index account, "withdrawal charge percentage" means a percentage not greater than ten percent less the premium charge percentage, if any, provided for under the contract.

(B) If the contract has an equity index account, "withdrawal charge

percentage" for such account means the percentage provided in subparagraph (A) of this paragraph reduced by one percent for each year beginning after the third year the contract has been in force and further reduced to zero after the tenth year the contract has been in force.

(4) If the cash surrender benefit is computed on the basis of the actual accumulation amount adjusted by a market value adjustment formula, "withdrawal charge percentage" means a percentage not greater than seven percent reduced by one percent for each year the contract has been in force or, if the contract is premium specific, for each year after the net consideration associated with such withdrawal charge percentage was credited to the contract and less the premium charge percentage, if any, provided in the contract (but not less than zero). After any period during which interest was credited to the contract at a specified rate and the company, pursuant to the contract, set a new specified rate and a new period during which such rate is to be so credited, the withdrawal charge percentage for such new period shall be a percentage not in excess of the greater of (A) any remaining withdrawal charge percentage at the beginning of the new period and (B) the lesser of (i) five percent and (ii) one percent times the number of years in such new period, reduced (but not below zero) by one percent for each year the contract remains in force during such period, provided, however, that the withdrawal charge percentage for such new period shall be zero unless the contract provides for a date, within thirty days of the last day of such new period, on which the contract may be surrendered for a cash surrender benefit determined without the use of a market-value adjustment formula.

(5) "Market-value adjustment formula" means a formula which is described in the contract for increasing and decreasing the actual accumulation amount in order to determine cash surrender values payable in accordance with subparagraph (B) of paragraph one of subsection (a) of this section and which takes into account (i) changes in interest rates on publicly-traded obligations or other investments or in interest rates provided in, or declared pursuant to, contracts of the same class as the contract being surrendered and (ii) the length of time between the date on which the contract is surrendered and the next date on which the contract would have provided cash surrender benefits determined

without the use of any market-value adjustment formula. The superintendent may promulgate reasonable regulations to define permissible forms of market-value adjustment formulae.

(f) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the greater of (1) the sum for each account other than an equity index account of the actual accumulation amount as defined in paragraph two of subsection (c) of this section plus the sum for each equity index account of the value of the equity index account as defined in paragraph four of subsection (c) of this section and (2) the present value of that portion of the maturity value of the annuity benefit provided at maturity under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the guaranteed interest rate specified in the contract for determining the maturity value of the annuity benefit provided at maturity, but not less than the accumulation interest rate as defined in subsection (c) of this section, and increased by any existing additional amounts and dividends credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit, increased by any additional amounts and dividends credited by the company to the contract.

(g) For the purpose of determining the benefits calculated under subsections (e) and (f) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(h) If the contract fails at any time prior to the commencement of annuity payments to provide cash surrender benefits or to provide death

benefits at least equal to the actual accumulation amount, it shall contain a statement in a prominent place that such benefits are not provided.

(i) Any paid-up annuity, cash surrender or death benefits available at any time other than on the contract anniversary under any contract with fixed scheduled considerations shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(j) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (d), (e), (f), (g) and (i) of this section, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the accumulation amounts, and the paid-up annuity, cash surrender and death benefits, that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum paid-up annuity, cash surrender or death benefits.

(k) (1) At least once in each contract year, the company shall mail to each holder of a contract subject to this section under which benefit payments have not yet commenced a statement as of a date during such year as to any paid-up annuity benefit or the amount available under each account to provide a paid-up annuity benefit, any cash surrender benefit and any death benefit, under the contract. If the minimum annual effective rate of interest is subject to redetermination, then the statement shall include the current minimum annual effective rate of interest and the next redetermination date. For contracts containing an

equity index account, the statement shall identify the minimum accumulation value, the equity index value, any changes in the participation rate, margin, cap, floor or other factor used in the equity index formula. The statement shall be addressed to the last post-office address of the contractholder known to the company.

(2) This subsection shall not apply to any contract providing for a single consideration if the paid-up annuity benefits, any cash surrender benefits and any death benefits under the contract are identical in amount to those specified at issue.

(l) The operative date of this section shall be:

(1) as to a company which filed with the superintendent a written notice of its election to comply with this section after a specified date before January first, nineteen hundred eighty-one, such specified date; and

(2) as to a company which made no such election, January first, nineteen hundred eighty-one.

§ 4224. Life, accident and health insurance; discrimination and rebating; prohibited inducements and interdependent sales. (a) No life insurance company doing business in this state and no savings and insurance bank shall:

(1) make or permit any unfair discrimination between individuals of the same class and of equal expectation of life, in the amount or payment or return of premiums, or rates charged for policies of life insurance or annuity contracts, or in the dividends or other benefits payable thereon, or in any of the terms and conditions thereof;

(2) refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of the physical or mental disability, impairment or disease, or prior history thereof, of the insured or potential insured, except where the refusal, limitation or rate differential is permitted by law or regulation and is based on sound actuarial principles or is related to actual or reasonably anticipated experience, in which case the insurer, subject to the limitations contained in section twenty-six hundred eleven of this chapter, shall notify the insured or potential insured of the right to

receive, or to designate a medical professional to receive, the specific reason or reasons for such refusal, limitation or rate differential;

(3) refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because the insured or potential insured was prescribed pre-exposure prophylaxis (PrEP) medication for the prevention of HIV infection;

(4) knowingly permit, and no agent thereof and no licensed insurance broker shall offer to make or make, any policy of life insurance or annuity contract or agreement as to such policy or contract other than as plainly expressed in the policy or contract.

(b) No insurer doing in this state the business of accident and health insurance, as specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter, and no officer or agent of such insurer and no licensed insurance broker, and no employee or other representative of such insurer, agent or broker shall:

(1) make or permit any unfair discrimination between individuals of the same class in the amount of premiums, policy fees, or rates charged for any policy of accident and health insurance, or in the benefits payable thereon, or in any of the terms or conditions of such policies, or in any other manner whatsoever;

(2) refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of the physical or mental disability, impairment or disease, or prior history thereof, of the insured or potential insured, except where the refusal, limitation or rate differential is permitted by law or regulation and is based on sound actuarial principles or is related to actual or reasonably anticipated experience, in which case the insurer, subject to the limitations contained in section twenty-six hundred eleven of this chapter shall notify the insured or potential insured of the right to receive, or to designate a medical professional to receive, the specific reason or reasons for such refusal, limitation or rate differential;

(3) refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because the insured or potential insured was prescribed pre-exposure prophylaxis (PrEP)

medication for the prevention of HIV infection;

(4) knowingly permit or offer to make or make, any policy of accident and health insurance, other than as plainly expressed in the policy.

(c) Except as permitted by section three thousand two hundred thirty-nine of this chapter or subsection (f) of this section, no such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract other than any valuable consideration, including but not limited to merchandise or periodical subscriptions, not exceeding twenty-five dollars in value; nor shall any person in this state knowingly receive as such inducement, any rebate of premium or policy fee or any special favor or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever which is not specified in such policy or contract.

(d) (1) No insurer authorized to do one or more of the kinds of insurance business specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter or authorized to do the kind of insurance business specified in section three thousand two hundred twenty-two of this chapter shall directly or indirectly, or by any of its agents or representatives, or by any broker or brokers, participate in any plan to offer or effect any kind or kinds of such insurance business in this state as an inducement to, or interdependent with, the purchase by the public of any goods, securities, commodities, housing, services or subscriptions to periodicals, except as provided by subsection (e) of section three

thousand four hundred thirty-six, paragraph three of subsection (b) of section four thousand two hundred sixteen of this article, by subparagraph (E) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this article or by article forty-six of the public health law.

(2) This subsection shall not prohibit payment plans which are otherwise in compliance with this subsection and this chapter.

(e) This section shall not prohibit the giving by any company, in its discretion, of medical examinations and diagnoses and of nursing services to all or any part of its policyholders, under reasonable rules and regulations.

(f) (1) This subsection shall apply only with respect to a group or blanket accident and health insurance policy issued by an insurer licensed to write accident and health insurance in this state or a group contract issued by a corporation organized pursuant to article forty-three of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law.

(2) Notwithstanding subsection (c) of this section, a licensed agent or insurance broker may develop, implement, and administer wellness programs established in accordance with section three thousand two hundred thirty-nine of this chapter without charging a service fee or, in the case of a licensed insurance broker, for a reduced service fee pursuant to a written memorandum made in accordance with subsection (c) of section two thousand one hundred nineteen of this chapter, if such programs are provided in a fair and nondiscriminatory manner and incidental to a group or blanket policy or contract sold by the insurance agent or insurance broker.

§ 4225. Domestic life insurance companies; discrimination as to brokers. No officer, trustee or director of a domestic life insurance company shall direct or require a borrower from the life insurance company on mortgage to negotiate any policy of insurance on the mortgaged property through any particular insurance broker, or attempt to divert to any particular insurance broker the patronage of borrowers from the life insurance company, or refuse to accept any such insurance policy because it was not negotiated through a particular insurance

broker.

§ 4226. Misrepresentations, misleading statements and incomplete comparisons by insurers. (a) No insurer authorized to do in this state the business of life, or accident and health insurance, or to make annuity contracts shall:

(1) issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts;

(2) make any estimate of the dividends or share of surplus or additional amounts to be received on such policies or contracts;

(3) make any false or misleading statement of the dividends or share of surplus or additional amounts paid by any such insurer on similar policies or contracts;

(4) make any misleading representation, or any misrepresentation of the financial condition of any such insurer or of the legal reserve system upon which it operates; or

(5) make or deliver to any person or persons any incomplete comparison of any such policies or contracts for the purpose of inducing, or tending to induce, such person or persons to lapse, forfeit or surrender any insurance policy or contract.

(6) replace the individual life insurance policies or individual annuity contracts of an insurer by the same or different insurer without conforming to the standards promulgated by regulation by the superintendent. Such regulation shall:

(A) specify what constitutes the replacement of a life insurance policy or annuity contract and the proper disclosure and notification procedures to replace a policy or contract;

(B) require notification of the proposed replacement to the insurer whose policies or contracts are intended to be replaced;

(C) require the timely exchange of illustrative and cost information required by section three thousand two hundred nine of this chapter and necessary for completion of a comparison of the proposed and replaced coverage; and

(D) provide for a sixty-day period following issuance of the

replacement policies or contracts during which the policy or contract owner may return the policies or contracts and reinstate the replaced policies or contracts.

(b) Any comparison of the policies or contracts of any such insurer or insurers shall be deemed to be an incomplete comparison if it does not conform to all the requirements for comparisons established by the superintendent by regulation.

(c) In any determination, judicial or otherwise, of the incompleteness or misleading character of any such comparison or of representation, it shall not be presumed that the insured knew or knows of any of the provisions or benefits contained in any insurance policy or contract.

(d) Any such insurer that knowingly violates any provision of this section, or knowingly receives any premium or other compensation in consequence of such violation shall, in addition to any other penalty provided in this chapter, be liable to a penalty in the amount of such premium or compensation, which penalty may be sued for and recovered by any person aggrieved for his own use and benefit, in accordance with the provisions of the civil practice law and rules.

§ 4228. Life insurance and annuity business; limitations of expenses. (a) The provisions of this section shall apply to all domestic life insurance companies and to all foreign and alien life insurance companies doing business in this state, but not the alien branches of such companies or such companies' subsidiaries not licensed in this state to do an insurance business, except as provided in subsection (h) of this section, engaged in the direct sale of individual life insurance policies or individual annuity contracts, hereinafter referred to as "companies". Except as provided in subsection (h) of this section, the provisions hereof shall apply only to individual life insurance policies and riders and individual annuity contracts and riders and shall not apply to fraternal benefit societies nor to the following categories of insurance: (1) accident and health insurance having the meaning ascribed in section one thousand one hundred thirteen of this chapter, group life insurance having the meaning ascribed in section four thousand two hundred sixteen of this article, group annuity contracts having the meaning ascribed in section four thousand two hundred thirty-eight of

this article, and credit insurance having the meaning ascribed in section four thousand two hundred sixteen and four thousand two hundred thirty-five of this article; (2) debit life insurance, except as otherwise expressly provided herein; or (3) policies and contracts issued for delivery outside the United States and its possessions. Neither these categories of insurance nor reinsurance either assumed or ceded will be included in any calculations or tests conducted for any purpose in connection with this section or any regulations or schedules promulgated hereunder.

(b) For purposes of this section:

(1) "Advance" and "loan" shall have the following meanings: "advance" means any amount paid to an agent, up to an amount not exceeding the value of three months' expected compensation payments, that is expected to be repaid within the next twelve months through reductions in future compensation. "Loan" means any payment to an agent, other than an advance, that is expected to be repaid from future compensation. An amount paid to an agent in an annualization as defined in this subsection is not an advance or loan.

(2) "Agent" shall have the meaning ascribed in section two thousand one hundred one of this chapter and "broker" shall have the meaning ascribed in section two thousand one hundred four of this chapter.

(3) "Annualization" means: with respect to any amounts paid to an agent or broker, the paying or crediting to an agent or broker at the beginning of a policy year compensation or other payments based on all or a portion of the amount of premiums scheduled to be received by the company with respect to such policy year; with respect to the calculation of any limits of payment or expense prescribed in this section, the calculation of such limit is based on the assumption that a company receives, at the beginning of a policy year, all or a portion of the amount of premiums scheduled to be received by the company with respect to such policy year.

(4) "Benchmark gross level premium", is calculated as of the issue date of a policy, or as of any subsequent date on which the face amount of the policy, or the types or amounts of supplemental benefits provided under the policy, are increased, whether by addition of a rider or otherwise, at the request of the policy owner. The benchmark gross level premium is calculated as one hundred twenty-five percent of the net

level premium for a whole life insurance policy with level premiums payable during the life of the insured, with payments starting on the same date and for the same face amount as the policy for which the benchmark gross level premium is being computed, based on three and one-half percent interest and male aggregate (smoker and non-smoker combined), Commissioners 1980 Standard Ordinary Mortality Table, ultimate mortality, age last birthday and immediate payment of death claims, further adjusted as follows:

(A) An amount of one hundred dollars shall be added to the benchmark gross level premium for a policy; however, this amount shall not be added to the benchmark gross level premium for a rider.

(B) The benchmark gross level premium for a policy providing supplemental insurance benefits, whether by rider or otherwise, shall be increased (i) if the company makes an additional premium charge for such benefits, by the amount of such premium charge, and (ii) if the company does not make an additional premium charge for such benefits, by one hundred twenty-five percent of the amount of the levelized annual cost of insurance charge for such benefits; such levelized charge is to be based on the actual schedule of charges applicable to the policy at the time with respect to which the calculation is made, levelized using the mortality table and interest rate defined in this section.

(C) The benchmark gross level premium for a policy in which the guaranteed table of mortality charges exceeds the Commissioners 1980 Standard Ordinary Mortality Table for male smokers for age last birthday may be appropriately adjusted to reflect any excess of the amount of the benchmark gross level premium computed based on the actual mortality guarantees of the policy over the benchmark gross level premium computed based on the Commissioners 1980 Standard Ordinary Mortality Table for male smokers for age last birthday; however, if the company makes an additional premium charge because the insured is a substandard risk, the company may, instead, increase the amount of the benchmark gross level premium by the amount of such charge.

(D) The benchmark gross level premium for a policy providing life insurance benefits, other than supplemental benefits, for more than one person shall be adjusted to reflect the joint mortality status of the insured lives, consistent with the nature of the life insurance coverage provided by the policy, using the mortality table and interest rates

defined in this section.

(E) The benchmark gross level premium for a policy, including all of its riders and benefits, is the sum of the benchmark gross level premium for the policy and the benchmark gross level premium for each rider, each adjusted as provided in subparagraphs (A), (B), (C) and (D) of this paragraph.

(F) The benchmark gross level premium for a policy with premiums payable more frequently than annually shall be the benchmark gross level premium based on annual premium payments, adjusted by the company's actual adjustment factors for the actual mode of premium payment.

(5) "Commission" means a payment to an agent or broker, as compensation for the sale or service of a specific policy or contract, based upon a percentage of the premium or consideration for that policy or contract.

(6) A "compensation arrangement" means any arrangement by a company for compensating its agents or brokers on business that includes any of the following:

(A) A commission that, for any policy or contract in policy or contract years two through four, exceeds the limit set forth in paragraph two, three or four, whichever is applicable, of subsection (d) of this section for that year or, with respect to any year after the fourth policy or contract year that exceeds the limit set forth in paragraph two, three or four of subsection (d) of this section for the fourth policy or contract year;

(B) A fund-based compensation arrangement that, for any policy or contract year, exceeds two percent of the fund annually in any of the policy's or contract's first four years;

(C) Any plan providing for a training allowance subsidy pursuant to the provisions of subparagraphs (A) through (F) of paragraph three of subsection (e) of this section;

(D) Any plan of agent or broker compensation other than commission-based and fund-based compensation pursuant to paragraph two of subsection (e) of this section; and

(E) Any plan involving the payment of an expense allowance, other than plans under which the company provides no goods and services to the recipient of the expense allowance payments and the expense allowance payments are described as percentages of qualifying first year premium,

excess premium, single consideration, or periodic consideration, or any of them, and none of the percentages exceeds the corresponding percentages set forth in paragraph five of subsection (d) of this section.

(7) "Contract" means an individual annuity contract. A rider to a contract will be treated as a separate policy or contract for all purposes hereunder, unless otherwise specified. The determination of a policy or contract type is done separately for each policy, contract and rider.

(8) "Debit life insurance" means all life insurance with premiums payable monthly or more frequently, normally collectible by an agency force organized to make systematic house to house collections of premiums.

(9) "Effective date" means the first day of January next succeeding the date on which this section shall have become a law.

(10) "Excess premiums" are premiums in the first policy year that exceed the benchmark gross level premium.

(11) "Expense allowance" is a payment to an agent or broker in lieu of reimbursement for expenses incurred in connection with the sale or servicing of the company's policies or contracts.

(12) "Filing" shall mean the delivery of information by a company to the superintendent or his designee concerning plans under which a company makes payments to its agents and to brokers.

(13) "Fund" is a policy or contract accumulation account or any other similar policy or contract value at a particular time, before application of any surrender charges and market value adjustments, if any, whether or not it is immediately available to the owner of a policy or contract. At the option of the company "fund" may mean the company's statutory reserve for the policy or contract.

(14) "General agent" is an agent who is appointed directly by a company, other than a local salaried representative of such company, who recruits, trains or supervises other agents or who has the right to appoint agents.

(15) "Goods and services" as used in this section shall refer to (A) reimbursements to an agent or broker for vouchered expenses made or incurred in connection with the production or servicing of policies or contracts on behalf of the company and (B) similar expenses assumed

directly by the company. These expenses do not include those that the company incurs for the recruitment, training, supervision or management of such agent, nor the cost of security benefits provided to such agent, nor those expenses described in item (iv) of subparagraph (D) of paragraph two of subsection (c) of this section.

(16) A "periodic premium policy" or "periodic consideration contract" is any policy or contract, respectively, other than a single premium policy or single consideration contract. The determination of a policy or contract type is done separately for each policy or contract.

(17) "Periodic premiums" and "periodic considerations" are premiums and considerations, respectively, recorded by a company for a policy or contract other than single premiums and single considerations.

(18) "Policy" means an individual life insurance policy. A rider to a policy will be treated as a separate policy or contract for all purposes hereunder, unless otherwise specified. The determination of a policy or contract type is done separately for each policy, contract and rider.

(19) "Premiums" and "considerations" include all amounts (including amounts for supplementary benefits) recorded for a policy or contract, except dividends applied to purchase additional insurance under the same policy, as well as amounts meeting the requirements of subparagraphs (B) and (C) of paragraph twenty-five of this subsection. Premiums and considerations include all amounts so recorded that arise from the application of values inherent in a policy or contract, such as dividend deposits, any excess of actual policy or contract cash values over guaranteed cash values, dividend additions, premiums paid in advance, and policy loans.

(20) A "qualified annuity contract" is an annuity defined by the Internal Revenue Code sections 401, 403 or 457, and any other similar annuities defined by the superintendent.

(21) "Qualifying first year premiums" are premiums under each policy, including all of its riders and benefits, which are:

(A) in the first policy year, premiums recorded, including the entire amount of a premium recorded in the first policy year of a conversion of a term policy or rider to a permanent policy up to the benchmark gross level premium for the policy, including all of its riders and benefits; or

(B) in any year after the first, premiums recorded up to the benchmark

gross level premium for the current face amount of the policy, including all of its riders and benefits, less the total previous qualifying first year premiums, but not less than zero; or

(C) all premiums recorded up to the benchmark gross level premium to renew a policy on more favorable terms than those guaranteed in the policy when such renewal is subject to new underwriting and a new contestable period.

(22) "Recorded" shall mean the crediting of an amount to the company's premium or consideration accounts for purposes of the company's statutory annual statement.

(23) "Renewal premiums" are all periodic premiums other than qualifying first year premiums or excess premiums.

(24) A "security benefit" is any benefit provided to an agent that is both (A) provided under an employee benefit plan, as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, et seq. and (B) either (i) a benefit under an employee benefit plan that qualifies as such under the relevant sections of the Internal Revenue Code and regulations thereunder that require compliance with standards of non-discrimination in benefit coverage and eligibility, or (ii) a benefit that does not permit an agent to obtain a cash payment other than at the time of death, permanent and total disability, or retirement. "Permanent and total disability" as used herein shall mean any condition caused by injury or disease that prevents the agent from performing substantially all of the work normally performed by the agent. If the definition of "employee benefit plan" under the Employee Retirement Income Security Act of 1974 is repealed, replaced or significantly amended, the superintendent shall promulgate a regulation establishing a definition for the purposes of this section. Benefits that would meet the requirements of subparagraph (A) or (B) of this paragraph but for the fact that the agent covered under such benefits is an independent contractor rather than an employee are security benefits.

(25) "Single considerations" are:

(A) all amounts (including amounts for supplementary benefits) recorded as single considerations or single deposits for contracts; or

(B) contract values that are applied under the same contract at the later of (i) the end of a surrender charge period or (ii) five years after issuance of the contract or, if a previous such application of

contract values has occurred, five years after such application, when such application results in new sales loads or surrender charges; or

(C) settlement option proceeds generated from the death of an individual or maturity of a policy or contract that are applied to purchase a new contract or that are applied to the purchase of annuity benefits under the existing contract.

(26) "Single premiums" are:

(A) all amounts (including amounts for supplementary benefits) recorded as single premiums for policies, except dividends applied to purchase additional insurance under the same policy; or

(B) policy values that are applied under the same policy at the later of (i) the end of a surrender charge period or (ii) five years after issuance of the policy or, if a previous such application of policy values has occurred, five years after such application, when such application results in new sales loads or surrender charges.

(27) A "single premium policy" or "single consideration contract" is a policy or contract that, according to its terms, provides for the payment of a single premium or consideration at time of purchase and no subsequent premiums or considerations during the life of the policy or contract. The determination of a policy or contract type is done separately for each policy, contract and rider.

(28) "Supplemental benefits" are any benefits provided as part of a policy or contract, whether by rider or otherwise, excluding life insurance coverage on named insureds under the policy.

(29) "Training allowance subsidy" is the excess of the amount that is paid to an agent under a training allowance plan over the amount that would be paid in commissions and expense allowance to an experienced agent, in the same sales force, producing the same sales of policies and contracts.

(c)(1) No company shall pay or incur in any calendar year total selling expenses as calculated hereunder in excess of its total selling expense limit referred to in paragraph four of this subsection, except that the total selling expense limit shall not apply to a company in any calendar year in which the company does not sell any policies or contracts subject to this section.

(2) Total selling expenses shall include the following expenses incurred directly or indirectly by the company, without regard to

whether they are incurred in the company's home office or in a field or regional office:

(A) commissions;

(B) the increase during the year in the amount of outstanding advances and loans to agents, including any accrued and unpaid interest thereon, and including amounts charged off by the company, however, if such amount is negative, it shall be treated as a reduction of the amount of total selling expenses;

(C) the expense of direct solicitation advertising that either includes an application or solicits a response to obtain an application for a policy or contract regulated under this section;

(D) distribution, marketing and sales support expenses directly related to the procurement of new business, which includes but is not limited to:

(i) recruiting and training of agents, including related recordkeeping;

(ii) sales management and supervision; and

(iii) clerical functions in sales offices;

(E) any expense allowance paid to the agent or broker by the company or any expenses of the agent, agency or broker, assumed or reimbursed by the company;

(F) the travel expenses, meals and entertainment paid for by the company; and

(G) all other compensation paid to or expense incurred on behalf of active and retired agents and brokers, including the cost of any security benefits.

(3) Total selling expenses shall not include expenses related to the following activities and the compensation of individuals working full-time on the following activities and other activities not included within paragraph two of this subsection, even if they are working in a sales office:

(A) development and maintenance of products, systems and software;

(B) medical examinations and inspections of proposed risks;

(C) underwriting;

(D) policy issue;

(E) policy conservation;

(F) premium billing and collection;

(G) policy administration;

(H) claim administration and management;

(I) investment management;

(J) statutory and regulatory filing and compliance;

(K) overall company management and direction;

(L) taxes, licenses and fees; and

(M) all other activities not related to selling.

(4) The total selling expense limit shall be the sum of the amounts determined pursuant to subparagraphs (A), (B), (C), (D), (E), (F), (G), (H), (I) and (J) of this paragraph, except as any of those subparagraphs may be adjusted pursuant to the provisions of subparagraph (K) of this paragraph.

(A) For each life insurance policy, fifty-five percent of the qualifying first year premium.

(B) Five percent of excess premiums, single premiums and all considerations.

(C) One hundred ten percent of the sum of the amount determined pursuant to subparagraphs (A) and (B) of this paragraph.

(D) For all new life insurance paid for during the year, other than term insurance for less than one year, for which any premium is paid during the year, one dollar for each one thousand dollars of such insurance. New life insurance paid for shall include:

(i) life insurance on new policies paid for during the calendar year;

(ii) life insurance on term conversions during the calendar year to permanent life insurance;

(iii) life insurance on policies which were renewed under more favorable terms than those guaranteed in the policy, subject to new underwriting requirements and new contestable period; and

(iv) increases in the death benefit of life insurance during the calendar year, other than those provided for in the policy, on policies in force.

(E) Seventy dollars for each new policy, other than policies for term insurance for less than one year, and for each new contract paid for during such year. For purposes of this subparagraph, riders will not be considered as separate policies or contracts. New policies paid for during the year shall include policies referred to in items (i), (ii) and (iii) of subparagraph (D) of this paragraph.

(F) Twelve percent of renewal premiums.

(G) Fifteen cents for each one thousand dollars of face amount of policies in force at the end of such year.

(H) The sum of the amounts below:

(i) one dollar for each one thousand dollars of the first one billion dollars of life insurance in force;

(ii) fifty cents for each one thousand dollars of the next one billion dollars of life insurance in force;

(iii) five one-hundredths of one percent of the first one billion dollars of annuity reserves; and

(iv) two and one-half of one hundredths of one percent of the next one billion dollars of annuity reserves.

(I) For each agent who qualifies under paragraph three of subsection (e) of this section, thirty thousand dollars for each such agent appointed to represent the company during the year, twenty thousand dollars for each such agent who was initially appointed during the immediately preceding year and is still contracted with the company on January first of the current year, and ten thousand dollars for each such agent who was initially appointed during the second preceding year and is still contracted with the company on January first of the current year.

(J) The excess, if any, of the total selling expense limit over the total selling expenses for the immediately preceding calendar year; however, such excess shall not exceed five percent of the total selling expense limit for such preceding calendar year, calculated without regard to the effect of this subparagraph.

(K) For a company that makes commitments to pay compensation to agents or brokers or to incur other agent-related or broker-related expense with respect to policies or contracts in their renewal years:

(i) with respect to policies, if such commitment includes compensation or other agent-related or broker-related expense expressed as a percentage of premium and if it exceeds twelve percent of premium with respect to any policy year after the first, the company may, at its option reduce the amount of the limit calculated pursuant to subparagraph (A) of this paragraph in the calendar year in which such policies are sold and increase the amount of the limit calculated pursuant to subparagraph (F) of this paragraph in subsequent calendar

years;

(ii) with respect to policies, if such commitment includes compensation or other agent-related or broker-related expense expressed as a percentage of the policy fund with respect to the second or any later policy year, the company may, at its option reduce the amount of the limit calculated pursuant to subparagraph (F) of this paragraph in subsequent calendar years and add, in such subsequent calendar years, an amount based on the reserves of such policies;

(iii) with respect to contracts, if such commitment includes compensation or other agent-related or broker-related expense expressed as a percentage of the contract fund with respect to any contract year, the company may, at its option, reduce the amount of the limit calculated pursuant to subparagraph (B) of this paragraph in the calendar year in which such contracts are sold and add, in such calendar year and subsequent calendar years, an amount based on the reserves of such contracts.

(L) Such adjustment shall:

(i) in the case of item (i) of subparagraph (K) of this paragraph, be based on the relationship that a reduction of three percent of premiums in the amount of the limit calculated pursuant to subparagraph (A) of this paragraph in the year of sale is equivalent to an increase of one percent of premiums in the amount of the limit calculated pursuant to subparagraph (F) of this paragraph if the commitment applies to all later policy years;

(ii) in the case of item (ii) of subparagraph (K) of this paragraph, be based on the relationship that a reduction of one percent of premiums in the amount of the limit calculated pursuant to subparagraph (F) of this paragraph in all later policy years is equivalent to an increase in the limit of fifteen one-hundredths of one percent of policy reserves if the commitment applies to all later policy years;

(iii) in the case of item (iii) of subparagraph (K) of this paragraph, be based on the relationship that a reduction of one-half of one percent of considerations in the amount of the limit calculated pursuant to subparagraph (B) of this paragraph in the year of sale is equivalent to an increase in the limit of fifteen one-hundredths of one percent of contract reserves if the commitment applies to all contract years.

The superintendent shall by regulation describe the bases for adjustments in other situations, consistent with these relationships. Reasonable use of averaging methods shall be allowed. In particular, the regulation shall provide that a company shall approximate the percentage of its policies, contracts, premiums, and reserves with respect to which it has opted to make such adjustments, and shall derive adjustment factors such that, when such factors are applied to all of its business issued or in force, they will approximate the results that would be obtained if more precise calculations were made.

(5) A company may make arrangements, such as entering into agent contracts, incurring expenses, and generally organizing its activities, in such a manner that some or all of its expenses are applicable partially to policies and contracts subject to this section and partially to other business or to other companies with which it has business arrangements and, in such cases, the company shall determine the portion of such expenses subject to this subsection by using an equitable basis of allocation, consistent with the company's allocation methodology for annual statement reporting.

(d) A company may pay agents and brokers as it sees fit for the sale and service of policies and contracts. However:

(1) No company shall pay or permit to be paid to an agent or broker a commission in excess of the sum of (A) fifty-five percent of any qualifying first year premium and (B) seven percent of any excess premium; or to a general agent with respect to business not personally produced by such general agent, a commission in excess of the sum of (C) sixty-three percent of any qualifying first year premium and (D) eight percent of any excess premium.

(2) Except as provided in paragraph four of this subsection, no company shall pay or permit to be paid to an agent or broker commission in excess of seven percent of any single consideration or any periodic consideration received in the first four contract years; or to a general agent, on business not personally produced by such general agent, a commission in excess of eight percent of any single consideration or any periodic consideration.

(3) No company shall pay or permit to be paid to an agent or broker a commission in excess of twenty-two percent of renewal premiums for the second policy year, twenty percent of renewal premiums for the third

policy year, or eighteen percent of renewal premiums for the fourth policy year; or to a general agent on business not personally produced by such general agent, a commission in excess of twenty-seven percent of renewal premiums in the second policy year, twenty-three percent of renewal premiums in the third policy and twenty percent of renewal premiums in the fourth policy year.

(4) Notwithstanding the limitations set forth in paragraph two of this subsection, with respect to a qualified annuity contract, no company shall pay or permit to be paid to an agent or broker a commission in excess of fourteen and one-half percent of periodic considerations incurred in the first contract year and four and one-half percent of periodic considerations incurred respectively in each of three contract years following the first, or to a general agent on business not personally produced by the general agent, a commission in excess of sixteen percent of periodic considerations incurred in the first contract year and six percent of periodic considerations incurred respectively in each of the three contract years following the first.

(5) With respect to premiums and considerations recorded within a period of twelve consecutive months on business written by any agent or broker, no company shall pay or permit to be paid to an agent or broker expense allowance greater than the excess, if any, of the sum of:

(A) ninety-one percent of all qualifying first year premiums; and

(B) with respect to qualified annuity contracts, fourteen and one-half percent of periodic considerations incurred in the first contract year; and

(C) seven percent of any excess premiums, single considerations and periodic considerations, other than those addressed in subparagraph (B) of this paragraph, incurred in the first four contract years,
over the sum of commissions paid pursuant to paragraphs one, two and four of this subsection, and the value of any goods and services provided to such agent or broker by the company. With respect to premiums and considerations recorded within a period of twelve consecutive months on business written under the supervision of any general agent, no company shall pay or permit to be paid to a general agent, on business not personally produced by such general agent, expense allowances greater than the excess, if any of the sum of

(D) ninety-nine percent of all qualifying first year premiums; and

(E) with respect to qualified annuity contracts, sixteen percent of periodic considerations incurred in the first contract year; and

(F) eight and one-half percent of any excess premiums, single considerations and periodic considerations, other than those addressed in subparagraph (E) of this paragraph, incurred in the first four contract years,

over the sum of commissions paid pursuant to paragraphs one, two and four of this subsection, and any goods and services provided to such general agent by the company. The company may, in implementing this subsection, use reasonable estimation techniques in arriving at the amount of goods and services, including but not limited to the estimation of the average value of goods and services provided to a group of agents or brokers to whom similar goods and services are provided.

(e) Notwithstanding any limitations set forth in subsection (d) of this section:

(1) (A) A company may compensate an agent or broker wholly or in part upon a plan that bases compensation on the fund underlying the policy or contract. For policies other than single premium policies, a company may pay up to three-tenths of one percent of the fund in each of policy years two through four for each one percent of premium by which the commission paid to the agent or broker in such policy years is less than the percentages set forth in paragraph three of subsection (d) of this section. For single premium policies and all contracts, a company may pay up to three-tenths of one percent of the fund in each of policy or contract years one through four for each one percent by which the sum of commissions and expense allowance paid to the agent or broker in policy or contract years one through four is less than the percentages set forth in subparagraph (C) or (D) of paragraph five of subsection (d) of this section, whichever is applicable.

(B) Any company may compensate an agent or broker on a plan of fund-based compensation using translations other than those set forth in subparagraph (A) of this paragraph, provided that the translation factors are equivalent to those set forth therein, based on reasonable and consistent assumptions as to mortality, policy or contract persistency and interest.

(2) (A) A company may compensate an agent or broker pursuant to a plan

of agent compensation that consists wholly or partly of elements other than commission-based compensation and fund-based compensation.

(B) When a company implements such a plan, it must be able to demonstrate, after the plan has been in operation for two years, that an agent or broker being compensated under the plan and meeting its requirements for continuation in the plan will receive no more compensation under the plan, over the period of a projected career, than could have been earned under a plan consisting entirely of commissions and expense allowance, each limited as described in subsection (d) of this section. In making this demonstration, the company may take into account commission compensation that would have been paid, under its renewal commission plans, with respect to policies and contracts in their fifth and later policy and contract years.

(C) To the extent that an agent being compensated under such plan is eligible to receive a training allowance under the provisions of paragraph three of this subsection, the comparison in subparagraph (B) of this paragraph shall take into account, as well, the amount of training allowance subsidy that could have been paid to such agent.

(D) To the extent that an agent or broker being compensated under such plan is assigned servicing responsibilities for policies or contracts that have been in force for more than four years, the comparison in subparagraph (B) of this paragraph shall take into account, as well, the renewal commissions that the company pays with respect to such policies and contracts.

(E) The comparison in subparagraph (B) of this paragraph shall be based on reasonable assumptions as to mortality, policy or contract persistency, and interest and agent or broker sales.

(F) If a company employs one or more salaried employees whose principal function is not the sale of new policies or contracts and not the supervision of agents or agencies, and if no more than twenty-five percent of the total compensation of such employees is related to business personally produced by such employees, the provisions of this subsection or subsection (d) of this section shall not apply to such employees' total compensation, notwithstanding that they may be licensed as life insurance agents.

(G) If a company compensates an agent or broker within the limits in subsection (d) of this section, and that agent or broker retains as

assistants other agents or brokers who are compensated by the agent or broker on the basis of a plan of compensation other than commissions, such arrangement between such agent or broker and that agent's or broker's assistant is not subject to the provisions of this subsection and subsection (d) of this section.

(3)(A) A company may pay reasonable training allowance subsidies to agents pursuant to a plan of agent compensation, provided that such agents are full-time agents of the company and the principal business activity of such agents is the solicitation of policies and contracts primarily but not necessarily exclusively for the company, and its affiliates, and such agents are not simultaneously receiving training allowance from any other life insurance company.

(B) Agents receiving training allowance subsidies may also receive expense allowance payments.

(C) An agent is eligible to receive such a training allowance subsidy, provided (i) such agent has earned less than forty thousand dollars from the sale of policies and contracts cumulatively during the three years prior to such agent's appointment, (ii) less than twenty-five percent of such agent's earned income has been received from the sale of policies and contracts during each of the three years prior to appointment, or (iii) less than twenty-five percent of such agent's worktime during each of the three years prior to appointment was allocated to individual life and annuity sales. The company may establish that an agent is eligible to receive a training allowance subsidy by requiring the agent to attest that such agent meets one of the criteria set forth in this subparagraph prior to appointment. Such attestation shall be sufficient to establish eligibility, provided the company does not have actual knowledge to reject the attestation based on the agent's credentials and background.

(D) An agent receiving such training allowance subsidies may not receive, on a cumulative basis, for an agent in the first year of such subsidies, the greater of fifty-four thousand dollars and sixty percent of the first year commission limit, and for an agent in the second year of such subsidies, the greater of eighty-five thousand dollars and sixty percent of the first year commission limit in the first year and forty percent of the first year commission limit in the second year, and for an agent in the third year of such subsidies, the greater of one hundred five thousand dollars and sixty percent of the first year commission

limit in the first year and forty percent of the first year commission limit in the second year, and twenty percent of the first year commission limit for the third year, and for an agent in the fourth year of such subsidies, the greater of one hundred sixteen thousand dollars and sixty percent of the first year commission limit in the first year and forty percent of the first year commission limit in the second year, twenty percent of the first year commission limit in the third year, and ten percent of the first year commission limit in the fourth year.

(E) With respect to any agent eligible to receive training allowance subsidy who has earned at least one hundred twenty-seven thousand dollars of income during either of the two calendar years immediately preceding commencement of receipt of training allowance subsidies, a company may pay additional training allowance subsidies of two thousand dollars to such agent during each of the first two years of his receipt of training allowance subsidies for every four thousand dollars of such earned income in excess of one hundred twenty-seven thousand dollars, provided that the cumulative training allowance subsidy does not exceed eighty-seven thousand dollars in such agent's first year of receipt of training allowance subsidy and provided further that the agent receives not greater than one hundred sixteen thousand dollars in total training allowance subsidies.

(F) For purposes of this paragraph, the period of time that a person worked for a company under a company-sponsored training program and was not acting as an agent for that company shall not be counted as time spent receiving training allowance subsidies, and any salary paid by the company to that person during that time shall not count toward the cumulative maximum training allowance subsidy.

(G) The superintendent shall periodically adjust the cumulative maximum training allowance subsidy limits set forth in this paragraph. The superintendent may also, at any time, approve training allowance subsidies with cumulative maximum amounts that exceed the limits set forth in this paragraph.

(H) A company may, upon approval of the superintendent, establish a plan for training allowance subsidies for which the conditions of eligibility or the amounts or periods of subsidy, of any of these, differ from those set forth in this subsection. The superintendent shall approve such a plan, subject to such conditions as he may prescribe, if

he finds that it is likely to meet the objective of developing new agents for the sale of policies or contracts or both in a cost-effective manner.

(4) A company may pay additional compensation to a general agent pursuant to a plan of agent compensation for a period not exceeding ten years; provided, however, that if such general agent has had prior service as a general agent or agency manager, with any life insurance company or companies, whether as an individual, partner or officer of a corporation, and such prior service was for a period of less than five years, additional compensation may be paid only during the balance of such five years, but if such prior service was of five years duration or more, then no additional compensation may be paid; provided, further, that the company shall not permit to be paid expense allowances to agents under his supervision on business written while such additional compensation is paid in excess of those permitted to agents pursuant to paragraph five of subsection (d) of this section. For the purposes of this paragraph only, service as a general agent or agency manager shall not include service as an assistant general manager, assistant agency manager, agency supervisor, or service in a similar position regardless of its title. The additional compensation in the sixth year of the period shall not be in excess of twenty percent of the first year commission limit of the business of the agency, sixteen percent in the seventh year of the period, twelve percent in the eighth year of the period, eight percent in the ninth year of the period and four percent in the tenth year of the period, and shall not be payable pursuant to a plan of agent compensation on any business personally obtained by such general agent.

(5) The cost of all security benefits provided to agents shall not be included in applying the limits established in subsection (d) of this section.

(6) A company, including any person, firm or corporation on its behalf or under any agreement with it, may pay or award, or permit to be paid or awarded, prizes and awards to agents and brokers pursuant to a plan of agent or broker compensation, provided that no single prize or award may exceed a value of five hundred dollars, and that the total value of such prizes and awards paid or awarded to any agent or broker within a calendar year may not exceed two thousand dollars. Notwithstanding the

foregoing, a company may also pay or award not more frequently than monthly a prize or award valued at not more than fifty dollars. The costs of all such prizes and awards shall not be included in applying the limits established in subsection (d) of this section. The superintendent may authorize higher limits on the value of prizes and awards than those set forth herein.

(7) A company may conduct agent conventions, conferences and business meetings, and no portion of the expenses associated with agent conventions, conferences or business meetings, nor the value thereof, will be considered to be a prize or award, or additional commissions or compensation, or a payment pursuant to an expense allowance plan, a direct payment of an expense or an assumption of any expense for purposes of paragraph five of subsection (d) of this section, or any other type of compensation or payment described in this subsection or subsection (d) of this section, if, for conventions, conferences or business meetings held in the United States, a company's expenses for same meet the Internal Revenue Code's current standard for ordinary and necessary business expenses and

(A) are not includable in the recipient's gross income for federal income tax purposes, and

(B) represent reasonable allowances for agents' incidental ordinary and necessary business expenses associated with the convention, conference or business meeting, such as meals, local transportation and similar items, and for conventions, conferences and business meetings held outside the United States, a company's expenses for same would have met those current standards if the convention, conference or business meeting was held within the United States. The expenses paid by a company shall be included in the limit established in subsection (c) of this section. Any portion of such expenses paid by a company that do not comply with this paragraph must be considered to be compensation hereunder and, if not recovered from the recipient, charged against the limits of subsection (d) of this section in the year the expense is incurred.

(8) A company that, with respect to any policy or contract year, pays an agent or broker with respect to the business of that agent or broker a commission based on a percentage lower than the percentage set forth in paragraph one, two, three or four of subsection (d) of this section,

whichever is appropriate, for such policy or contract year may, with respect to any later policy or contract year of the same policy or contract, pay the agent or broker (or a successor agent or broker to whom the policy or contract has been assigned) a commission based on a higher percentage than the percentage set forth in paragraph two, three or four of subsection (d) of this section, whichever is appropriate, for such later policy or contract year, to the extent that the total of the percentages on which actual commissions were calculated in the preceding policy or contract years was lower than the total of the percentages set forth in paragraph one, two, three or four of subsection (d) of this section, whichever is appropriate, for such preceding policy or contract years.

(9) (A) A company may make an advance to any of its agents pursuant to a plan of agent compensation. A company may, but is not required to, charge interest on outstanding advances.

(B) A company may make a loan to any of its agents pursuant to a plan of agent compensation. The maximum amount of any loan shall not exceed the expected compensation of the agent over the next twelve months. A company shall charge interest on loans at a rate not less than a rate consistent with current short-term borrowing rates. If the interest rate charged on a loan is less than a rate consistent with current short-term borrowing rates, the amount by which the interest actually charged is lower than the interest that would have been charged based on a rate consistent with current short-term borrowing rates, the difference will be subject to the limits of either paragraph one, two, four or five of subsection (d) of this section.

(C) A company shall secure adequate collateral for any advance or loan to an agent; such collateral shall, as a minimum, consist of any compensation earned by the agent from sales of new policies or contracts.

(10) (A) If a broker or an agent who is not a general agent performs services for a company other than those related to the sale or servicing of a policy or contract, or if a general agent performs services for a company other than those related to the sale or servicing of a policy or contract, or the recruiting, training or supervision of agents, the company may compensate the broker or agent for the performance of such services. Such payments are not subject to the limits in subsection (d)

of this section. No company shall pay or cause to be paid to any broker or agent for the services described herein, any amounts that exceed the reasonable value of the services performed.

(B) If an agent of a company also performs the duties of a local salaried representative of such company, the company may compensate the agent within the limits of this section with respect to policies or contracts sold or serviced by such agent for which agent compensation is subject to the limits of this section, and may also compensate such agent for services performed as a local salaried representative of the company; however, such compensation as a local salaried representative shall not include any compensation with respect to policies or contracts sold or serviced by such agent.

(11) If a company pays an agent or a general agent for the production of policies or contracts issued by the company, the company shall not be required to monitor for compliance with this section the payments and allowances paid by such agent or general agent to any agent or general agent with respect to such policies or contracts if the agent or general agent receiving such payments:

(A) receives no company-provided security benefits;

(B) does not receive additional compensation as permitted by paragraph four of this subsection, compensation or expense allowance from a paying entity that itself is receiving additional compensation from the company as permitted by paragraph four of this subsection;

(C) receives no prizes or awards from the company; and

(D) is not eligible to qualify for attendance at company-sponsored agent conventions, conferences, or business meetings based on the amount of business produced by such agent or general agent.

(12) A company that, with respect to premiums and considerations recorded within a period of twelve consecutive months on policies or contracts written by any agent or broker pursuant to a plan of agent or broker compensation, pays an agent, general agent or broker an amount of expense allowance smaller than the limiting amount defined in paragraph five of subsection (d) of this section, may pay the agent, general agent or broker, in any later twelve month period or periods, the amount by which the amount of expense allowance paid in the prior period was less than the limiting amount, provided such agent, general agent or broker still is engaged in selling or servicing the company's policies or

contracts pursuant to one of the company's compensation or expense allowance plans. Such subsequent payments may be made in addition to any expense allowance payments for which the agent, general agent or broker is otherwise eligible within the limits of paragraph five of subsection (d) of this section for such subsequent period.

(13) Notwithstanding any limitation or restriction imposed by this section, the superintendent may approve compensation arrangements for any company to permit it to compensate its agents or brokers, or any of them, in whole or in part, upon any plan other than those described in this section, provided that the aggregate limits imposed in subsection (c) of this section are not exceeded and that the limits in subsection (d) of this section are generally observed over policy years and agent careers.

(14) A company may, but is not required to, use annualization in calculating any of the limits set forth in this section.

(f) (1) Filing requirements for agent and broker compensation plans are as follows:

(A) A company shall make annual information filings with respect to any newly-introduced plans or changes under which the company makes payments to agents or brokers if such plans are commission plans for which the commission percentages are, in all policy or contract years, no greater than the commission percentages set forth in paragraphs one, two, three and four of subsection (d) of this section, expense allowance plans other than those meeting the definition of a compensation arrangement, plans subject to the provisions of paragraph one of subsection (e) of this section under which compensation is not in excess of two percent of the fund annually in any of the first four policy or contract years, or plans subject to the provisions of paragraph four of subsection (e) of this section. These filings shall consist of a summary of information in enough detail to generally describe the filing content, and shall be made not later than the last day of February next following the year in which such plans were placed in use or changed. The first such filing shall be due not later than the last day of February following the end of the year which includes the effective date of this section.

(B) Filings are required on or before the effective date of any changes to compensation arrangements as defined in this section, or to

plans described in paragraphs one and two of subsection (g) of this section. These filings shall consist of a summary of information in enough detail to generally describe the filing's contents. A company may implement such compensation arrangements immediately upon filing same. If the superintendent notifies the company within ninety days of the receipt of the filing, that in his opinion the compensation arrangement described in such filing is not permitted under the law, and if the company within sixty days of the superintendent's notice, is not able to satisfy the superintendent's concern, with or without modifying the plan, the superintendent may order the company to cease using the plan. The company may request a formal hearing, but the plan that is the subject of the hearing may not be used unless and until permitted as a result of the hearing.

(C) Filings for prior approval of the superintendent are required before plans described in subparagraph (B) of paragraph one, subparagraph (H) of paragraph three and paragraphs twelve and thirteen of subsection (e) of this section can be used. The filings will consist of descriptive information, including assumptions and techniques when applicable, in enough detail for the superintendent's review. Plans not approved or disapproved by the superintendent within ninety days following their filing will be deemed approved.

(D) For plans described under subparagraphs (A), (B), (C) and (D) of paragraph two of subsection (e) of this section, if the plan is still to be used six months after the end of the two year period described in subparagraph (B) of paragraph two of subsection (e) of this section, the company must, within six months after the end of the two year period, make a filing with the superintendent and obtain his approval for the continued use of the plan.

(E) All filings and related correspondence shall be proprietary and confidential, and not disclosed by the superintendent.

Changes whose effect is to reduce or not increase the compensation payable to every individual covered by the arrangement in each and every year, need not be filed with the superintendent, but must be maintained in the company's records for at least six years.

(2) The annual statement schedule for reporting compliance on an aggregate basis with subsection (c) of this section shall be signed by a knowledgeable officer of the company. The signing of the schedule shall

be deemed confirmation by the officer that the officer has performed a personal review of the information included and responses provided to the interrogatories. The signature is to be preceded by the following statement: "I have reviewed the sources of total selling expenses and, to the best of my knowledge and belief, on the basis of the projected experience over the next three years based on reasonable assumptions, including changes currently being contemplated, the company's expenses will not exceed the limit imposed thereon by New York Insurance Law Section 4228." If the officer cannot attest to the final clause of this statement, the officer must disclose the year or years in which expenses are expected to exceed the limit and the amount by which the limit is expected to be exceeded.

(3) Any company that exceeds the limit in subsection (c) of this section in any year shall:

(A) File a plan of action with the superintendent by June thirtieth of the following year, which shall:

(i) describe actions the company will take promptly to bring expenses into compliance; and

(ii) demonstrate how the company will meet the limit in the second year following the year the company first exceeded the limit and will remain under the limit in the next subsequent year;

(B) Monitor the company's progress under such plan of action and immediately notify the superintendent if at any time it appears that compliance will not be accomplished as planned; and

(C) Report the company's interim progress during the period described in item (ii) of subparagraph (A) of this paragraph as frequently as the superintendent may request.

(4) (A) If the superintendent finds that any plan of action filed pursuant to paragraph three of this subsection will not cause the company to comply with the limit in subsection (c) of this section, or that the company is not itself complying with the provisions of such a plan of action, the superintendent may impose controls on the company's activities, such as limitations on recruiting or production incentives, or a requirement that projections of experience anticipated for compensation arrangements be submitted to the superintendent prior to the introduction of new, or changes to existing, compensation arrangements, until such company meets that limit.

(B) In addition to the actions set forth in subparagraph (A) of this paragraph, and upon finding that a company's actions constitute a willful violation of the provisions of subsection (c) of this section, the superintendent is authorized to impose a fine on the company in an amount not to exceed the lesser of one million dollars or one-half of one percent of the company's total selling expense limit for the most recent calendar year, and the superintendent may impose controls as described in subparagraph (A) of this paragraph until the completion of a year in which the company meets the limit in subsection (c) of this section. For purposes of determining the amount of the fine in any one proceeding, each day or each act of a continuing willful violation shall not be deemed a separate and distinct violation.

(C) Any action under subparagraph (A) of this paragraph or any fine or penalty under subparagraph (B) of this paragraph shall be ordered by the superintendent only after notice and hearing.

(5) Any company making one or more payments that exceed any limit in subsection (d) of this section that is unable to recover such excess payments shall notify the superintendent within ninety days of the date that it learns or realizes that it exceeded the limit; however, if the company recovers such excess payments prior to the required notification date, or, for agents or brokers who are no longer appointed with the company, the company has made reasonable efforts to recover such excess payments, it need not make such notification. At that time, the company shall report the reason the company exceeded the limit, the number of agents and brokers to whom payments in excess of the limit were made, and the amount of money paid in excess of the limit, and shall describe the actions the company will take promptly to prevent any further instances of it exceeding this limit.

(A) If the superintendent finds that the company is not taking the actions it described to prevent any further instances of exceeding a limit in subsection (d) of this section, the superintendent may require that the company file for prior approval future changes to compensation arrangements and plans, for a period not to exceed one year.

(B) In addition to the actions set forth in the preceding subparagraph, and upon finding that a company's actions constitute a willful violation of the provisions of subsection (d) of this section, the superintendent is authorized to impose a fine on the company in an

amount not to exceed the lesser of one thousand dollars per violation or three times the amount of any overpayments that are found to constitute a willful violation.

(C) Any action under subparagraph (A) of this paragraph or any fine or penalty under subparagraph (B) of this paragraph shall be ordered by the superintendent only after notice and hearing.

(g) The following rules shall apply, beginning on the effective date of this section, for the periods of time indicated in this subsection:

(1) With respect to commissions paid by the company to an agent subsequent to the fourth policy or contract year on business in force on the effective date of this subsection, any increase in such commission within four years of the effective date of this subsection, provided the increase is contingent upon the volume of new business written by such agent, in excess of one percent of periodic premiums and considerations incurred in each such year with respect to such business in force on the effective date of this subsection, shall be treated as expense allowance payments in determining the maximum amount of expense allowance that can be paid to such an agent in that year.

(2) With respect to fund-based compensation paid by the company to an agent subsequent to the fourth policy or contract year on business in force on the effective date of this subsection, any increase in such fund-based compensation within four years of the effective date of this subsection, provided the increase is contingent upon the volume of new business written by such agent, in excess of three-tenths of one percent annually of the funds of such policies or contracts, shall be treated as expense allowance payments in determining the maximum amount of expense allowance that can be paid to such agent in that year.

(3) Any company that, as of any part of the year before the effective date of this subsection, was using a plan approved by the superintendent for any plan of renewal commissions, including such plan that, in whole or in part, conditions the payment of such commissions upon the efficiency of service of the agent receiving the commissions or upon the amount and quality of the business renewed under his supervision, may, notwithstanding the limits of paragraph three of subsection (d) of this section, continue to employ such plan, consistent with the terms of its approval, for a period of four years after the effective date of this subsection.

(4) A company may, for a period of one year after the effective date of this subsection, continue to employ any plan of compensation, including any expense allowance plan, that it was using as of the effective date, unless the superintendent shall determine that such plan was not approvable at the time it was placed in effect.

(5) For the first year after the effective date, the total selling expense limit described in subsection (c) of this section shall be increased by five percent of the sum of the amounts determined pursuant to subparagraphs (A), (B), (C), (D), (E), (F), (G), (H), and (I) of paragraph four of subsection (c) of this section.

(h) No company shall offer for sale any life insurance policy form or annuity contract form covered by this section or any debit life insurance policy form which shall not appear to be self-supporting on reasonable assumptions as to interest, mortality, persistency, taxes, agents' and brokers' survival and expenses resulting from the sale of the policy or contract form. For all such forms offered for sale in this state, and for all forms filed for use outside this state by domestic life insurance companies, a statement that the requirements of this subsection have been met, signed by an actuary who is a member in good standing of the American Academy of Actuaries and meets the requirements prescribed by the superintendent by regulation shall be submitted with each such life insurance policy or annuity contract form filed pursuant to paragraph one or six of subsection (b) of section three thousand two hundred one of this chapter. A demonstration supporting each such statement, signed by an actuary meeting such qualifications, shall be retained in the company's home office, while such form is being offered in this state and for a period of six years thereafter and be available for inspection. The superintendent shall promulgate a regulation establishing the guidelines applicable to such demonstration.

§ 4230. Salaries and pensions to officers and employees. (a) No domestic life insurance company shall pay any salary, compensation or emolument in any amount to any officer, deemed by a committee or committees of the board to be a principal officer pursuant to subsection (b) of section one thousand two hundred two of this chapter, or to any salaried employee of the company if the level of compensation to be paid

to such employee is equal to, or greater than, the compensation received by any of its principal officers, or to any trustee or director thereof, unless such payment be first authorized by a vote of the board of directors of such company.

(b) (1) No such company shall make any agreement with any of its officers or salaried employees whereby it agrees that for any services rendered or to be rendered he or she shall receive any salary, compensation or emolument that will extend beyond a period of sixty months from the date of such agreement, except that payment of the salary or other compensation of any of its officers or employees, other than a mechanic, worker or laborer, may by written contract be deferred beyond such period of sixty months, which contract may include conditions to be met by such officer or employee before payment will be made.

(2) Paragraph one of this subsection shall not apply to contracts by the company with its agents for the payment of first year or renewal commissions and additional compensation as provided in section four thousand two hundred twenty-eight of this article.

(3) Paragraph one of this subsection shall not apply to any long-term incentive compensation plan offered to any officer or employee of such company which has been approved by the board of directors, is based in whole or in part upon the financial performance of the company and is submitted for informational purposes to the superintendent prior to its implementation.

(c) No principal officer or employee of the class described in subsection (a) hereof who is paid a salary for his services shall receive any other compensation, bonus or emolument from such company, directly or indirectly, except in accordance with a plan recommended by a committee of the board pursuant to subsection (b) of section one thousand two hundred two of this chapter and approved by the board of directors.

(d) No such company shall grant any pension to any officer, trustee or director thereof or to any member of his family after his death, except that such company may pursuant to the terms of a retirement plan adopted by the board of directors of such company, provide for any person who is or has been a salaried officer or employee of such company, a pension payable at the time of his retirement by reason of age or disability,

and also life insurance benefits payable at his death.

§ 4231. Policyholder's participation in surplus of life insurance companies. (a) (1) Except as herein otherwise provided, every domestic life insurance company shall ascertain and distribute annually, and not otherwise, the proportion of any surplus accruing upon every participating insurance policy and annuity or pure endowment contract entitled as hereinafter provided to share therein, issued on or after the first day of January, nineteen hundred seven.

(2) Upon the thirty-first day of December of each year, or as soon thereafter as practicable, every such company shall ascertain the surplus earned by it during such year.

(3) After setting aside from such surplus such sums as may be required for the payment of authorized dividends upon the capital stock, if any, such sums as may properly be held for account of outstanding deferred dividend policies, if any, and such sums as may be deemed advisable for the accumulation of a surplus not in excess of the maximum prescribed in this chapter, every such company shall thereupon apportion the remainder of such earnings, if any, derived from participating policies and contracts, equitably to all policies or contracts entitled to share therein during the full dividend year adopted by the company for such purpose. Such apportionment shall not after the first policy year be made contingent upon the payment of the whole or any part of the premium for any subsequent policy year.

(4) No dividend shall be apportioned or distributed for the first policy or contract year unless, upon reasonable assumptions as to expenses, mortality, policy and contract claims, investment income and lapses, it was actually earned for such year; nor shall any such company defer the apportionment and distribution of dividends beyond the calendar year following that in which they were earned, except that any such company which in good faith apportions and distributes its divisible surplus (except on policies issued on a deferred dividend basis prior to the first day of January, nineteen hundred seven, and continued as such thereafter) on an annual basis as dividends to all classes of policies and contracts entitled to share therein, may apportion and distribute all or any part of its accumulated surplus, in

excess of its required minimum surplus, as a part of its dividends apportioned and distributed on an annual basis, or, with the approval of the superintendent, at reasonable intervals with respect to any policy or contract or on its termination by death, maturity or surrender, as additional or extra dividends in an amount deemed by him not inequitable in proportion to the annual dividends paid in preceding years on such policies or contracts. When this apportionment and distribution at reasonable intervals, for a class of industrial life insurance policies, takes the form of an equitable addition to the death benefit, the superintendent need not require any addition to the cash surrender values of the policies, anything in this chapter to the contrary notwithstanding.

(5) Dividends apportioned as aforesaid in the case of a policy or contract, other than an industrial life insurance policy, issued on or after the first day of January, nineteen hundred seven, shall, unless otherwise provided in the policy or contract, be payable at the option of the company, either upon the anniversary of the policy or contract next after each thirty-first day of December, or upon the anniversary of the policy or contract next following each thirtieth day of April; and in every case after the first policy or contract year shall be payable upon the sole condition that premium or stipulated payments of the policy or contract year current upon said respective dates shall have been completed.

(b) (1) Except as hereinafter provided, the dividend so apportioned in the case of any participating policy or contract issued on or after the first day of January, nineteen hundred seven, shall, at the option of the person entitled to elect such option, be either:

(A) payable in cash except that cash payment will not be required for a policy or contract qualified for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code to the extent that such payment would prevent such qualification or for a policy or contract with respect to which the superintendent has determined that cash payment of dividends would be inappropriate, or

(B) applicable to the payment of any premium or premiums upon said policy or contract, or

(C) applicable to the purchase of a paid-up addition thereto, or

(D) permitted to accumulate to the credit of the policy or contract,

at such rate of interest as shall be allowed by the company, and, with such interest shall be payable upon the maturity of the policy or contract, or shall be withdrawable in cash on any anniversary of the date of issue thereof.

(2) Where subparagraph (A) of paragraph one hereof has been selected and payment cannot be effected by the company, the funds shall be applied under option subparagraph (C) or (D) of such paragraph, as determined by the company.

(3) Such company shall, unless an election has previously been made, require such person to elect the manner in which such dividends shall be applied, as above provided, by mailing a written notice of the amount of the said dividends and the options available as aforesaid in a sealed envelope in the manner required by paragraph one of subsection (b) of section three thousand two hundred eleven of this chapter.

(4) In case the person entitled to elect such option shall fail to notify the company in writing of his election within three months after the date of the mailing of said notice, the dividends shall, except as otherwise herein provided, be applied by the company pursuant to the option specified in subparagraph (C) of paragraph one hereof.

(5) In the case of any extended term or reduced paid-up insurance, the dividends so apportioned shall be applicable as provided in the policy with the approval of the superintendent.

(6) In the case of any individual term policy and of every individual participating annuity, other than an annuity described in paragraph eight of this subsection, or pure endowment contract, the dividends so apportioned shall be applicable, at the election of the holder of such policy or contract, in accordance with the options specified in subparagraph (A) or (B) of paragraph one of this subsection or if the policy or contract so provides, subparagraph (D) of paragraph one of this subsection. In the case of any such term policy or annuity or pure endowment contract, the requirement as to notice of election hereinbefore specified shall be applicable, but the option which shall be applied in case the holder of such contract fails to make such election shall be determined by the company with the approval of the superintendent.

(7) In the case of any participating group policy of life insurance or any participating group or blanket policy of accident and health

insurance, or of any participating group annuity contract, other than an annuity described in paragraph eight of this subsection, the dividend so apportioned shall, at the option of the policyholder or holder of the master contract, be applied pursuant to subparagraph (A) or (B) of paragraph one of this subsection. Any dividend so apportioned on any such participating group insurance policy, or any rate reduction made or continued on any non-participating group insurance policy for the first or any subsequent year of insurance under any such policy issued to an employer, may be applied to reduce the employer's part of the cost of such policy, except that the excess, if any, of the employees' aggregate contribution under the policy over the net cost of the insurance shall be applied by the employer for the sole benefit of the employees.

(8) In the case of any individual or group participating immediate annuity and of any individual or group participating deferred annuity in which each consideration paid into the annuity purchases guaranteed paid-up annuity benefits determined at the time the consideration is paid, the dividend so apportioned shall be applicable, at the election of the holder of the individual contract or group certificate, in accordance with the options specified in subparagraph (A), (B) or (C) of paragraph one of this subsection or if the contract or certificate so provides, subparagraph (D) of paragraph one of this subsection.

(c) (1) In the case of participating industrial life insurance policies, the provisions of subsection (b) hereof specifying the options available to the policyholder with respect to the mode of application or payment of such dividends, and requiring notice of such options, and specifying the option effective in the absence of election, shall not be applicable.

(2) The dividends apportioned on such policies pursuant to this section shall be distributed annually except as provided in subsection (a) hereof in such manner as may be determined by the company, with the approval of the superintendent. Such dividends shall be paid or applied upon the first day of January of each year upon the sole condition that the premium payments for the next preceding calendar year have been completed, except that the company may, at its option, exclude the premium payments within the period of grace as a condition for payment or application of such dividends.

(3) Participating endowment policies which, by their terms, mature in

twenty or more years and which are for amounts of less than one thousand dollars and which are subject to the provisions of section three thousand two hundred three of this chapter, may be issued without including the provisions of subsection (b) hereof specifying the option available to the policyholder with respect to the mode of application or payment of such dividend, and requiring notice of such option and specifying the option effective in the absence of application, and if so issued the dividend shall be paid in cash.

(d) In addition to all other grounds provided in or pursuant to this chapter for the refusal to issue or renew a license to do business in this state and for the revocation of an existing license to do business in this state, no foreign or alien life insurance company shall be or continue to be authorized to do business in this state, unless it shall provide in every participating life insurance policy and in every participating annuity or pure endowment contract issued or delivered by it in this state that the proportion of the divisible surplus accruing upon such policy or contract shall be ascertained and distributed annually and not otherwise, except as otherwise provided in this section for domestic life insurance companies.

(e) (1) Any domestic mutual life insurance company may issue on a non-participating basis, subject to the other requirements of this chapter, any policies and contracts described in paragraph two of subsection (g) of this section and deferred annuity contracts providing a period of deferment of annuity payments not in excess of one year. No domestic mutual life insurance company shall issue non-participating policies or contracts, other than those specified in the preceding sentence, unless it has a special revocable permit from the superintendent to do so. Any such company may apply to the superintendent for such a permit. Such application shall be in the form prescribed by the superintendent and contain or be accompanied by a statement showing the manner in which any general outlays of the company are to be apportioned to participating and non-participating business and such other information as the superintendent may require for the purpose of determining whether its methods of operation are fair and equitable to its participating and non-participating policyholders. Such company shall keep separate books and records of its participating and non-participating business. The superintendent may prescribe the form in

which such books and records shall be kept.

(2) Within the meaning of this subsection any domestic stock life insurance company shall be deemed to be a domestic mutual life insurance company if and after ninety-five percent or more of its outstanding capital stock is, pursuant to section seven thousand three hundred two of this chapter or any former insurance law, held in trust for the exclusive benefit of the holders of the policies and contracts of such insurance company.

(3) Foreign or alien mutual life insurance companies authorized to do business in this state may deliver or issue for delivery in this state non-participating policies and contracts of the same kinds and subject to the same requirements provided for domestic mutual life insurers in paragraph one of this subsection.

(f) (1) No domestic stock life insurance company shall deliver or issue for delivery in this state both participating and non-participating policies or contracts and no foreign or alien stock life insurance company shall deliver or issue for delivery in this state any participating policy or contract unless it has a special permit from the superintendent to do so.

(2) Any such company authorized to do business in this state may apply to the superintendent for such a permit. Such application shall be in the form prescribed by and contain information the superintendent requires. Such application shall contain or be accompanied by:

(A) If such applicant has done any participating business prior to the making of such application, a statement showing the profits and losses, expense limits and expenses with reference to its participating and its non-participating business, if any, and the manner in which any general outlays of the company have been and are being apportioned to each of such kinds of business, and such other information as the superintendent may require for the purpose of determining whether its method of operation is fair and equitable to its participating policyholders.

(B) An agreement by such company, evidenced by a resolution of its board of directors or other appropriate body having power to bind such corporation and its shareholders, to the effect that, so long as any outstanding participating policies or contracts of such company are held by persons resident in the state of New York, no profits on participating policies and contracts in excess of the larger of ten

percent of such profits, or fifty cents per year per thousand dollars of participating life insurance other than group term insurance in force at the end of the year, shall inure to the benefit of the stockholders; and that the profits on its participating policies and annuity contracts shall be ascertained by allocating to such policies and annuity contracts specific items of gain, expense or loss attributable to such policies and contracts and an equitable proportion of the general gains or outlays of the company.

(3) (A) Upon the filing of such application and accompanying documents, the superintendent may, in his discretion, issue a revocable permit to such company authorizing it to issue participating policies and contracts in this state.

(B) If the superintendent finds, after notice and hearing, that any such company has failed to comply with the agreement specified in subparagraph (B) of paragraph two hereof, he may, in his discretion, revoke the permit of such company to do a participating business in this state, and he may, in addition thereto, in the case of a domestic stock life insurance company, order such company to cease issuing any new participating policies elsewhere in the continental United States, and in the case of a foreign or alien company, order such company to cease issuing any new policies in this state.

(C) Any violation of such an order shall constitute a violation of this chapter.

(4) (A) In every annual statement made by any such company to the superintendent after the issuance of such permit, and so long as its agreement pursuant to subparagraph (B) of paragraph two hereof is in force, such company shall exhibit the amount of participating policyholders' surplus.

(B) Such participating policyholders' surplus shall be used only for the payment or apportionment of dividends to participating policyholders at least to the extent hereinbefore required, or for the purpose of making up any loss on the participating policies of such company.

(C) Nothing herein contained shall be deemed to give any class of policyholders priority with respect to the assets of any such company in liquidation.

(5) This subsection shall not apply to any foreign or alien stock life insurance company if and after ninety-five percent or more of its

outstanding capital stock is wholly owned by a non-profit corporation, or by any other person or persons, who or which holds such stock in trust for the exclusive benefit of the holders of the policies and contracts of such insurance company; but no such insurance company shall be authorized to do business in this state if it thereafter issues any new non-participating policies or contracts, except as provided in subsection (g) hereof.

(g) (1) The inclusion in any life or accident and health insurance policy, or in any annuity or pure endowment contract, or in any funding agreement, of any provision to the effect that the owner thereof shall participate in the surplus of the company issuing such policy or contract, shall be deemed to make such policy or contract a participating one, with the following exceptions:

(A) Both participating and non-participating policies or contracts or agreements may provide that in addition to any rate of interest guaranteed by the issuing company to be paid on deferred payments of the proceeds thereof, additional interest may be paid thereon at such rate as the company may annually declare.

(B) Any policy or contract subject to section four thousand two hundred twenty-one or section four thousand two hundred twenty-three of this article may provide that, in addition to any minimum benefits guaranteed in the contract, additional amounts may be credited to the policy or contract in accordance with section four thousand two hundred thirty-two of this article or section four thousand five hundred eighteen of this chapter. The inclusion of any such provision in any non-participating policy or contract shall not be deemed to make the policy or contract participating and the crediting of such additional amounts in accordance with the preceding provisions to any participating policy or contract shall not be deemed to be a distribution of surplus under subsections (a) and (b) of this section.

(C) Any policy of insurance or contract of annuity providing for readjustment of the rate of premium, consideration, or deposit under the provisions of paragraph two of subsection (c) of section four thousand two hundred sixteen, or of paragraphs one and two of subsection (j) of section four thousand two hundred thirty-five, or of subsection (d) of section four thousand two hundred thirty-eight of this article shall not, solely because of such rate readjustment provision, be deemed

participating.

(D) Any individual life policy issued or delivered in this state may provide for prospective readjustment of the rate of premium, but the readjustment may not cause the readjusted premium to exceed the maximum guaranteed premium rate stated in the policy. The readjustment shall be determined upon reasonable assumptions as to expenses, mortality, policy and contract claims, taxes, investment income and lapses. The readjustment shall be on a basis equitable to all policy and contract holders and shall be based on written criteria approved by the board of directors of the company or a committee thereof. The rate readjustment provision shall not be deemed to make the policy participating.

(E) Readjustments in the rate of premium or stipulated contribution or consideration or deposit for any insurance policy or annuity or pure endowment contract or funding agreement, issued or delivered by a domestic life insurer within or without this state, shall be determined on the basis which is equitable to all policy or contract holders and shall be based on written criteria approved by the board of directors of the company or a committee thereof. The readjustment shall be determined upon reasonable assumptions as to expenses, mortality, policy and contract claims, taxes, investment income and lapses. Such a readjustment shall not be deemed to be a distribution of surplus under subsections (a) and (b) of this section.

(2) This section shall not require the apportionment or distribution of dividends on any deferred annuity contract for the period following the period of deferment of annuity payments, in accordance with the provisions of such contract, nor on extended term insurance, or pure endowment, which takes effect in the case of default in the payment of a premium or payment on any policy or contract, nor on any dividend additions nor on any contract or agreement of reinsurance, nor on any group annuity contract providing deferred annuities for a class or classes of participants in a pension or profit sharing plan qualified under subsection (a) of section four hundred one of the United States internal revenue code (or comparable law of any other jurisdiction) who have terminated their participation under such plan, or with respect to which class or classes further contributions have been discontinued under the plan and notice of such discontinuance has been given to the commissioner of internal revenue (or regulatory authority of such other

jurisdiction).

§ 4232. Amounts credited on certain contracts or life insurance policies. (a) (1) If any contract subject to section four thousand two hundred twenty-three of this article, provides for additional amounts to be credited to the contract during any period in accordance with the provisions of paragraph one of subsection (g) of section four thousand two hundred thirty-one of this article, then any additional amounts to be so credited must be determined for each year during such period. Except as otherwise provided in the contract in accordance with section four thousand two hundred twenty-three of this article, the total amount so credited shall be available to the contract holder upon surrender of the contract for its cash surrender benefits.

(2) No such additional amounts shall be guaranteed or credited except upon: (i) reasonable assumptions as to investment income, mortality, and expenses; (ii) a basis equitable to all contract holders of a given class; and (iii) written criteria approved by the board of directors of the company or a committee thereof.

(3) Any such additional amounts credited under a group annuity contract for which certificates are subject to section four thousand two hundred twenty-three of this article shall be credited to such certificates.

(b) (1) Any individual life insurance policy may provide that in addition to any minimum benefits guaranteed in the policy, additional amounts may be credited to the policy.

(2) No such additional amounts shall be guaranteed or credited except upon reasonable assumptions as to investment income, mortality, persistency, and expenses. The declaration of such additional amounts by an insurer must be made prospectively; no such additional amounts shall be credited retroactively to apply to any period prior to such declaration.

(3) Such additional amounts are required to be credited to any policy, providing for the crediting of additional amounts, while continued under a reduced paid-up insurance option, with respect to the period after the termination or lapse of such policy by reason of default in payment of any premium, installment or interest on any policy loan and before the

reinstatement of such policy, if it is reinstated. However, an insurer may use reasonable assumptions as to investment income, mortality, persistency, and expenses which differ from the assumptions used for policies in force on a premium paying basis.

(4) Any such additional amounts shall be credited on a basis equitable to all policyholders of a given class and shall be based on written criteria approved by the board of directors of the company or a committee thereof.

§ 4233. Annual statements of life insurance companies. (a) In addition to any other matter which may be required to be stated therein, either by law or by the superintendent pursuant to law, every annual statement of every life insurance company doing business in this state shall conform substantially to the form of statement adopted from time to time for such purpose by, or by the authority of, the National Association of Insurance Commissioners, together with such additions, omissions or modifications, similarly adopted from time to time, as may be approved by the superintendent.

(b) The annual statement required by subsection (a) hereof shall include an accurate, concise and complete statement of the following matters:

(1) All moneys expended in connection with any matter pending before any legislative body or any officer or department of government, giving particulars with respect to all items of one hundred dollars or more as to dates, amounts, names and addresses of payees, the measure or proceeding in connection with which the payment was made, and the interest of the company therein.

(2) The names of the officers and directors of the company and the proceedings at the last annual election of directors, giving the names of candidates and the number of votes cast for each and whether in person, by proxy or by mail.

(3) The compensation and names of the chief executive officer, the four most highly paid other executive officers, regardless of the amount of the compensation, the next five highly compensated employees whose individual total compensation exceeds one hundred thousand dollars and all directors, other than those officers or employees who may otherwise

have been disclosed pursuant to this paragraph and who also serve as directors. A list of the job titles and compensation for any officer or employee not otherwise disclosed pursuant to this paragraph where the individual's total compensation is in excess of seven hundred fifty thousand dollars. Compensation shall consist of any and all remuneration paid to or on behalf of an officer, employee or director provided for in this paragraph during the year, including wages, salaries, bonuses, commissions, stock grants, gains from the exercise of stock options and any other emolument. Amounts disclosed for directors must include all compensation paid for services on the board and committees, as well as any other compensation for any other activity or service, such as consulting agreements.

(4) All banks and trust companies in which an account was maintained at any time during the year, and the balance at the end of the year, if any, carried by such company in each such bank or trust company and the largest balances carried by such company during each month of the year in each bank or trust company in which the largest balance during the year exceeded one-fortieth of one percent of admitted assets at the beginning of the year or five hundred thousand dollars, whichever is smaller.

(5) All death claims resisted or compromised by such company during the year, and, for each such case the sums insured, the sums paid and the reasons for resisting or compromising the claim.

(6) A complete statement of the gains and losses upon all of its business transacted during the year and the sources of such gains and losses. Any life insurance company which is authorized or permitted to issue in this state participating policies or contracts, and which issues in the United States both participating and non-participating policies or contracts, shall make a separate statement showing gains and losses, with respect to each of such classes of business, and also showing the manner in which any general gains and outlays of the company have been apportioned to each of such classes of business, in conformity with section four thousand two hundred thirty-one of this article. Any life insurance company issuing industrial life insurance policies shall make a similar separate statement showing gains and losses with respect to such industrial business and with respect to the company's other business and also showing the manner in which any general gains and

outlays of the company have been apportioned to each of such classes of business.

(7) A statement showing separately the first year and total expense limits and the first year and total expenses, determined in accordance with section four thousand two hundred twenty-eight of this article. Any life insurance company which is authorized or permitted to issue in this state both participating and non-participating policies or contracts shall make a separate statement showing these expense limits and expenses, with respect to each of such classes of business.

(8) The rates of annual dividends declared during the year for all plans of insurance for policies issued during each of the last five years and during each fifth year of the preceding seventy years and for ages at entry, twenty-five, thirty-five, forty-five and fifty-five, and the precise method by which such dividends have been calculated.

(9) All income, disbursements and reserves relative to noncancellable disability insurance issued in connection with or supplementary to policies of life insurance or annuity contracts shall be reported in such annual statement.

(10) With respect to participating policies subject to the provisions of section four thousand two hundred twenty or four thousand two hundred twenty-one of this article upon which the reserves determined in accordance with section four thousand two hundred seventeen of this article were calculated at an interest rate lower than that used in calculating the cash surrender values permanently guaranteed for such policies:

(A) The approximate amount by which such reserves for policies issued prior to January first, nineteen hundred forty-eight, are greater than they would have been had they been computed at the interest rate used in computing the reserves for such policies as of December thirty-first, nineteen hundred forty-seven.

(B) The approximate amount by which such reserves for policies issued on and after January first, nineteen hundred forty-eight, are greater than they would have been had they been computed at the interest rate used in computing the cash surrender values permanently guaranteed for such policies.

(C) A schedule supporting the amounts shown in subparagraphs (A) and (B) hereof, in accordance with the same paragraphs as are used in

reporting the reserve in the annual statement.

(D) A statement of the nature of increase, if any, in the cash surrender values and nonforfeiture benefits allowed on policies on which a default in payment of a premium occurred during the year over those permanently guaranteed for such policies and the aggregate amount in excess of guaranteed values paid out during the year on policies surrendered for cash.

(11) A statement setting forth a description of the investments, activities or other contributions of the company relating to New York state, its residents, municipalities, businesses and institutions shall be considered to fulfill the requirements of this paragraph. Investments, activities or contributions shall include, but need not be limited to: obligations of state government, its agencies, municipalities or other instrumentalities; real estate and mortgages, including financing of housing, the construction or rehabilitation of which is undertaken in conjunction with federal, state or local housing assistance programs, including the federal low-income housing tax credit program; common stock and other securities of business and industry, including existing and new small business, and commercial enterprise in state empire zones or in federal empowerment zones or enterprise communities; charitable and philanthropic contributions; activities conducted by the company to make its customers aware of the investments, activities, or other contributions described in the statement; and such other investment, activities or contributions within the intent of the requirements of this paragraph as the superintendent may deem appropriate pursuant to rules or regulations of the department.

§ 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 podiatrical 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.

§ 4236. Joint underwriting of group health insurance for persons aged sixty-five and over. (a) It is the concern of the legislature that many residents of this state of advanced years do not have readily available to them health insurance adequate to their needs. It is the legislature's intent to encourage and facilitate the writing of such insurance by private insurers on a non-profit group basis in order to make available to such persons broader coverage at lower rates than is possible on a regular commercial basis. It is, therefore, the purpose of the legislature to authorize and regulate, in the public interest, cooperative action among such insurers in the preparation and issuance of policies of health insurance, the making of rates to be charged therefor and other matters within the scope of this section.

(b) In this section, unless the context otherwise requires,

(1) "Association" means a voluntary unincorporated non-profit association formed for the sole purpose of enabling cooperative action to provide health insurance in accordance with this section.

(2) "Health insurance" means hospital, surgical and medical expense insurance, provided by a group health insurance policy or contract issued in accordance with this section.

(3) "Insurer" means any insurance company authorized to do the business of accident and health insurance in this state.

(4) "Insured" means a person covered under a group policy or contract issued pursuant to this section.

(c) (1) Notwithstanding any other provision of this chapter or of any other law which may be inconsistent herewith, any insurer may join with one or more other insurers, on a uniform basis with respect to premium rates, policy provisions, commissions and other matters within the scope of this section, to offer, sell and issue to a policyholder group health insurance covering residents of this state who are sixty-five years of age or older and the spouses of such residents.

(2) Such insurance may also cover an employer's non-resident employees and non-resident retired employees sixty-five years of age or older and their spouses, provided such employees are regularly employed within this state or were so employed at the time of their retirement.

(3) Such insurance may be offered, issued and administered jointly by two or more such insurers through an association formed by such insurers solely for the purpose of offering, selling, issuing and administering

such insurance in accordance with this section. Membership in such association shall be open to any insurer.

(d) (1) Such association shall offer health insurance coverage to all residents of this state who are sixty-five years of age or over and their spouses, subject to reasonable underwriting restrictions to be set forth in the plan of the association.

(2) Such coverage may consist of one or more of the following types: (i) basic hospital and surgical coverage, (ii) basic medical coverage, (iii) major medical coverage, and any combination of those types; provided, however, that if coverage of the first or second type is offered, it shall not be required as a condition of obtaining same that coverage of the third type also be obtained.

(e) (1) Such association shall file with the superintendent its plan for offering, selling, issuing and administering health insurance which plan shall be subject to his approval as conforming to the purpose and requirements of this section, and any policy, contract, certificate or other evidence of insurance, application or other forms pertaining to such insurance together with the premium rates to be charged therefor.

(2) No such policy, contract, certificate or other evidence of insurance, application or other form shall be sold, issued or used and no endorsement shall be attached to or printed or stamped thereon unless the form thereof and the premium rates to be charged therefor shall have been approved by the superintendent.

(3) The superintendent shall, within a reasonable time after the filing of any such premium rates, policies, contracts, endorsements, applications or other forms, notify the association filing the same of his approval or disapproval thereof.

(4) The superintendent may disapprove such premium rates if he finds them to be unfairly discriminatory or unreasonable in relation to the benefits provided and he may disapprove such policies, contracts, certificates, applications, endorsements or other forms if in his judgment they contain provisions which he finds to be unjust, unfair, inequitable, misleading, deceptive, prejudicial to the insured or otherwise contrary to law or to the public policy of this state.

(5) The superintendent may, after notice and hearing, withdraw an approval previously given, if the use thereof is contrary to the legal requirements applicable thereto at the time of such withdrawal, or the

premiums are unfairly discriminatory or unreasonable in relation to the benefits provided, or in his judgment they contain provisions which are, or the continued use thereof would be, unjust, unfair, inequitable, misleading, deceptive, prejudicial to the insured or otherwise contrary to law or to the public policy of this state. Any such withdrawal of approval shall be effective at the expiration of such period, not less than ninety days after the giving of notice of withdrawal, as the superintendent shall in such notice prescribe.

(6) In exercising the powers conferred upon him by this subsection the superintendent shall not be bound by any other requirement of this chapter with respect to standard provisions to be included in accident and health policies or forms.

(7) The name of such association or any advertising and other promotional and solicitation material used in connection with health insurance offered, sold or delivered pursuant to this section shall not be such as to mislead or deceive the public.

(f) Such association may solicit the sale of such health insurance through any insurance agent licensed pursuant to section two thousand one hundred three of this chapter and any insurance broker licensed pursuant to section two thousand one hundred four of this chapter. It shall not pay to such agent or broker or any other person any commission, compensation or other fee or allowance not in accordance with a schedule thereof which shall have been filed by it with and approved by the superintendent. Except as aforesaid, it shall not pay any commission, compensation, fee or allowance to any person but it may pay a salary or compensation to persons regularly employed by it.

(g) Such association shall file annually with the superintendent, on such date and in such form as he may prescribe, a statement with respect to its operations.

(h) Notwithstanding any other provision of this chapter, an association may offer, sell, issue or administer such a group policy or contract of health insurance on a non-participating basis, provided, however, that the excess, if any, of premiums received by it from insureds over the cost of providing such insurance benefits shall be used solely for the benefit of the insureds.

(i) Premiums for policies issued pursuant to this section shall not be included in "premiums" for purposes of section five hundred fifty-two of

the former insurance law in effect immediately preceding the effective date of this chapter and former section one hundred eighty-seven of the tax law, nor shall section one thousand one hundred twelve of this chapter be construed as subjecting the premiums for such policies to taxation; nor shall such premiums be subject to any other tax imposed by any other governmental subdivision.

§ 4237. Blanket accident and health insurance. (a) (1) Any policy or contract of insurance against death or injury resulting from accident which insures a group of persons conforming to the requirements of one of the subparagraphs (A) through (F) of paragraph three hereof shall be deemed a blanket accident policy.

(2) Any policy or contract which insures a group of persons conforming to the requirements of subparagraph (C), (E) or (F) of paragraph three hereof against total or partial disability, excluding such disability from accident, shall be deemed a blanket health insurance policy.

(3) Any policy or contract of insurance which combines the coverage of blanket accident insurance and of blanket health insurance on such a group of persons shall be deemed a blanket accident and health insurance policy:

(A) Under a policy or contract issued to any railroad, steamship, motorbus or airplane carrier of passengers, which shall be deemed the policyholder, a group defined as all persons who may become such passengers may be insured against death or bodily injury either while, or as a result of, being such passengers.

(B) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employee against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.

(C) Under a policy or contract issued to an institution of higher education, as defined in the higher education act of 1965, 20 U.S.C. § 1001, other school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, provided, with respect to a policy or contract issued to an institution of higher education, the policy or contract shall be a policy or

contract:

(i) of hospital, medical, or surgical expense insurance that meets the requirements of section three thousand two hundred forty of this chapter;

(ii) that provides limited scope dental or vision benefits meeting the definition of "excepted benefits" set forth in section 2791 of the public health service act, 42 U.S.C. § 300gg-91(c); or

(iii) as described in item (ii), (iii) or (iv) of subparagraph (B) of paragraph one of subsection (a) of section three thousand two hundred forty of this chapter.

(D) Under a policy or contract issued in the name of

(i) any county, city, town, village or fire district,

(ii) any duly organized fire department, or fire company, of any such municipal corporation or fire district, whether or not any such corporation has been incorporated under any general or special law,

(iii) any fire corporation incorporated under or subject to the provisions of section one thousand four hundred two of the not-for-profit corporation law, or any general or special law, if such corporation is by law under the general control of, or recognized as a fire corporation by, the governing board of a city, town, village or fire district, which municipal corporation, fire district, fire department, fire company or fire corporation, as the case may be, shall be deemed the policyholder, covering all, but not less than twenty-five, volunteer members of such department, company or corporation. A district corporation which has the general powers of and operates as a fire district shall be considered a fire district for the purposes of this paragraph. A volunteer firefighter whose services are offered and accepted pursuant to the provisions of section two hundred nine-i of the general municipal law shall be deemed a volunteer member of any such fire department, fire company or fire corporation except for the purpose of determining the minimum number of twenty-five volunteer members for which any such policy or contract must provide coverage. Any such policy or contract issued to a municipal corporation or a fire district shall be subject to any limitations on the amount, coverage or benefits as are set forth in any applicable general, special or local law or city or village charter.

(E) Under a policy or contract issued to and in the name of an

incorporated or unincorporated association of persons having a common interest or calling, which association shall be deemed the policyholder, having not less than fifty members, covering all the members of such association or if part or all of the premium is to be derived from funds contributed by the insured members and if the opportunity to take such insurance is offered to all eligible members, then such policy must cover not less than seventy-five percent of any class or classes of members determined by conditions pertaining to membership in the association.

(F) Under a policy or contract issued to insure; (i) any other substantially similar group approved by the superintendent as eligible for insurance under a blanket accident and health insurance policy or contract; or (ii) 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.

(b) All benefits under any blanket accident, blanket health or blanket accident and health insurance policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting him, or to a person or persons chiefly dependent upon him for support and maintenance.

(c) This section shall not affect the legal liability of policyholders for the death of or injury to, any such member of such group.

(d) (1) Any dividend hereafter apportioned on any participating blanket insurance policy, or any rate reduction hereafter made or continued on any non-participating blanket policy for the first or any subsequent year of insurance under any such policy heretofore or hereafter issued under item (ii) of subparagraph (F) of paragraph three of subsection (a) of this section 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.

(2) The provisions of paragraph one of this subsection 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 (E) and item (i) of subparagraph (F) of paragraph three of subsection (a) of this section.

(e)(1) For the purposes of any policy or contract of insurance issued pursuant to this section, the term "employees" may include 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; and the individual proprietor or partners if the employer is an individual proprietorship or partnership.

(2) For purposes of subparagraph (B) of paragraph three of subsection (a) of this section, the term "employees" may also include the directors of the employer, and of subsidiary or affiliated corporations of a corporate employer.

§ 4237-a. Stop-loss insurance. (a) An insurer authorized to do the business of accident and health insurance in this state and a health service corporation organized under article forty-three of this chapter shall be authorized to issue stop-loss insurance as provided in this section.

(b) "Stop-loss insurance" means an insurance policy whereby the insurer agrees to pay claims or indemnify an employer for losses

incurred under a self-insured employee benefit plan or a student health plan as authorized by section one thousand one hundred twenty-four of this chapter in excess of specified loss limits for individual claims and/or for all claims combined, or any similar arrangement.

(c) A stop-loss insurance policy delivered, issued for delivery, or entered into in this state shall clearly describe:

(1) the entire money or other consideration for the policy;

(2) the time at which the insurance takes effect and terminates;

(3) the specified per-claim, per-employee or, in the case of a student health plan under section one thousand one hundred twenty-four of this chapter, per student, or aggregate amount of claims above which payment or reimbursement is to be made by the insurer; and

(4) the payments to be made by the insurer once the specified stop-loss thresholds have been exceeded.

(d) No stop-loss insurance contract shall be issued or renewed if issuance of the policy would be prohibited by section two thousand six hundred thirteen, three thousand two hundred thirty-one, four thousand three hundred seventeen or four thousand three hundred twenty of this chapter.

(e) The superintendent may promulgate such rules and regulations he deems necessary or desirable to establish financial requirements and standards for the form and content of stop-loss insurance policies authorized by this section.

§ 4238. Group annuity contracts. (a) Any policy or contract, except a joint, reversionary or survivorship annuity contract, whereby annuities are payable dependent upon the continuance of the lives of more than one person, shall be deemed a group annuity contract. The party or parties to whom or to which such contract is issued, as herein provided, shall be deemed the holder of such contract. The term "annuitant", as used herein, refers to any person upon whose continued life such annuity is dependent.

(b) No authorized insurer shall deliver or issue for delivery in this state any group annuity contract except the following:

(1) A contract issued to an employer, which permits all of the employees of such employer or of any specified class or classes thereof

to become annuitants.

(2) A contract issued to an employers' association which permits all of the employees of such employers or of any specified class or classes thereof to become annuitants. Such employers' association may provide for the representation of annuitants on its board of directors.

(3) A contract issued to a labor union which permits all of the members of such union or of any specified class or classes thereof to become annuitants.

(4) A contract issued to the trustees of a trust established by an employer, or by an employers' association, or by one or more labor unions, or by one or more employers and one or more labor unions, which permits all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof, to become annuitants.

(5) A contract issued to an association of persons having a common interest, calling or profession who constitute a homogeneous group, which association has a constitution and by-laws and is organized and maintained in good faith for purposes other than obtaining annuities or to trustees of a trust established by such an association which permits all members of the association and their employees or of any specified class or classes thereof to become annuitants.

(6) A contract issued to a bank or trust company or trustees of one or more trusts which permit individuals for whom contributions are made to individual retirement accounts or for individual retirement annuities described in section four hundred eight of the Internal Revenue Code of 1954 to become annuitants.

(7) A contract issued to the trustees of one or more trusts (other than trusts described in paragraph four hereof) for employees of more than one employer which permits all of the employees of each such employer or of any specified class or classes thereof to become annuitants, provided that if payments made to the insurer are derived wholly from funds contributed by such employees, the insurer shall issue a certificate complying with the requirements of this chapter applicable to individual annuities for delivery to each employee who contributes to the contract.

(8) A contract issued to the trustees of a foundation or endowment fund which permits any specified class or classes of professional

persons to become annuitants.

(9) A contract issued to an association, or the trustee or trustees of a trust established, or participated in, by one or more associations, which permits all of the members of the associations, or all of any specified class or classes thereof, to become annuitants subject to the following:

each association shall have:

(A) a minimum of two hundred covered members at the contract's date of issue;

(B) been organized and maintained in good faith for purposes principally other than that of obtaining annuities;

(C) been in active existence for at least two years; and

(D) a constitution and by-laws which provide that:

(i) the association holds regular meetings not less than annually to further purposes of the association;

(ii) the association collects dues or solicits contributions from members; and

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

(10) A contract issued to any organization, or the trustee or trustees of a trust established, or participated in, by one or more of such organizations which permits certain persons to become annuitants subject to the following:

(A) 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 contract must cover holders of that card; or

(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 contract must cover the depositors, account holders, or members of that institution; and

(B) the organization or organizations shall have a minimum of two hundred covered persons at the contract's date of issue.

(11) A contract issued to the trustees of one or more trusts which permits any specified class or classes of plaintiffs or claimants to become annuitants with respect to amounts paid or payable on their

behalf by way of settlement, judgment or other award. Any such contract or any certificate issued in connection with such contract shall not be subject to section four thousand two hundred twenty-three of this article.

(c) Payments made to the insurer under a group annuity contract may be derived in whole or in part from funds contributed by the persons covered thereunder. A group of employees covered under a contract may include retired employees, employees of affiliates and subsidiaries of the employer, individual proprietors affiliated with the employer, and partners and employees of individuals affiliated with the employer and of firms controlled by the employer.

(d) Anything in this chapter to the contrary notwithstanding, any group annuity contract may provide for readjustment of the rate of premium consideration or deposit based on the experience thereunder at the end of the first contract year or of any subsequent contract year, and such readjustment may be made retroactive only for such contract year. Any such rate readjustment shall be computed on a basis which is equitable to all group annuity contracts.

(e) No domestic, foreign or alien life insurance company shall be permitted to do business in this state if it hereafter issues, within or without this state, any group annuity contract which on its issuance does not appear to be self-supporting on reasonable assumptions as to interest, mortality and expense.

§ 4239. Allocation and reporting of income and expenses of life insurers. (a) In order to enable the superintendent to determine compliance with this chapter, he may issue reasonable regulations prescribing standards for the equitable allocation of income and expenses as among lines of business and as between investment expenses and insurance expenses. No such regulation or amendment thereto shall be promulgated except upon notice to all insurers affected thereby, and after hearing. Such regulation or amendment shall not preclude the use of other reasonable and equitable standards previously approved by the superintendent. He may also promulgate regulations defining the items of income and expenses to be reported in each line of the annual statement. Any regulation or amendment thereto shall be promulgated at least six

months before the beginning of the calendar year in which the same shall take effect.

(b) The restrictions in subsection (a) hereof as to notice, hearing, and effective period shall not apply to such regulations or amendments as may be approved by the superintendent for calendar years as to which similar regulations or amendments have been adopted by the National Association of Insurance Commissioners.

(c) If the superintendent finds, after notice and hearing, that any such insurer has failed to comply with the requirements of this section, he may order such insurer to change its methods of reporting or to modify its basis of allocation so as to produce reasonable and equitable results.

§ 4240. Separate accounts; fixed and variable life insurance and annuities and funding agreements. (a) In accordance with paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen and section three thousand two hundred twenty-two of this chapter, a domestic life insurance company may establish one or more separate accounts and allocate thereto, pursuant to agreements for separate accounts, amounts paid to it (i) to provide for annuities which are payable in fixed amounts guaranteed by it, or variable amounts, or both, including any amounts paid to it which are subject to annuity options; or (ii) to provide life insurance with benefits, premiums or both payable on a variable basis and the reserves for which vary according to the investment experience of such separate account; or (iii) to accumulate in such separate account funds to be applied to provide life insurance, whether fixed or variable, or both; or (iv) to accumulate or hold in such separate account funds to be applied to provide health insurance; or (v) to accumulate or hold in such separate account proceeds applied under settlement or dividend options; or (vi) to accumulate or hold in such separate account funds credited under funding agreements delivered pursuant to section three thousand two hundred twenty-two of this chapter; provided that any such separate account shall be maintained in accordance with the following:

(1) Income, gains and losses, whether or not realized, from assets allocated to a separate account shall, in accordance with the applicable

agreement or agreements, be credited to or charged against such account without regard to other income, gains or losses of the insurer.

(2) With respect to investments allocated to a separate account:

(A) except as provided in paragraphs three and five of this subsection, the insurer may invest in any investments contractually permitted for such separate account, the restrictions, limitations and other provisions relating to investments specified in this chapter shall not apply to such investments, and such investments shall be disregarded, and shall be excluded from admitted assets, in applying the quantitative investment limitations contained in this chapter to other investments;

(B) no stock, bond, note or other security of a subsidiary or affiliate of the insurer, or of any company controlling or under common control with the insurer, shall be allocated to any separate account if, after giving effect to such allocation, any security of a different class issued by such subsidiary or affiliate would be held in any other account of the insurer, or by any company controlling or under common control with the insurer or by any other subsidiary or affiliate of the insurer; and

(C) The insurer shall invest and reinvest for such separate account in good faith and with that degree of care that an ordinarily prudent person in a like position would use under similar circumstances.

(3) The insurer may allocate amounts to a separate account to facilitate its initial operations and amounts so allocated shall be deemed to be invested under section one thousand four hundred four (in the case of insurers making investments under the authority of section one thousand four hundred four) of this chapter or under section one thousand four hundred five (in the case of insurers making investments under the authority of section one thousand four hundred five) of this chapter and shall be subject to the qualitative standards and quantitative limitations provided in section one thousand four hundred four or one thousand four hundred five of this chapter, as the case may be.

(4) Amounts received by the insurer pursuant to one or more such agreements may be maintained in one or more separate accounts.

(5) No guarantee of the value of the assets allocated to a separate account, or any interest therein, or the investment results thereof, or

the income thereon, shall be made to a contractholder by the insurer, without limitation of liability under all such guarantees to the extent of the interest of the contractholder in assets allocated to said separate account (i) unless the investments allocated to such separate account are deemed part of the general assets of the insurer and are subject to the qualitative standards and quantitative limitations contained in section one thousand four hundred four or section one thousand four hundred five of this chapter or (ii) if the applicable agreements provide that the assets in such separate account shall not be chargeable with liabilities arising out of any other business of the insurer, unless such investments are subject to the requirements and limitations on investments imposed by articles thirteen and fourteen (except section one thousand four hundred two) of this chapter applied as though the aggregate assets allocated to such separate account were the insurer's total admitted assets or (iii) unless the insurer shall submit annually to the superintendent an opinion, in form and substance satisfactory to the superintendent, of a qualified actuary (as defined in item (vi) of subparagraph (B) of paragraph four of subsection (c) of section four thousand two hundred seventeen of this article) that, after taking into account any risk charge payable from the assets of such separate account with respect to such guarantee, the assets in such separate account make good and sufficient provision for the liabilities of the insurer with respect thereto, such opinion to be accompanied by a memorandum, also in form and substance satisfactory to the superintendent, of the qualified actuary describing the calculations made in support of such opinion and the assumptions used in the calculations, provided that, notwithstanding any other provision of this paragraph, reserve liabilities for guaranteed minimum death benefits and fixed incidental insurance benefits with respect to variable life insurance policies shall be maintained in the general account of the insurer.

(6) The insurer shall not, in connection with the allocation of investments or expenses, or in any other respect, discriminate unfairly between separate accounts or between separate and other accounts, but this provision shall not require the insurer to follow uniform investment policies for its accounts.

(7) Except as otherwise provided in paragraph ten hereof, assets

allocated to separate accounts shall, for the purpose of any valuation required by this chapter, be valued at their market value at the date as of which valued in accordance with the terms of the applicable agreements, or if there is no readily available market, then in accordance with the terms of such agreements, and no special reserve under subsection (b) of section one thousand four hundred fourteen of this chapter shall be required in respect thereof.

(8) Unless otherwise provided in approvals given by the superintendent and under such conditions as he may prescribe, the insurer shall maintain in each separate account assets with a value at least equal to the amounts accumulated in accordance with the terms of the applicable agreements with respect to such separate account and the reserves for annuities in the course of payment that vary with the investment experience of such separate account.

(9) Except as may be required by subsection (b) hereof, the insurer shall not transfer any investment, or asset held for investment, between separate accounts or between separate and other accounts, provided that the superintendent may authorize transfers in circumstances where such transfers would not be inequitable.

(10) Except with respect to separate accounts qualifying under item (iii) of paragraph five of this subsection, assets supporting reserves which do not vary with the investment experience of the separate account shall be maintained in the separate account at their value determined in accordance with section one thousand four hundred fourteen of this chapter.

(11) Any contract providing for benefits, premiums or both, payable on a variable basis, delivered or issued for delivery in this state, and any certificate or other writing furnished by the insurer to the employee under such a group contract in evidence of either benefits or contributions, or both, payable on a variable basis, shall

(A) contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of such variable elements thereunder,

(B) state in clear terms that such amount may decrease or increase according to such procedure, and

(C) contain on its first page a statement that such elements thereunder are on a variable basis.

(12) Amounts allocated by the insurer to separate accounts shall be owned by the insurer, the assets therein shall be the property of the insurer, and no insurer by reason of such accounts shall be or hold itself out to be a trustee. If and to the extent so provided in the applicable agreements, the assets in a separate account shall not be chargeable with liabilities arising out of any other business of the insurer.

(13) Every individual variable annuity contract and every certificate subject to this section and subsection (a) of section three thousand two hundred nineteen of this chapter shall contain a provision, or a notice attached to the contract or certificate, to the effect that during a period, specified in such provision or notice, it may be surrendered to the insurer together with a written request for cancellation of the contract or certificate, and in such event, the insurer will pay an amount equal to the sum of (i) and (ii), where (i) is the difference between the premiums paid, including any fees or other charges, and the amounts, if any, allocated to any separate accounts under the contract or certificate, and (ii) is the cash value of the contract or certificate, or, if the contract or certificate does not have a cash value, the reserve for the contract or certificate, on the date of surrender attributable to the amounts so allocated. The period specified in such provision or notice for a contract or certificate sold other than by mail order shall not be less than ten nor more than thirty days, and for a contract or certificate sold by mail order shall be thirty days, from the date the contract or certificate is received by the owner.

(14) The superintendent may, from time to time, promulgate reasonable regulations setting forth:

(A) standards to be followed in the approval of forms for use in connection with separate accounts; such standards may relate to, but need not be limited to, any one or more of the following: guaranteed face amounts, termination of contract, withdrawal of funds by the contract holder, commitments with respect to future price of guaranteed annuities, valuation of assets, and other elements required to effect compliance with section three thousand two hundred one of this chapter;

(B) rules with respect to accounting and reporting of funds allocated to separate accounts, identification of assets allocated to any separate

accounts, and the application of expenses to agreements relating to separate accounts;

(C) rules with respect to adequate disclosure of information relating to separate accounts; and

(D) rules with respect to required and prohibited contract provisions for variable life insurance and variable annuity contracts delivered or issued for delivery in this state by an authorized fraternal benefit society.

(c) This section shall have no application to a charitable annuity society.

(d) Except as otherwise provided in this section, all pertinent provisions of this chapter shall apply to separate accounts and agreements relating thereto.

(1) The following provisions of this chapter shall not apply to annuity contracts or to certificates subject to this section and subsection (a) of section three thousand two hundred nineteen of this chapter: paragraphs one, seven, eight, and nine of subsection (a) of section three thousand two hundred nineteen of this chapter, subsections (a) and (d) of section three thousand two hundred twenty-three of this chapter, sections four thousand two hundred seventeen, four thousand two hundred twenty-one and four thousand two hundred twenty-three and subsection (e) of section four thousand two hundred thirty-one of this article, provided, however, that this paragraph shall not apply to any contract or certificate providing benefits with respect to amounts allocated to a separate account, if such benefits are guaranteed at any time to be not less than an amount equal to or greater than such allocated amounts accumulated to such time at three percent per annum.

(2) Individual variable annuity contracts and group variable annuity certificates delivered or issued for delivery in this state shall contain grace, reinstatement, and nonforfeiture provisions appropriate to such variable contracts and certificates. Payment of death benefits under such contracts and certificates shall be made within seven calendar days following receipt of the beneficiary's completed election form with all information required by such form for the payment of proceeds. If such death benefits are not paid within seven calendar days following receipt of such completed election form, interest shall be computed daily from the end of such seven day period at the rate of

interest currently paid by the insurer on proceeds left under the interest settlement option and such contracts or certificates shall not be subject to the payment of interest under subsection (c) of section three thousand two hundred fourteen of this chapter. For amounts received under actions commenced to recover proceeds pursuant to subsections (a) and (b) of section three thousand two hundred fourteen of this chapter, interest shall be computed daily at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option from the earlier of the date the action is commenced or the insurer's receipt of the beneficiary's completed election form to: (A) the date the verdict is rendered or the report or decision is made and thereafter in accordance with the provisions of sections five thousand two and five thousand three of the civil practice law and rules, for amounts received under subsection (a) of section three thousand two hundred fourteen of this chapter; or (B) the date the settlement is reached, for amounts received under subsection (b) of such section.

(3) The following provisions of this chapter shall not apply to life insurance policies to the extent that they provide for allocation of amounts to separate accounts: paragraphs one, seven, eight, nine and ten of subsection (a) of section three thousand two hundred three of this chapter, section four thousand two hundred twenty-one and subsection (b) of section four thousand two hundred thirty-two of this article, provided, however, that this paragraph shall not apply to any policy providing benefits with respect to the amounts so allocated, if such benefits are guaranteed at any time to be not less than an amount equal to or greater than such allocated amounts accumulated to such time at three percent per annum.

(4) Contracts delivered or issued for delivery in this state for individual variable life insurance policies shall contain loan, grace, reinstatement and nonforfeiture provisions, and may provide for settlement options, under conditions acceptable to the superintendent.

(5) Individual variable contracts shall be included in determining the aggregate limits prescribed in section four thousand two hundred twenty-eight of this article, with appropriate modification of expense limits for such contracts, as required by the superintendent, to recognize the variable nature of the contracts.

(6) The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees provided in the contract.

(7) Notwithstanding any other provision of law, the superintendent shall have the sole authority to regulate the issuance and sale of such agreements; and, in addition to the powers expressly given by this section, the superintendent shall have the power to promulgate, from time to time, such regulations, not inconsistent with the provisions of this chapter, as may be appropriate to carry out the provisions of this section and, insofar as applicable to this section, other provisions of this chapter.

(e) No authorized insurer shall make any such agreement in this state providing for the allocation of amounts to a separate account until such insurer has filed with the superintendent a statement as to its methods of operation of such separate account and the superintendent has approved such statement. Subject to the approval of the superintendent, any such statement may apply to one or more groups of separate accounts classified by investment policy, number or kinds of separate account participants, methods of distribution of such agreements or otherwise. In determining whether or not to approve any such statement, the superintendent shall consider, among other things, the history, reputation and financial stability of the insurer and the character, experience, responsibility, competence and general fitness of the officers and directors of the insurer. If the insurer files an amendment of any such statement with the superintendent that does not change the investment policy of a separate account and the superintendent does not approve or disapprove such amendment within a period of thirty days after such filing, such amendment shall be deemed to be approved as of the end of such thirty day period, except that if the superintendent requests further information on the statement during such period from the insurer, such period shall be extended until thirty days after the day on which the superintendent receives such information. An amendment of any such statement that changes the investment policy of a separate account shall be treated as an original filing.

(f) Notwithstanding the restrictions and limitations herein or otherwise imposed by law, the insurer may with respect to any separate

account, (i) exercise any voting rights of any securities allocated thereto in accordance with instructions from persons having interests in such account ratably as determined by the insurer, or (ii) establish a committee for such account, the members of which may be directors or officers or other employees of the insurer or persons having no such relationship to the insurer, or any combination thereof, who may be elected to such membership by vote of the persons having interests in such account ratably as determined by the insurer. Such committee may have the power, which may be exercisable alone or in conjunction with others, or which may be delegated to the insurer or any other person, as investment manager or investment adviser, to authorize, approve or review the acquisition and disposition of investments for such account. In addition, the insurer may make such other provisions in respect to the separate account, including but not limited to voting, investments, audits and otherwise regarding management and administration, as the insurer may deem appropriate to facilitate compliance with any requirements of or pursuant to any federal or state law now or hereafter in effect; provided that the superintendent approve such provisions as not hazardous to the public or its policyholders in this state.

§ 4241. Penalty for violation of filing requirements. (a) Any authorized insurer, representative of such insurer, licensed insurance agent or licensed insurance broker wilfully violating any of the provisions of this article or of articles thirty-one or thirty-two of this chapter relating to filings of life, accident and health and annuity contract forms, premium rates, rules, classification of risks, and commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of fees or allowances to any individuals, firms or corporations for services pertaining to the service or administration of such group insurance and annuity contracts, shall, in addition to any other penalty provided by law, be liable for a penalty as provided in subsection (b) hereof.

(b) If the superintendent finds after notice and hearing, that any authorized insurer, representative of such insurer, licensed insurance agent or licensed insurance broker has wilfully violated the provisions

of subsection (d) hereof or this article relating to such filings, he may, in lieu of any other penalty provided by law, order such insurer, or person to pay to the people of this state a penalty not exceeding one thousand dollars for each such offense.

(c) Failure of any such insurer or person to pay such penalty within thirty days after the making of such order, unless suspended by an order of a court of competent jurisdiction, shall constitute a violation of this chapter.

(d) In this section, the issuance, procurement or negotiation of each policy of insurance, by such insurer or person in wilful violation of the provisions of this subsection or this article shall be deemed a separate offense.

ARTICLE 43

NON-PROFIT MEDICAL AND DENTAL INDEMNITY, OR HEALTH AND HOSPITAL SERVICE CORPORATIONS

Section 4301. Organization of corporation; purposes; board of directors.
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4320. Limitations on administrative services and stop-loss coverage.
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4328. Individual enrollee direct payment contracts offered by health maintenance organization on and after October first, two thousand thirteen.
4329. Prescription drug coverage.

4330. Discrimination because of sex or marital status in hospital, surgical or medical expense insurance.

§ 4301. Organization of corporation; purposes; board of directors. (a) A corporation may be organized under the not-for-profit corporation law, and a consumers' cooperative stock corporation may be organized under article two of the cooperative corporations law, for the purpose of furnishing medical expense indemnity, dental expense indemnity, hospital service, or health service or, upon compliance with the applicable provisions of subsection (h) of this section, both medical expense indemnity and hospital service, to persons who become covered under contracts with such corporations.

(b) (1) Medical expense indemnity shall consist of reimbursement for:

(A) medical care provided through licensed physicians,

(B) dental care provided through licensed dentists,

(C) optometric care provided through licensed optometrists,

(D) podiatrical care provided through licensed podiatrists,

(E) chiropractic care provided through licensed chiropractors,

(F) psychiatric or psychological services provided through physicians, psychiatrists or certified and registered psychologists,

(G) physical and occupational therapy care provided through licensed physical and occupational therapists upon the prescription of a physician,

(H) nursing service,

(I) speech-language pathology or audiology services provided through licensed speech-language pathologists or audiologists, provided however, that nothing contained herein shall be construed to prohibit a contract from requiring said service from being performed pursuant to a medical order or 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 a corporation from covering more than one test or evaluation provided by a speech-language pathologist or audiologist within a twelve-month period where such tests or evaluations 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,

(J) necessary appliances, drugs, medicines and supplies, and

(K) bio-analytical or clinical laboratory examinations and reports thereof reported to a physician, osteopath, dentist, optometrist, podiatrist, chiropractor or physical therapist made by any privately operated bioanalytical or clinical laboratory.

(2) It is not mandatory that a contract issued by a medical expense indemnity corporation provide for and offer all of the services hereinabove described, but when any service is provided which can be performed by more than one of the practitioners hereinbefore referred to, benefits under the contract shall be provided regardless of which practitioner performed the service, provided that the performance of such service was within the scope of the license of such practitioner. Unless such contract shall otherwise provide there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, and/or appurtenances thereto.

(3) Every medical expense indemnity corporation shall be open to the participation of licensed physicians, podiatrists, chiropractors, optometrists, physical and occupational therapists, speech-language pathologists, audiologists, and dentists, certified and registered psychologists without discrimination against schools of medical practice, podiatry practice, chiropractic practice, optometric practice, physical and occupational therapy practice, dental practice, speech-language pathology practice (subject to the permitted limitations of paragraph one of this subsection), audiology practice (subject to the permitted limitations of paragraph one of this subsection), and psychological training as defined in the education law.

(c) Dental expense indemnity shall consist of reimbursement for dental care provided through licensed dentists and of furnishing necessary appliances, drugs, medicines, and supplies, prosthetic appliances, orthodontic appliances, precious metal and ceramic restorations.

(d) (1) Hospital service shall consist of in-patient hospital care and out-patient hospital care when such hospital care is provided through a hospital which is maintained by the state or any of its political

subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as shall be designated by the state department of health, and hospitals of other states subject to the supervision of such other state, convalescent care provided by any convalescent institution, or nursing care provided by any nursing home.

(2) A hospital service corporation may also provide reimbursement for expenses incurred outside of the hospital, convalescent institution or nursing home, for nursing service, necessary appliances, drugs, medicines, supplies, and any other services which would have been available in the hospital, convalescent institution or nursing home (excluding physicians' services), whether or not provided through a hospital, convalescent institution or nursing home.

(3) A hospital service corporation may also furnish reimbursement for ambulance service expenses.

(e) (1) Health service, as used in this article, shall consist of the types of services referred to in this section.

(2) A health service corporation, in any hospital, facility or center directly operated by it may provide hospital or medical care to persons other than persons covered under contracts issued by such corporation.

(3) A health service corporation may:

(A) exercise all of the powers of a medical expense indemnity, dental expense indemnity and hospital service corporation;

(B) organize, manage and promote a health maintenance organization as such term is defined in article forty-four of the public health law;

(C) contract or otherwise act jointly with a hospital corporation organized under article twenty-eight of the public health law, a hospital service corporation organized pursuant to this article, a health maintenance organization possessing a certificate of authority pursuant to article forty-four of the public health law, a professional service corporation organized under article fifteen of the business corporation law, a university faculty practice corporation organized under section fourteen hundred twelve of the not-for-profit corporation law or a partnership for the purpose of organizing, managing and promoting such prepaid comprehensive health services plan;

(D) contract or otherwise act jointly with an insurance company, authorized to do an accident and health insurance business in this

state, for the purpose of organizing, managing and promoting such a health maintenance organization.

(4) A health service corporation engaged in providing medical care through medical groups, hospital services and dental care, may include as a component of its rate a sum of five per centum of such rate to be used for the purchase or construction of facilities for the conduct of its business, and for the implementation of its program, or for making loans for the purposes of implementing the program of such corporation.

(5) To encourage the development in this state of health maintenance organizations as such term is defined in article forty-four of the public health law, the superintendent may modify any requirement applicable to health service corporations and other corporations organized under this article to permit such corporations to make fuller use of their resources in the development of such plans, including the acquisition and construction of hospitals, medical service centers and other health facilities and the equipment therefor, subject to such limitations as the superintendent shall deem necessary or proper to ensure the performance of contracts issued by such corporations and to protect the interests of persons covered under such contracts.

(6) Any other corporation subject to the provisions of this article may by appropriate amendment to its certificate of incorporation become a health service corporation.

(f) No foreign or alien medical expense indemnity corporation, dental expense indemnity corporation, health service corporation, or hospital service corporation shall be authorized to do business in this state. No person, firm, association or corporation shall in this state furnish or contract to furnish medical expense indemnity, dental expense indemnity, hospital service or health service under any insurance plan unless authorized so to do under the provisions of this chapter.

(g) Two or more corporations organized pursuant to the provisions of this article may, upon compliance with the applicable provisions of article seventy-one of this chapter, consolidate, if the superintendent finds that such consolidation will promote the public interest. No corporation resulting from any such consolidation shall operate in any county in which none of the corporations so consolidated was empowered to operate immediately prior to such consolidation.

(h) A medical expense indemnity corporation or a hospital service

corporation may, pursuant to a plan submitted to and approved by the superintendent, furnish both medical expense indemnity and hospital service benefits, as these are defined in subsections (b) and (d) of this section, by amending its certificate or act of incorporation in the manner provided in the applicable provisions of the not-for-profit corporation law and the cooperative corporations law. Except as the context otherwise requires, a corporation writing both medical expense indemnity and hospital service benefits shall be subject to all of the provisions of this article applicable to medical expense indemnity and hospital service corporations.

(i) Subject to the provisions of the preceding subsections, a hospital service corporation and a medical expense indemnity corporation and a dental expense indemnity corporation or any two of such corporations may issue a combined contract providing for hospital service, medical expense indemnity or dental expense indemnity, but no one of such corporations shall issue any such combined contract unless it complies with the applicable provisions of subsection (h) hereof. A hospital service corporation and a medical expense indemnity corporation and a dental expense indemnity corporation or any two of such corporations may underwrite jointly in such a combined contract such benefits as each might otherwise individually provide under this article. Any one of such corporations may act as agent for the other without being required to obtain a license as an agent under article twenty-one of this chapter.

(j) (1) Except as provided in this subsection, no medical expense indemnity corporation, dental expense indemnity corporation, health service corporation, or hospital service corporation shall be converted into a corporation organized for pecuniary profit. Every such corporation shall be maintained and operated for the benefit of its members and subscribers as a co-operative corporation.

(2) An article forty-three corporation which was the subject of an initial opinion and decision issued by the superintendent on or before December thirty-first, nineteen hundred ninety-nine, as the same may be amended or one or more article forty-three corporations whose main offices on January first, two thousand seven were located in one of the counties listed in section one thousand two hundred sixty-two of the public authorities law and its or their not-for-profit subsidiaries (including, without limitation, any such subsidiary licensed as a health

service corporation pursuant to this chapter or as a health maintenance organization organized pursuant to article forty-four of the public health law), hereinafter referred to in the singular, may be converted into one or more corporations or other entities organized for pecuniary profit, or into one or more for-profit organizations, in any such case, in accordance with the provisions of section seven thousand three hundred seventeen of this chapter.

(3) For the purposes of this subsection and section seven thousand three hundred seventeen of this chapter, "public asset" shall mean assets representing ninety-five percent of the fair market value of the corporation seeking to convert into a corporation or other entity organized for pecuniary profit pursuant to paragraph two of this subsection; provided, however, that for the purposes of the conversion of a corporation or corporations after the effective date of the chapter of the laws of two thousand seven which amended this paragraph, "public asset" shall mean assets representing ninety percent of the fair market value of the corporation or corporations. Fair market value, as defined in subsection (l) of section seven thousand three hundred seventeen of this chapter, shall be determined as of the date the superintendent approves the conversion transaction pursuant to subsection (f) of section seven thousand three hundred seventeen of this chapter.

(4) In addition to any other requirements of law, rule or regulation, the following requirements shall be applicable to the public asset:

(A) The public asset shall be transferred to the fund established pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter and the public asset shall be irrevocably dedicated to the purpose as set forth in such section;

(B) There is hereby established a board for the purpose of advising and making decisions with respect to the investment of assets and moneys in the fund created pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter. Such board shall be composed of five members appointed as follows: three members shall be appointed by the governor; one member appointed by the temporary president of the senate; and one member appointed by the speaker of the assembly. Each member of the board shall be appointed for a term of three years and may be reappointed at the end of said term by the same person that made the original appointment. A vacancy in the membership of the board shall be

filled for the unexpired portion of the term provided for by the original appointment by the same person that made the original appointment. Each member may be removed, other than upon the expiration of his or her term, only for neglect of duty, misconduct or other good cause. Each member of the board shall be a member of the public with knowledge and expertise in capital markets and a demonstrated commitment to ensuring continued access to, and availability of, health care services and may not be an officer or employee of the state or any municipal subdivision thereof;

(C) The members shall serve without compensation for their services as members, but shall be entitled to reimbursement for actual and necessary expenses incurred in the performance of their official duties. Such members, except as otherwise provided by law, may engage in private employment, or in a profession or business;

(D) The board and its corporate existence shall continue until there are no longer any assets or moneys in the fund created pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter available for distribution;

(E) The affirmative vote of three of the members shall be necessary for the transaction of any business or the exercise of any power or function of the board. The board may delegate to one or more of its members, or its agents, such powers and duties as it may deem proper;

(F) The board shall have the power to:

(i) direct, in consultation with the director of the division of the budget regarding the anticipated schedule of payments to the state, the manner in which moneys in the fund created pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter are invested so as to maximize the value of the assets in such fund consistent with the board's statutory obligation to direct disbursements as described below and in subsection (e) of section seven thousand three hundred seventeen of this chapter;

(ii) direct that disbursements be made from such fund in accordance with the direction of the director of the division of the budget and as described in subsection (e) of section seven thousand three hundred seventeen of this chapter; and

(iii) make and execute contracts and all other instruments, and to exercise such other powers, necessary or convenient for the exercise of

its powers and functions.

In directing investments pursuant to this subparagraph, the board shall not be limited by any restrictions on investments contained in any other section of law, subject only to the board's obligations and the considerations set forth above;

(G) (i) Neither the members of the board nor any agent or other person or persons acting on its behalf, while acting within the scope of their authority as members or agents of the board, shall be subject to any personal liability resulting from the carrying out of the powers conferred hereunder, and (ii) the provisions of section seventeen of the public officers law shall apply to members of the board and agents or other persons acting on its behalf, in connection with any and all claims, demands, suits, actions or proceedings which may be made or brought against any of them arising out of any determination made or actions taken or omitted to be taken in compliance with any obligations under or pursuant to the terms of this section or section seven thousand three hundred seventeen of this chapter. The provisions of this subparagraph shall be severable from and shall survive any legal challenge to the legality, validity, or constitutionality of this section;

(H) Any action or proceeding in which any question arises as to the validity of any provision in this subsection or in section seven thousand three hundred seventeen of this chapter, shall be preferred over all other civil causes except election causes in all courts of the state of New York and shall be heard and determined in preference to all other civil business pending therein except election causes, irrespective of position on the calendar. The same preference shall be granted upon application of counsel to the board in any action or proceeding questioning the validity of any provision herein in which he or she may be allowed to intervene;

(I) To assist in carrying out its functions, the board shall be authorized to hire independent financial, legal and other experts and consultants;

(J) Inconsistent provisions of other laws are superseded. Insofar as any provision in this section is inconsistent with the provisions of any other law, general, special or local, the provisions in this section

shall be controlling;

(K) This section, being necessary for the welfare of the state and its inhabitants, shall be liberally construed so as to effectuate its purposes;

(L) Each member of the board shall be and shall remain independent of any control or influence by the surviving corporation or other surviving entity organized for pecuniary profit and its affiliates and successors. Such requirement shall not prevent the board from voting its equity shares in the for-profit organization in accordance with the voting and shareholders rights agreement. No person who is an officer, director or employee of the corporation seeking conversion at the time such corporation applies to the superintendent for permission to convert shall be a member of the board;

(M) The board shall establish formal mechanisms to avoid conflicts of interest;

(N) The board shall enter into an asset preservation agreement with the converted corporation; and

(O) Notwithstanding any other provision of law, the board shall direct that such proceeds of the public asset are disbursed in accordance with direction from the director of the division of the budget and transferred to the credit of the tobacco control and insurance initiatives pool, or its successor to be used for the exclusive purposes provided therein.

(P) Section one hundred twelve of the state finance law shall apply to the fund established pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter and its board solely and exclusively with respect to procurement contracts for consulting and professional services recommended for award by the fund after June twenty-third, two thousand five; provided that all such contracts recommended for award by the fund on or before June twenty-third, two thousand five shall be valid and effective in accordance with their terms.

(Q) Section one hundred twelve of the state finance law shall not otherwise apply to the fund established pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter and its board except as provided in subparagraph (P) of this paragraph. Without in any way limiting the foregoing, section one hundred twelve of the

state finance law specifically shall not apply to any and all agreements such fund, its board, or any medical expense indemnity corporation, dental expense indemnity corporation, health service corporation or hospital service corporation that has converted to for-profit status pursuant to this section and section seven thousand three hundred seventeen of this chapter, may enter into, or has entered into, in connection with, or in anticipation of, sales of stock including, but not limited to, any and all underwriting agreements, pricing agreements and other documents related to such sales of stock or stock offerings, whether such agreements are entered into in connection with initial public offerings or subsequent public or private sales of stock.

(R) All disbursements from the fund established pursuant to subsection (e) of section seven thousand three hundred seventeen of this chapter shall be made pursuant to the provisions of this section and section seven thousand three hundred seventeen of this chapter without an appropriation. The provisions of this section and section seven thousand three hundred seventeen of this chapter shall be controlling, any other general, special or local law inconsistent therewith notwithstanding.

(5) For the purpose of this subsection and section seven thousand three hundred seventeen of this chapter, "charitable asset" shall mean assets representing five percent of the fair market value of the corporation seeking to convert into a corporation or other entity organized for pecuniary profit pursuant to paragraph two of this subsection; provided, however, that for the purposes of the conversion of a corporation or corporations after the effective date of the chapter of the laws of two thousand seven which amended this paragraph, "charitable asset" shall mean assets representing ten percent of the fair market value of the corporation or corporations. Fair market value, as defined in subsection (l) of section seven thousand three hundred seventeen of this chapter, shall be determined as of the date the superintendent approves the conversion transaction pursuant to subsection (f) of section seven thousand three hundred seventeen of this chapter. If one hundred percent of the stock is not transferred in connection with the conversion transaction, the proportion of stock to cash that is distributed as the charitable asset shall be the same as the proportion of stock to cash that is distributed as the public asset.

(k) (1) The board of directors of each health service, hospital

service or medical expense indemnity corporation subject to this article shall be composed of persons who are representative of the member hospitals or licensed medical professionals of such corporation, persons covered under its contracts and the general public. The board of directors of such corporations may also include persons who are employees of such corporations and who also serve as officers of such corporations. Not more than one-fifth of the directors of any such corporation shall be persons who are licensed to practice medicine in this state (other than physicians employed on a full-time basis in the fields of public health, public welfare, medical research or medical education) or who are trustees, directors or employees of a corporation organized for hospital purposes, or any combination thereof. Not more than one-eighth of the directors of any such corporation shall be persons who are employees of such corporation and who also serve as officers of such corporation. Any person who is an officer of such corporation but not an employee of such corporation shall be considered under one of the other classifications of directors set forth in this section, as appropriate. Whenever the maximum number of directors in either of the classifications set forth in the preceding sentences includes a fractional number equal to or greater than one-half, the number shall be rounded to the next greater whole number. Whenever the maximum number of directors in either of the classifications set forth in the preceding sentences includes a fractional number less than one-half, the number shall be rounded to the next lesser whole number. Of the directors not included in the classifications set forth in the preceding sentences,

(A) one-half in number, as nearly as possible, shall be persons covered under a contract or contracts issued by such health service, hospital service or medical expense indemnity corporation, and who are generally representative of broad segments of such covered persons, and

(B) one-half in number, as nearly as possible, shall be persons whose background and experience indicate that they are qualified to act in the broad public interest, whether or not they are persons covered under a contract or contracts issued by such health service, hospital service or medical expense indemnity corporation.

(C) A person who, or whose spouse or minor child, is an officer, director, or owner of more than ten per centum of the stock of a

corporation whose aggregate sales to hospitals and licensed medical professionals and to facilities of a health service, hospital service or medical expense indemnity corporation exceed five per centum of its total sales may not serve as a director under subparagraph (A) or (B) hereof.

(D) Each such health service, hospital service or medical expense indemnity corporation shall have an executive committee the members of which shall be composed, as nearly as possible, of representatives of any member hospitals or licensed medical professionals of such corporation, employee-officers of such corporation, persons covered under its contracts and the general public in the same proportions as the membership of the board of directors.

(E) The board of directors of a health service, hospital service or medical expense indemnity corporation with a combined premium volume exceeding two billion dollars annually as of December thirty-first, nineteen hundred ninety-six shall, in addition to its other responsibilities, have responsibility for ensuring that the corporation implements and maintains effective standards and procedures for operating efficiency and for quality of consumer service and claims payment, including but not limited to coordination of benefits and fraud prevention and shall establish one or more committees comprised solely of directors who are not officers or employees of the corporation. Such committee or committees shall have responsibility for recommending the selection of independent certified public accountants, reviewing the corporation's financial condition, the scope and results of the independent audit and any internal audit, nominating candidates for director for election by members, and evaluating the performance of officers deemed by such committee or committees to be principal officers of the company and recommending to the board of directors the selection and compensation of such principal officers.

(2) (A) Compliance with the provisions of paragraph one hereof shall be under the supervision of the superintendent.

(B) Within ten days after a vacancy in the board of directors of a health service, hospital service or medical expense indemnity corporation shall occur, such corporation shall notify the superintendent in writing that such vacancy exists. Not more than ten days after the election of a person as a director of a health service,

hospital service or medical expense indemnity corporation, such corporation shall furnish, in writing, the following information to the superintendent: the name and address of the person so elected; whether such person is representative of any member hospital or licensed medical professional of such corporation or persons covered under its contracts or the general public and qualified to serve pursuant to the provisions of paragraph one hereof or is an employee-officer of such corporation; and a biographical statement concerning such person. If the superintendent finds, after a hearing, that the composition of the board of directors of a health service, hospital service or medical expense indemnity corporation is not in compliance with the provisions of paragraph one hereof, he may direct that such board of directors be reconstituted in accordance with his finding.

(3) No person who has served as a director of any corporation subject to this article for ten consecutive years shall thereafter be elected for an additional term of office as such until at least one year has elapsed since the expiration of his prior term of office. The preceding sentence shall not apply to a director of any corporation subject to this article who is an employee of the corporation and who also serves as an officer of the corporation. The superintendent, upon application by a corporation subject to the provisions of this article, may waive the ten year limit in this paragraph for a non-employee serving as chairman of its board of directors.

(4) A director of a corporation subject to this article shall automatically forfeit his office if (i) he fails to attend at least one of the regular meetings of the board of directors held during any period of eighteen consecutive months, or (ii) unless excused by the board of directors of which he is a member, which action shall be entered on the minutes of such board, it shall appear at the end of any calendar year that he failed to attend at least one-half of the regular meetings of such board held in such calendar year. A director whose office becomes vacant pursuant to the provisions of this paragraph shall not be eligible for election to such office for a period of one year from the date the vacancy occurred.

§ 4302. Permit and license to do business. (a) Corporations subject to

this article shall not solicit the purchase of, or enter into, any contract with any individual or group until it has obtained from the superintendent a permit so to do. Such permit shall be issued by the superintendent upon receipt of an application in a form to be prescribed by the superintendent and upon payment of a fee of ten dollars. Such application shall include a statement of the territory in which the corporation will operate, which, in the case of hospital service corporations, shall not exceed eighteen counties of this state, the services to be rendered by the corporation and the rates to be charged therefor, and shall be accompanied by two copies of each type of contract for service which the corporation proposes to render and by a bond in the sum of one thousand dollars conditioned upon return to applicants for contracts of any advance payments made if within one year from the date of the issuance of such permit a license to do business as hereafter provided has not been issued.

(b) No such corporation shall furnish medical expense indemnity, dental expense indemnity, hospital service or health service as set forth in section four thousand three hundred one of this article until it has obtained from the superintendent a license to do business. Such license may be issued by the superintendent upon the filing of an application, subscribed by two officers of such corporation and affirmed by such officers as true under the penalties of perjury, and in a form prescribed by the superintendent and upon payment of a fee of ten dollars. Such application shall include (i) a statement of the number of individuals and groups from whom the corporation has received applications for medical expense indemnity, dental expense indemnity, hospital service or health service, as the case may be, to be rendered during one year, and from each of whom it has received payment of not less than one-sixth of the full payment required from such individuals and groups; and (ii) a statement of the total amount so collected, which shall be not less than eighteen hundred dollars. Before issuing any such license the superintendent may make such examination or investigation as he deems expedient, including an investigation of the sponsors of such proposed corporation and if after such examination or investigation he determines the issuance of such license is contrary to the interest of the people, he shall refuse to issue. Upon the issuance of such license, the corporation may begin to furnish medical expense indemnity, dental

expense indemnity, hospital service or health service, as the case may be.

(c) Notwithstanding the other provisions of this article, the superintendent may issue a permit to organize and a license to do business to a not-for-profit corporation organized and operated under the supervision of the New York State Public High School Athletic Association, unrestricted as to its territorial operations in this state, for the sole purpose, however, of furnishing medical, dental and hospital expense indemnity to bona fide students in elementary and high schools injured (i) in intramural and interscholastic athletic games and sports activities, (ii) while engaged in preparation for such games, sports or contests, (iii) in physical education classes, and (iv) in any other accidents which in the judgment of the superintendent should be included. The dental indemnity is to apply, however, only in case of dental expense caused by injury occurring as above set forth.

§ 4303. Benefits. (a) Every contract issued by a hospital service corporation or health service corporation which provides coverage for in-patient hospital care shall also provide coverage:

(1) For preadmission testing performed in hospital facilities prior to scheduled surgery. A patient who uses the out-patient facilities of a hospital shall be entitled to benefits for tests ordered by a physician which are performed as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital, provided that:

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

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

(C) surgery actually takes place within seven days of such presurgical tests, and

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

(2) (A) For services to treat an emergency condition in hospital facilities:

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

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

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

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

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

(C) For the purpose of this provision, "emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(D) For the purpose of this provision, "emergency services" means, with respect to an emergency condition: (i) a medical screening examination as required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act, 42 U.S.C. § 1395dd, to stabilize the patient.

(E) For the purpose of this provision, "to stabilize" means, with

respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the subscriber from a facility or to deliver a newborn child (including the placenta).

(3) For home care to residents in this state. Such home care coverage shall be included at the inception of all new contracts and, with respect to all other contracts, added at any anniversary date of the contract subject to evidence of insurability. Such coverage may be subject to an annual deductible of not more than fifty dollars for each covered person and may be subject to a coinsurance provision which provides for coverage of not less than seventy-five percent of the reasonable cost of services for which payment may be made. No such corporation need provide such coverage to persons eligible for medicare.

(A) Home care shall mean the care and treatment of a covered person who is under the care of a physician but only if:

(i) hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq, would otherwise have been required if home care was not provided, and

(ii) the plan covering the home health service is established and approved in writing by such physician.

(B) Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law.

(C) Home care 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, and

(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 or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility as defined in subchapter XVIII of the Social Security Act, 42

U.S.C. § 1395 et seq.

(D) 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 covered person. Four hours of home health aide service shall be considered as one home care visit. Every contract issued by a hospital service corporation or health service corporation which provides coverage supplementing part A and part B of subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq, must make available and, if requested by a subscriber holding a direct payment contract or by all subscribers in a group remittance group or by the contract holder in the case of group contracts issued pursuant to section four thousand three hundred five of this article, 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 contract 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 group remitting agent or group contract holder prior to inception of such contract 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.

The provisions of this subsection shall not apply to a contract issued pursuant to section four thousand three hundred five of this article 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) Every contract issued by a medical expense indemnity corporation or a health service corporation 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 contract issued pursuant to section four thousand

three hundred five of this article 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.

(c) (1) (A) Every contract issued by a corporation subject to the provisions of this article which provides hospital service, medical expense indemnity or both shall provide coverage for maternity care including hospital, surgical or medical care to the same extent that hospital service, medical expense indemnity or both are provided for illness or disease under the contract. Such maternity care coverage, other than coverage for perinatal complications, shall include inpatient hospital coverage for mother and for newborn for at least forty-eight hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six hours following a caesarean section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to article one hundred forty of the education law, practicing consistent with section sixty-nine hundred fifty-one of the education law and affiliated or practicing in conjunction with a facility licensed pursuant to article twenty-eight of the public health law, but no insurer shall be required to pay for duplicative routine services actually provided by both a licensed midwife and a physician.

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

(C) The mother shall have the option to be discharged earlier than the time periods established in subparagraph (A) of this paragraph. 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 contract. The contract 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 contract and subject to the provisions of this paragraph, and not subject to deductibles, coinsurance or copayments.

* (D) Coverage provided under this paragraph for care and treatment

during pregnancy shall include medically necessary transvaginal ultrasounds when recommended by nationally recognized clinical practice guidelines. For the purposes of this subparagraph, "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

* NB Effective January 1, 2027

(2) Coverage provided under this subsection 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.

(c-1) Any contract issued by a medical expense indemnity corporation, a hospital service corporation or a health services corporation that provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for prenatal vitamins when prescribed by a health care practitioner licensed, certified, or authorized under title eight of the education law, and acting within their lawful scope of practice.

(d) (1) A hospital service corporation or a health service corporation which provides coverage for in-patient hospital care must make available and, if requested by a person holding a direct payment individual contract or by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide coverage for care in nursing homes. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts, at any anniversary date subject to evidence of insurability. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract 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) For the purpose of this subsection, care in nursing homes shall

mean 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 two thousand 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. 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. The level of benefits to be provided for nursing home care must be reasonably related to the benefits provided for hospital care.

(e) (1) A hospital service corporation or a health service corporation which provides coverage for in-patient hospital care must make available and, if requested by a person holding a direct payment individual contract or by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide coverage for ambulatory care in hospital out-patient facilities, as a hospital is defined in section two thousand eight hundred one of the public health law, or subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract 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) For the purpose of this subsection, ambulatory care in hospital out-patient facilities shall mean 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 (i) related to and necessary for

the treatment or diagnosis of the patient's illness or injury, (ii) ordered by a physician and (iii) in the case of physical therapy, services are to be furnished in connection with the same illness for which the patient had been hospitalized or in connection with surgical care, but in no event need benefits 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. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts, at any anniversary date subject to evidence of insurability.

(f) (1) A medical expense indemnity corporation or a health service corporation which provides coverage for physicians' services must make available and, if requested by a person holding an individual direct payment contract or by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide coverage for ambulatory care in physicians' offices. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract 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) For the purpose of this subsection, ambulatory care in physicians' offices shall mean 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 (i) related to and necessary for the treatment or diagnosis of the patient's illness or injury, and (ii) ordered by a physician. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts at any anniversary date subject to evidence of insurability.

(g) A medical expense indemnity corporation, hospital service

corporation or a health service corporation, that provides group, group remittance or school blanket coverage for inpatient hospital care or coverage for physician services shall provide as part of its contract coverage for the diagnosis and treatment of mental health conditions and:

* (1) where the contract provides coverage for inpatient hospital care, benefits for in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or for inpatient care provided in other states, to similarly licensed hospitals, and benefits for out-patient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or in a facility operated by the office of mental health or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law or for out-patient care provided in other states, to similarly certified facilities; and

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

* (1) where the contract provides coverage for inpatient hospital care, benefits for: in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law; sub-acute care in a residential facility licensed or operated by the office of mental health; outpatient care provided by a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or by a facility operated by the office of mental health; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or designated by the office of mental health or the office of addiction services and supports; outpatient and inpatient care for critical time intervention services and outpatient care for assertive community treatment services provided by facilities issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, beginning no later than thirty days following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of

a hospital licensed pursuant to article twenty-eight of the public health law; or for care provided in other states, to similarly licensed or certified hospitals, facilities, or licensed, certified or designated providers; and

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

(3) Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the contract.

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

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

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

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

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

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective until after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

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

* NB Effective after the superintendent of financial services and the

commissioner of health have promulgated regulations

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

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

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

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

* (10) This paragraph shall apply to mobile crisis intervention services providers licensed, certified, or designated by the office of mental health or the office of addiction services and supports. For purposes of this paragraph, "mobile crisis intervention services" means mental health and substance use disorder services, consisting of: (1) telephonic crisis triage and response; (2) mobile crisis response to provide intervention and facilitate access to other behavioral health services; and (3) mobile and telephonic follow-up services after the initial crisis response until the insured is stabilized, provided to an insured who is experiencing, or is at imminent risk of experiencing, a behavioral health crisis, which includes instances in which an insured cannot manage their primarily psychiatric or substance use related symptoms without de-escalation or intervention. Mobile crisis intervention services do not include services provided to an insured after the insured has been stabilized.

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

(B) Benefits for covered services provided by a mobile crisis intervention services provider shall be covered regardless of whether the mobile crisis intervention services provider is a participating provider.

(C) If the covered services are provided by a non-participating mobile crisis intervention services provider, a corporation shall not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to covered services received from a participating mobile crisis intervention services provider.

(D) If the covered services are provided by a non-participating mobile crisis intervention services provider, the insured's copayment, coinsurance, and deductible shall be the same as would apply if such covered services were provided by a participating mobile crisis intervention services provider.

(E) A mobile crisis intervention services provider reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against, an insured for the services provided pursuant to this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the contract.

* NB Effective after the superintendent of financial services and the commissioner of health have promulgated regulations

(11) This paragraph shall apply to school-based mental health clinics that are licensed pursuant to article thirty-one of the mental hygiene law and provide outpatient care in pre-school, elementary, or secondary schools. A corporation shall provide reimbursement for covered outpatient care when provided by such school-based mental health clinics at a pre-school, elementary, or secondary school, regardless of whether the school-based mental health clinic furnishing such services is a participating provider with respect to such services. Reimbursement for such covered services shall be at the rate negotiated between the corporation and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law. Payment by a corporation pursuant to this section shall be payment in full for the

services provided. The school-based mental health clinic reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against, a corporation for the services provided pursuant to this paragraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the contract.

(12) (A) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facility shall be at rates negotiated between the corporation and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(B) The office of mental health shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of mental health. Nothing in this subparagraph shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in subparagraph (A) of this paragraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide corporations with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and

applications, corporations may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

(j)(1) A health service corporation or medical expense indemnity corporation that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(2) For purposes of this paragraph and paragraph one of this subsection, preventive and primary care services shall mean the following services rendered to a covered child of a subscriber from the date of birth through the attainment of nineteen years of age:

(A) 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,

(B) 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

(C) 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.

(D) Such coverage required pursuant to this paragraph and paragraph one of this subsection shall not be subject to annual deductibles or coinsurance.

(E) Such coverage required pursuant to this paragraph and paragraph one of this subsection shall not restrict or eliminate existing coverage provided by the contract.

(3) In addition to paragraph one or two of this subsection, every contract that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under paragraph four of this subsection, shall provide coverage for the following preventive care and screenings for subscribers, and such coverage shall not be subject to annual deductibles or coinsurance:

(A) evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(B) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved, or that are recommended by the commissioner of health to the superintendent utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians and/or other similar nationally or internationally recognized scientific organizations;

(C) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(4) For purposes of this subsection, "grandfathered health plan" means coverage provided by a corporation 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).

* (k)(1) Every contract that provides hospital, major medical or similar comprehensive coverage shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(2) Coverage provided under this subsection may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse, or chemical dependence treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(4) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission. The facility shall perform daily clinical review of the patient, including periodic consultation with the corporation at or just prior to the fourteenth day

of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Prior to discharge, the facility shall provide the patient and the corporation with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the corporation whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(5) The criteria for medical necessity determinations under the contract with respect to inpatient substance use disorder benefits shall be made available by the corporation to any insured, prospective insured or in-network provider upon request.

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope

or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(7) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

* NB Effective until January 1, 2027

* (k)(1) Every contract that provides hospital, major medical or similar comprehensive coverage shall provide inpatient coverage for the diagnosis and treatment of substance-related and addictive disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance-related and addictive disorder treatment services provided in residential settings. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance-related and addictive disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(2) Coverage provided under this subsection may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of addiction services and supports and, in other states, to those which are accredited by the joint commission as

alcoholism, addiction, substance abuse, or chemical dependence treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(4) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission. The facility shall perform daily clinical review of the patient, including periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of addiction services and supports and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Prior to discharge, the facility shall provide the patient and the corporation with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the corporation which is designated by the office of addiction services and supports. Prior to discharge, the facility shall indicate to the corporation whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically

necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(5) The criteria for medical necessity determinations under the contract with respect to inpatient substance-related and addictive disorder benefits shall be made available by the corporation to any insured, prospective insured or in-network provider upon request.

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance-related and addictive disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(7) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §

1185a).

* NB Effective January 1, 2027

* (l) (1) Every contract that provides medical, major medical or similar comprehensive-type coverage shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(2) Coverage under this subsection may be limited to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(3-a) A contract that provides large group coverage under this subsection shall not impose copayments or coinsurance for outpatient substance use disorder services that exceed the copayment or coinsurance imposed for a primary care office visit. Provided that no greater than one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services to provide outpatient substance use disorder services.

(4) A contract providing coverage for substance use disorder services pursuant to this subsection shall provide up to twenty outpatient visits per contract or calendar year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable contract pursuant to this subsection. The

coverage required by this subsection shall include treatment as a family member pursuant to such family member's own contract provided such family member:

(A) does not exceed the allowable number of family visits provided by the applicable contract pursuant to this subsection; and

(B) is otherwise entitled to coverage pursuant to this subsection and such family member's applicable contract.

(5) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. A subscriber shall not have any financial obligation to the facility for any treatment under this

paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(6) The criteria for medical necessity determinations under the contract with respect to outpatient substance use disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(7) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement.

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(8) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(9) This paragraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the corporation's provider network. Benefits for

care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(10) (A) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the corporation and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(B) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this subparagraph shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in subparagraph (A) of this paragraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide corporations with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and

applications, corporations may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective until January 1, 2027

* (l) (1) Every contract that provides medical, major medical or similar comprehensive-type coverage shall provide outpatient coverage for the diagnosis and treatment of substance-related and addictive disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance-related and addictive disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(2) Coverage under this subsection may be limited to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports to provide outpatient substance-related and addictive disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those which are accredited by the joint commission as alcoholism, addiction or chemical dependence substance abuse treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(3-a) A contract that provides large group coverage under this subsection shall not impose copayments or coinsurance for outpatient substance-related and addictive disorder services that exceed the copayment or coinsurance imposed for a primary care office visit. Provided that no greater than one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of addiction services and supports to provide outpatient substance-related and addictive disorder services.

(4) A contract providing coverage for substance-related and addictive disorder services pursuant to this subsection shall provide up to twenty outpatient visits per contract or calendar year to an individual who

identifies themselves as a family member of a person suffering from substance-related and addictive disorder and who seeks treatment as a family member who is otherwise covered by the applicable contract pursuant to this subsection. The coverage required by this subsection shall include treatment as a family member pursuant to such family member's own contract provided such family member:

(A) does not exceed the allowable number of family visits provided by the applicable contract pursuant to this subsection; and

(B) is otherwise entitled to coverage pursuant to this subsection and such family member's applicable contract.

(5) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of addiction services and supports and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the

corporation which is designated by the office of addiction services and supports. A subscriber shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(6) The criteria for medical necessity determinations under the contract with respect to outpatient substance-related and addictive disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(7) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement.

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance-related and addictive disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(8) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(9) This paragraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the corporation's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(10) (A) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the corporation and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year.

(B) The office of addiction services and supports shall publish information adequate to calculate the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. Such information shall be provided in a form and manner to be determined by the commissioner of addiction services and supports. Nothing in this subparagraph shall be construed to relieve an insurer of the obligation to reimburse at no less than the applicable minimum rate set forth in subparagraph (A) of this paragraph. Prior to the submission of premium rate filings and applications, the superintendent shall provide corporations with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and

applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, corporations may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

* NB Effective January 1, 2027

(l-1) * (A) No contract that provides medical, major medical or similar comprehensive-type individual or small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every contract that provides medical, major medical, or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance use disorder and shall not require prior authorization for an initial or renewal prescription for the detoxification of maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

* NB Effective until January 1, 2027

* (A) No contract that provides medical, major medical or similar comprehensive-type individual or small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance-related and addictive disorder shall require prior authorization for an initial or renewal prescription for the

detoxification or maintenance treatment of a substance-related and addictive disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every contract that provides medical, major medical, or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance-related and addictive disorder and shall not require prior authorization for an initial or renewal prescription for the detoxification of maintenance treatment of a substance-related and addictive disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

* NB Effective January 1, 2027

(B) Coverage provided under this paragraph may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the policy.

(l-2) Every policy that provides coverage for treatment at an opioid treatment program shall not impose a co-payment fee during the course of treatment on any insured for such treatment. For the purposes of this section "opioid treatment program" means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.

(m) A medical expense indemnity corporation or a health service corporation which 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 all subscribers in a group remittance group, or by a contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this chapter, provide reimbursement for such services when performed by

a duly licensed registered professional nurse provided, however, that reimbursement shall not be made for nursing services provided to a subscriber 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 group remitting agent or group contract holder prior to inception of such contract 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.

(n) Every health service or medical expense indemnity corporation issuing a group contract pursuant to this section or a group remittance contract for delivery in this state which contract provides reimbursement to subscribers or physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diagnosis and treatment of mental health conditions, however defined in such contract, must provide the same coverage to persons covered under the group contract for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law and a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Nothing herein shall be construed to modify or expand the scope of practice of a mental health counselor,

marriage and family therapist, or psychoanalyst licensed pursuant to article one hundred sixty-three of the education law. Further, nothing herein shall be construed to create a new mandated health benefit. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection. The state board for mental health practitioners shall maintain a list of all licensed mental health counselors, marriage and family therapists, or psychoanalysts qualified for reimbursement under this subsection.

(o) A hospital service corporation or a health service corporation which provides coverage for inpatient hospital care must make available and, if requested by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contractholder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide coverage for hospice care. For the purposes of this subsection, 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. Hospice care coverage shall be at least equal to: (1) 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 (2) five visits for bereavement counseling services, either before or after the insured's death, provided to the family of the terminally ill insured. Such coverage shall be made available at the inception of all new contracts and, with respect to contracts 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. 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 contract period. Written notice of the availability of such coverage shall be delivered to the group remitting

agent or group contract holder prior to inception of such contract 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.

(p) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(A) upon the recommendation of a physician, a mammogram, which may be provided by breast tomosynthesis, at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

(B) a single baseline mammogram, which may be provided by breast tomosynthesis, for covered persons aged thirty-five through thirty-nine, inclusive;

(C) an annual mammogram, which may be provided by breast tomosythesis, for covered persons aged forty and older;

(D) for large group contracts offered by a medical expense indemnity corporation, a hospital service corporation or a health service corporation that provide coverage for hospital, surgical or medical care, an annual mammogram for covered persons aged thirty-five through thirty-nine, inclusive, upon the recommendation of a physician, subject to the corporation's determination that the mammogram is medically necessary;

(E) upon the recommendation of a physician, screening and diagnostic imaging, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging, recommended by nationally recognized clinical practice guidelines for the detection of breast cancer. For the purposes of this subparagraph, "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy; and

* (F) The coverage required in this paragraph or paragraph two of this

subsection shall not be subject to annual deductibles or coinsurance. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

* NB Effective until January 1, 2027

* (F) The coverage required in this paragraph or paragraph two of this subsection shall not be subject to annual deductibles or coinsurance. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the plan deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the plan deductible has been satisfied.

* NB Effective January 1, 2027

(2) For purposes of paragraph one of this subsection, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast; provided, however, that mammography screening shall also include breast tomosythesis.

(3) In addition to paragraph one or two of this subsection, every contract that provides coverage for hospital, surgical or medical care, except for a grandfathered health plan under paragraph four of this subsection, shall provide coverage for the following mammography screening services, and such coverage shall not be subject to annual deductibles or coinsurance:

(A) evidence-based items or services for mammography that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; and

(B) with respect to women, such additional preventive care and screenings for mammography not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(4) For purposes of this subsection, "grandfathered health plan" means coverage provided by a corporation 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).

(p-1) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker precision medical testing for the purposes of diagnosis, treatment, or appropriate management of, or ongoing monitoring to guide treatment decisions for, an insured's disease or condition when one or more of the following recognizes the efficacy and appropriateness of biomarker precision medical testing for diagnosis, treatment, appropriate management, or guiding treatment decisions for an insured's disease or condition:

(A) labeled indications for a test approved or cleared by the federal food and drug administration or indicated tests for a food and drug administration approved drug;

(B) centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations;

(C) nationally recognized clinical practice guidelines; or

(D) peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(3) As used in this subsection, the following terms shall have the following meanings:

(A) "Biomarker" means a characteristic that is measured as an

indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions.

(B) "Biomarker precision medical testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests and multi-plex panel tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration.

(C) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

(q) (1) Every policy issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation which provides coverage for prescribed drugs approved by the food and drug administration of the United States government for the treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

(i) the American Hospital Formulary Service-Drug Information (AHFS-DI);

(ii) National Comprehensive Cancer Networks Drugs and Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

(2) Notwithstanding the provisions of this subsection, coverage shall not be required for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. The provisions of this subsection 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.

(q-1) (1) Every contract issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation for delivery in this state that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs and for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. Such coverage may be subject to co-pays, coinsurance or deductibles, provided that the co-pays, coinsurance or deductibles are at least as favorable to an insured as the co-pays, coinsurance or deductibles that apply to coverage for intravenous or injected anticancer medications.

(2) An insurer providing coverage under this paragraph and any participating entity through which the insurer offers health services shall not:

(A) vary the terms of the contract for the purpose or with the effect of avoiding compliance with this paragraph;

(B) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this paragraph;

(C) 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;

(D) 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

(E) achieve compliance with this paragraph by imposing an increase in

cost sharing for an intravenous or injected anticancer medication.

(q-2) (1) Every large group contract delivered or issued for delivery in this state that provides medical, major medical, or similar comprehensive-type coverage and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment. Coverage provided under this subsection may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract.

(2) For the purposes of this subsection, "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(r) Consistent with federal law, a hospital service corporation or a health service corporation 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 a person holding a direct payment individual contract or by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by a contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, 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 when 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 contracts and, with respect to all other contracts at each anniversary date of the contract.

(1) Coverage shall be subject to a copayment of twenty-five dollars per day.

(2) Brochures describing such coverage must be provided at the time of application for all new contracts and thereafter on each anniversary date of the contract, and with respect to all other contracts annually at each anniversary date of the contract. Such brochures must be approved by the superintendent in consultation with the commissioner of health.

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.

(3) The commensurate rate for the coverage must be approved by the superintendent.

* (s) (1) A hospital service corporation or health service corporation 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:

(A) subject to the provisions of paragraph three of this subsection, 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

(B) provided, further however, that subject to the provisions of paragraph three of this subsection, 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 subsection, 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

(C) 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 paragraph three of this subsection.

(2) A medical expense indemnity or health service corporation 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:

(A) subject to the provisions of paragraph three of this subsection, in no case shall such coverage exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility; and

(B) provided, further however, that subject to the provisions of paragraph three of this subsection, 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 subsection, 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

(C) 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 paragraph three of this subsection.

(3) Coverage of diagnostic and treatment procedures, including prescription drugs used in the diagnosis and treatment of infertility as required by paragraphs one and two of this subsection shall be provided in accordance with this paragraph.

(A) 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 paragraph.

(B) 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.

(C) Except as provided in subparagraphs (F) and (G) of this paragraph, 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 subparagraph (D) of this paragraph.

(D) 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 paragraph, which shall include:

(i) The identification of experimental procedures and treatments not covered for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(ii) The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(iii) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

(E)(i) For the purposes of this subsection, "infertility" means a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

(ii) For purposes of this subsection, "iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(F) Coverage shall also include standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract.

(G) Every large group contract that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization used in the treatment of infertility. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract. For purposes of this subparagraph, a "cycle" is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.

(H) No corporation providing coverage under this subsection shall discriminate based on an insured's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

(4) Every contract issued by a medical expense indemnity corporation, a hospital service corporation or a health services corporation that provides coverage for prescription fertility drugs and requires or permits prescription drugs to be purchased through a network participating mail order or other non-retail pharmacy shall provide the same coverage for prescription fertility drugs when such drugs are purchased from a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount, as well as the same applicable terms and conditions, that the corporation has established for the network participating mail order or other non-retail pharmacy. In such case, the contract shall not impose any fee, co-payment, co-insurance, deductible or other condition on any covered person who does not elect to purchase prescription fertility drugs through a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a contract that is the result of a collective

bargaining agreement between an employer and a recognized or certified employee organization.

* NB There are 2 sb (s)'s

* (s) Notwithstanding any provision of a contract issued by a medical expense indemnity corporation, a dental expense indemnity corporation or health service corporation, every contract which provides coverage for care provided through licensed health professionals who can bill for services shall provide the same coverage and 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.

* NB There are 2 sb (s)'s

(t) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for hospital, surgical, or medical care shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Such coverage required by this paragraph may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract.

(2) For purposes of paragraph one of this subsection, 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.

(3) In addition to paragraph one or two of this subsection, every contract that provides coverage for hospital, surgical or medical care, except for a grandfathered health plan under paragraph four of this subsection, shall provide coverage for the following cervical cytology screening services, and such coverage shall not be subject to annual deductibles or coinsurance:

(A) evidence-based items or services for cervical cytology that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; and

(B) with respect to women, such additional preventive care and screenings for cervical cytology not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported

by the health resources and services administration.

(4) For purposes of this subsection, "grandfathered health plan" means coverage provided by a corporation 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).

(u) (1) A medical expense indemnity corporation or a health service corporation which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or other licensed

health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

(2) Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy; provided, however, that covered prescription insulin drugs shall not be subject to a deductible, copayment, coinsurance or any other cost sharing requirement.

(3) This subsection 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.

(u-1) A medical expense indemnity corporation or a health service corporation 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 equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. The coverage required by this subsection shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits as defined in subsection (a) of section four thousand three hundred six-h of this article.

(v) (1) Every contract issued by a medical expense indemnity corporation, hospital service corporation or health service corporation 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 after such covered person has undergone a lymph node dissection or a lumpectomy for

the treatment of breast cancer or a mastectomy covered by the contract. 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 group remitting agent or group contract holder prior to the inception of such contract and annually thereafter.

(2) A medical expense indemnity corporation, hospital service corporation or health service corporation which provides coverage under this subsection and any participating entity through which the insurer offers health services shall not:

(A) deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract or vary the terms of the contract for the purpose or with the effect of avoiding compliance with this subsection;

(B) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this subsection;

(C) 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 subsection;

(D) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this subsection intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this subsection; or

(E) restrict coverage for any portion of a period within a hospital length of stay required under this subsection in a manner which is inconsistent with the coverage provided for any preceding portion of such stay.

(3) The prohibitions in paragraph two of this subsection shall be in addition to the provisions of sections four thousand three hundred seventeen and four thousand three hundred eighteen of this article and nothing in this paragraph shall be construed to suspend, supersede, amend or otherwise modify such sections.

(w)(1) Every contract issued by a medical expense indemnity corporation or health service corporation 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 contract that requires, or provides financial incentives for, the covered person to receive covered services from health care providers participating in a provider network maintained by or under contract with the corporation, the contract 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 covered person beyond what such covered person would have paid for services from a participating appropriate specialist. Provided however that nothing herein shall impair the covered person's rights (if any) under the contract 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 contract for services provided by non-participating providers. The corporation 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 contract that does not provide financial incentives for, and does not require, the covered person to receive covered services from health care providers participating in a provider network maintained by or under contract with the corporation, the contract shall include coverage for a second medical opinion from a specialist at no additional cost to the covered person beyond what the covered person would have paid for comparable services covered under the contract.

(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 contract and, where applicable, consistent with the provisions of

subparagraphs (i) and (ii) of this paragraph.

Nothing in this subsection shall eliminate or diminish the corporation's obligation to comply with the provisions of section four thousand eight hundred four of this chapter and section forty-four hundred three of the public health law where applicable. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to the inception of such contract and annually thereafter.

(2) A medical expense indemnity corporation or health service corporation which provides coverage under this subsection and any participating entity through which the insurer offers health services shall not:

(A) deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract or vary the terms of the contract for the purpose or with the effect of avoiding compliance with this subsection;

(B) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this subsection;

(C) 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 subsection; or

(D) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this subsection intended to induce or have the effect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this subsection.

(3) The prohibitions in paragraph two of this subsection shall be in addition to the provisions of sections four thousand three hundred seventeen and four thousand three hundred eighteen of this article and nothing in this paragraph shall be construed to suspend, supersede, amend or otherwise modify such sections.

(x) (1) Every contract issued by a medical expense indemnity corporation, hospital service corporation or health service corporation which provides coverage for surgical or medical care shall provide the following coverage for breast or chest wall reconstruction surgery after

a mastectomy or partial mastectomy:

(A) all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; and

(B) surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance;

in the manner determined by the attending physician and the patient to be appropriate. Chest wall reconstruction surgery shall include aesthetic flat closure as such term is defined by the National Cancer institute. Such coverage may be subject to annual deductibles or 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 group remitting agent or group contract holder prior to the inception of such contract and annually thereafter.

(1-A) Every contract providing coverage as required by paragraph one of this subsection shall also provide coverage for the tattooing of the nipple-areolar complex pursuant to or as part of such reconstruction if such tattooing is performed by a licensed physician or other health care practitioner licensed, certified, or authorized pursuant to title eight of the education law and acting within their scope of practice.

(2) A medical expense indemnity corporation, hospital service corporation or health service corporation which provides coverage under this subsection and any participating entity through which the insurer offers health services shall not:

(A) 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 subsection;

(B) provide incentives (monetary or otherwise) to encourage a covered person to accept less than the minimum protections available under this subsection;

(C) 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 subsection;

(D) provide incentives (monetary or otherwise) to a health care practitioner relating to the services provided pursuant to this

subsection intended to induce or have the affect of inducing such practitioner to provide care to a covered person in a manner inconsistent with this subsection;

(E) restrict coverage for any portion of a period within a hospital length of stay required under this subsection in a manner which is inconsistent with the coverage provided for any preceding portion of such stay; or

(F) the prohibitions in this paragraph shall be in addition to the provisions of sections four thousand three hundred seventeen and four thousand three hundred eighteen of this article and nothing in this paragraph shall be construed to suspend, supersede, amend or otherwise modify such sections.

* (y) Every contract that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein, contain modified protein, or are amino acid based that are medically necessary.

* NB There are 2 sb§ (y)'s

* (y)(1) Every contract issued by a health service corporation or a medical expense indemnity corporation which is a "managed care product" as defined in paragraph four of this subsection that includes coverage for physician services in a physician's office, and every "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.

(3) Every contract issued by a health service corporation or a medical expense indemnity corporation which includes coverage for physician services in a physician's office, and every contract which provides major medical or similar comprehensive-type coverage, other than a "managed care product" as defined in paragraph four of this subsection, shall provide coverage for chiropractic care, as defined in section six thousand five hundred fifty-one of the education law, provided by a

doctor of chiropractic licensed pursuant to article one hundred thirty-two of the education law, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, chiropractic care and services may be subject to reasonable deductible, co-payment and co-insurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: (a) shall not function to direct treatment in a manner discriminative against chiropractic care, and (b) individually and collectively shall be no more restrictive than those applicable under the same contract 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.

(4) For purposes of this subsection, a "managed care product" shall mean 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 corporation'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 corporation's managed care provider network, in order for the insured to be entitled to the maximum reimbursement under the contract.

(5) The coverage required by this subsection shall not be abridged by

any regulation promulgated by the superintendent.

* NB There are 2 sb§ (y)'s

(z) No contract issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation shall exclude coverage of a health care service, as defined in paragraph two of subsection (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 subsection shall be provided subject to the terms and conditions generally applicable to other benefits provided under the policy.

(z-1) (1) 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:

(A) 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

(B) 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.

(2) Such coverage shall not be subject to annual deductibles or coinsurance.

(aa)(1) Every contract issued by a hospital service company or health service corporation 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.

(2) 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 subsection, except for the collection of copayments, coinsurance or deductibles for which the insured is responsible for under the terms of the policy.

(3) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable. The insurer shall send such payments directly to the provider of such ambulance services, if the ambulance service has on file an executed assignment of benefits form with the claim.

(4) The provisions of this subsection shall have no application to transfers of patients between hospitals or health care facilities by an ambulance service as described in paragraph one of this subsection unless such services are covered under the policy.

(5) As used in this subsection:

(A) "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 subsection, reimbursement shall be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such

transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(bb) A health service corporation or a medical service expense indemnity corporation that provides major medical or similar comprehensive-type coverage shall provide such coverage for bone mineral density measurements or tests, and if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes. In determining appropriate coverage provided by paragraphs one, two and three of this subsection, the insurer or health maintenance organization shall adopt standards that include the criteria of the federal Medicare program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(1) For purposes of paragraphs two and three of this subsection, bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of 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.

(2) For purposes of paragraphs one and three of this subsection, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage, consistent with 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.

(3) Such coverage required pursuant to paragraph one or two of this subsection 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.

(4) In addition to paragraph one, two or three of this subsection, every contract that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under paragraph five of this subsection, shall provide coverage for the following items or services for bone mineral density, and such coverage shall not be subject to annual deductibles or coinsurance:

(A) evidence-based items or services for bone mineral density that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; and

(B) with respect to women, such additional preventive care and screenings for bone mineral density not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(5) For purposes of this subsection, "grandfathered health plan" means coverage provided by a corporation 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).

(cc) (1) Every contract that provides medical, major medical, or similar comprehensive type coverage that is issued, amended, renewed, effective or delivered on or after January first, two thousand twenty, shall provide coverage for all of the following services and contraceptive methods:

(A) All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. The following applies to this coverage:

(i) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, a contract is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this subsection;

(ii) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a contract shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final. The superintendent shall promulgate regulations establishing a process, including timeframes, for an insured, an insured's designee or an insured's health care provider to request coverage of a non-covered contraceptive drug, device, or product. Such regulations shall include a requirement that insurers use an exception form that shall meet criteria established by the superintendent;

(iii) this coverage shall include emergency contraception without cost-sharing when provided pursuant to a prescription or order under section sixty-eight hundred thirty-one of the education law or when lawfully provided over the counter; and

(iv) this coverage must allow for the dispensing of up to twelve months worth of a contraceptive at one time;

(B) Voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and identified in the comprehensive guidelines supported by the health resources and services administration and thereby incorporated in the essential health benefits benchmark plan;

(C) Patient education and counseling on contraception; and

(D) Follow-up services related to the drugs, devices, products, and procedures covered under this subsection, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(2) A contract subject to this subsection shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subsection.

(3) Except as otherwise authorized under this subsection, a contract shall not impose any restrictions or delays on the coverage required under this subsection.

(4) Benefits for an enrollee under this subsection shall be the same for an enrollee's covered spouse or domestic partner and covered nonspouse dependents.

(5) 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.

(A) For purposes of this subsection, a "religious employer" is an entity for which each of the following is true:

(i) The inculcation of religious values is the purpose of the entity.

(ii) The entity primarily employs persons who share the religious tenets of the entity.

(iii) The entity serves primarily persons who share the religious tenets of the entity.

(iv) 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.

(B) 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.

(6) (A) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph five of this subsection, each enrollee covered under the contract issued to that group contractholder shall have the right to directly purchase the rider required by this subsection from the insurer or health maintenance organization which issued the group contract at the prevailing small group community rate for such rider whether or not the employee is part of a small group.

(B) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph five of this subsection, the insurer or health maintenance organization that provides such coverage shall provide written notice to enrollees upon enrollment with the insurer or health maintenance organization of their right to directly purchase a rider for coverage for the cost of contraceptive drugs or devices. The notice shall also advise the enrollees of the additional premium for such coverage.

(7) Nothing in this subsection shall be construed as authorizing a contract which provides coverage for prescription drugs to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes.

(8) For the purposes of this paragraph, "over-the-counter contraceptive products" shall mean those products provided for in comprehensive guidelines supported by the health resources and services administration as of January twenty-first, two thousand nineteen.

(dd) No health service corporation or medical service expense indemnity corporation which provides medical, major medical or similar comprehensive-type coverage shall exclude coverage for services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article thirty of the mental hygiene law; provided, however, that reimbursement by such corporation 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.

(ee) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation which provides coverage for hospital or surgical care coverage shall not exclude coverage for screening, diagnosis and treatment of medical conditions otherwise covered by the contract solely because the treatment is provided to diagnose or treat autism spectrum disorder.

(2) Every contract that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as case management and other managed care provisions.

(3) For purposes of this subsection:

(A) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders.

(B) "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(C) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided by a person that is licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(D) "diagnosis of autism spectrum disorder" means assessments, evaluations, or tests to diagnose whether an individual has autism spectrum disorder.

(E) "pharmacy care" means medications prescribed by a licensed health care provider legally authorized to prescribe under title eight of the education law.

(F) "psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(G) "psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(H) "therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists.

(I) "treatment of autism spectrum disorder" shall include the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:

(i) behavioral health treatment;

(ii) psychiatric care;

(iii) psychological care;

(iv) medical care provided by a licensed health care provider;

(v) therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and

(vi) pharmacy care in the event that the contract provides coverage for prescription drugs.

(4) Coverage may be denied on the basis that such treatment is being provided to the covered person pursuant to an individualized education plan under article eighty-nine of the education law. The provision of

services pursuant to an individualized family service plan under section twenty-five hundred forty-five of the public health law, an individualized education plan under article eighty-nine of the education law, or an individualized service plan pursuant to regulations of the office for persons with developmental disabilities shall not affect coverage under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

(5) Nothing in this subsection shall be construed to affect any obligation to provide services to an individual under an individualized family service plan under section twenty-five hundred forty-five of the public health law, an individualized education plan under article eighty-nine of the education law, or an individualized service plan pursuant to regulations of the office for persons with developmental disabilities.

(7) Nothing in this subsection shall be construed to prevent a contract from providing services through a network of participating providers who shall meet certain requirements for participation, including provider credentialing.

(8) Coverage under this subsection shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(9) The criteria for medical necessity determinations under the contract with respect to autism spectrum disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(10) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment

limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract.

(11) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(ff) (1) No managed care contract issued by a health service corporation, hospital service corporation or medical expense indemnity corporation that provides coverage for hospital, medical or surgical care shall provide that services of a participating hospital will be covered as out-of-network services solely on the basis that the health care provider admitting or rendering services to the insured is not a participating provider.

(2) No managed care contract issued by a health service corporation, hospital service corporation or medical expense indemnity corporation that provides coverage for hospital, medical or surgical care shall provide that services of a participating health care provider will be covered as out-of-network services solely on the basis that the services are rendered in a non-participating hospital.

(3) For purposes of this subsection, a "health care provider" is a health care professional licensed, registered or certified pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

(4) For purposes of this subsection, a "managed care contract" is a contract that requires that services be provided by a provider participating in the corporation's network in order for the subscriber to receive the maximum level of reimbursement under the contract.

(gg) (1) Every contract issued by a hospital service corporation, health service corporation or medical expense indemnity corporation that

includes coverage for dialysis treatment that requires such services to be provided by an in-network provider and that does not provide coverage for out-of-network dialysis treatment shall not deny coverage of such services because the services are provided by an out-of-network provider, provided that each of the following conditions are met:

(A) The out-of-network provider is duly licensed to practice and authorized to provide such treatment;

(B) The out-of-network provider is located outside the service area of the insurer;

(C) The in-network healthcare provider treating the covered person for the condition issues a written order for dialysis treatment stating that in his or her opinion such treatment is necessary;

(D) The covered person has notified, in writing, the corporation at least thirty days in advance of the proposed date or dates of such out-of-network dialysis treatment. The notice shall include the authorization required by subparagraph (C) of this paragraph. In the event the covered person must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the corporation has reasonable opportunity to review the travel and treatment plans of the covered person;

(E) The corporation shall have the right to pre-approve the dialysis treatment and schedule; and

(F) Such coverage is limited to no greater than ten out-of-network treatments in a calendar year.

(2) Where coverage for out-of-network dialysis treatment is provided pursuant to paragraph one of this subsection, no corporation shall be obligated to reimburse the out-of-network provider at an amount greater than it would have paid for the same treatment within a network, including all drugs and ancillary services tied to dialysis treatment, and any amount charged by a provider in excess of the amount reimbursed by the corporation shall be the responsibility of the covered person receiving the out-of-network services.

(3) Such coverage of out-of-network dialysis services required by paragraph one of this subsection shall otherwise be subject to the limitations, exclusions and terms of the policy, including, but not limited to, utilization review, annual deductibles, copayments, and coinsurance, consistent with those required for other similar benefits

under the policy.

(hh) Notwithstanding title eleven of article five of the social services law or any other law to the contrary, every policy which provides coverage for prescription drugs shall, with regard to eye drop medication requiring a prescription that has been approved by the insurer for coverage, allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals. Provided, however, that any refill dispensed prior to the expiration of the prescribed and approved coverage period pursuant to this subsection, shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. Provided, further, that such limited refilling shall not limit or restrict coverage with regard to any previously or subsequently approved prescription for eye drop medication and shall be subject to the terms and conditions of the policy otherwise applicable to this coverage. Provided, further, that a pharmacist may contact the prescribing physician or health care provider to verity the prescription.

(ii) Every contract issued by a corporation subject to the provisions of this article which provides medical, major medical or similar comprehensive-type coverage that includes coverage for a physical or well care visit once in every three hundred sixty-five days shall be interpreted to mean that such physical or well care visit can be had once every calendar year, regardless of whether or not a period of three hundred sixty-five days has passed since the previous physical or well care visit.

(jj) No medical expense indemnity corporation, a hospital service corporation or a health service corporation which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).

(kk) (1) Definitions. For the purpose of this subsection:

(A) "Same reimbursement amount" shall mean that any coverage described

under paragraph two of this subsection shall provide the same benchmark index, including the same average wholesale price, maximum allowable cost and national prescription drug codes to reimburse all pharmacies participating in the health benefit plan regardless of whether a pharmacy is a mail order pharmacy or a non-mail order pharmacy.

(B) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to patients through the use of the United States mail or other common or contract carrier services and provides any consultation with patients electronically rather than face-to-face.

(2) Any contract issued by a medical expense indemnity corporation, a hospital service corporation or a health services corporation that provides coverage for prescription drugs shall permit each covered person to fill any covered prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the covered person's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees to the same reimbursement amount that the corporation has established for the network participating mail order or other non-retail pharmacy. In such a case, the contract shall not impose a copayment fee or other condition on any covered person who elects to purchase drugs from a network participating non-mail order retail pharmacy which is not also imposed on covered persons electing to purchase drugs from a network participating mail order or other non-retail pharmacy; provided, however, that the provisions of this section shall not supersede the terms of a collective bargaining agreement or apply to a contract that is the result of a collective bargaining agreement between an employer and a recognized or certified employee organization.

(ll) Every small group contract or association group contract issued by a corporation subject to the provisions of this article that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health benefits package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in paragraph three of subsection (e) of section four thousand

three hundred six-h of this article;

(2) "grandfathered health plan" means coverage provided by a corporation 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

(3) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(4) "association group" means a group defined in subparagraphs (B), (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, provided that:

(A) the group includes one or more individual members; or

(B) the group includes one or more member employers or other member groups that are small groups.

(mm) A corporation shall not be required to offer the contract holder any benefits that must be made available pursuant to this section if such benefits must be covered pursuant to subsection (kk) of this section. For any contract issued within the health benefit exchange established by this state, a corporation shall not be required to offer the contract holder any benefits that must be made available pursuant to this section.

(nn) A corporation subject to the provisions of this article or an insurance producer subject to this chapter shall not permit the renewal of a small group policy which provides hospital, surgical or medical expense coverage that renews on or after January first, two thousand fourteen, but before July first, two thousand fourteen, so as to renew the same policy prior to the policy's annual renewal date for the sole purpose of evading the requirements of the affordable care act and regulations promulgated thereunder with respect to such policy. An isolated, inadvertent renewal date change which was not made for the sole purpose of evading the requirements of the affordable care act shall not be deemed a violation of this subsection.

(oo) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for hospital, surgical or medical care shall provide the following coverage for pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for which a licensed medical practitioner has

issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

(pp) No contract issued by a medical expense indemnity corporation, hospital service corporation, or health service corporation that provides reimbursement for non-physician surgical first assistant services when the services are provided by a non-physician surgical first assistant shall exclude such coverage on the basis that the non-physician surgical first assistant services were performed by a registered nurse first assistant provided that: (1) the registered nurse first assistant is certified in operating room nursing; (2) the services are within the scope of practice of a non-physician surgical first assistant; and (3) the terms and conditions of the contract otherwise provide for the coverage of the services. Nothing in this subsection shall be construed to prevent the medical management or utilization review of the services or prevent a policy from requiring that services are to be provided through a network of participating providers who meet certain requirements for participation, including provider credentialing.

* (qq) Every medical expense indemnity corporation, hospital service corporation or health service corporation that provides coverage for prescription drugs subject to a copayment shall charge a copayment for a limited initial prescription of an opioid drug, which is prescribed in accordance with paragraph (b) of subdivision five of section thirty-three hundred one of the public health law, that is either (i) proportional between the copayment for a thirty-day supply and the amount of drugs the patient was prescribed; or (ii) equivalent to the copayment for a full thirty-day supply of the opioid drug, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the thirty-day supply.

* NB There are 2 sb§ (qq)'s

* (qq) Whenever in this section a corporation is required to provide

benefits with no coinsurance or deductible, the requirement only applies with respect to participating providers in the corporation's network, or with respect to non-participating providers, if the corporation does not have a participating provider in the in-network benefits portion of its network with the appropriate training and experience to meet the particular health care needs of the covered person pursuant to subsection (d) of section four thousand three hundred six-c of this article, or as applicable, pursuant to paragraph (a) of subdivision six of section forty-four hundred three of the public health law.

* NB There are 2 sb§ (qq)'s

(rr) Health care forensic examinations performed pursuant to section twenty-eight hundred five-i of the public health law covered under the contract shall not be subject to annual deductibles or coinsurance.

(ss)(1) Every policy which provides hospital, surgical, or medical coverage and which offers maternity care coverage pursuant to subsection (c) of this section shall also provide coverage for abortion services for an enrollee.

(2) Coverage for abortion shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986, in which case coverage for abortion may be subject to the plan's annual deductible.

(3) coverage for abortion shall include coverage of any drug prescribed for the purpose of an abortion, including both generic and brand name drugs, even if such drug has not been approved by the food and drug administration for abortion, provided, however, that such drug shall be a recognized medication for abortion in one of the following established reference compendia:

(A) The WHO Model Lists of Essential Medicines;

(B) The WHO Abortion Care Guidance; or

(C) The National Academies of Science, Engineering, and Medicine Consensus Study Report.

(4) Notwithstanding any other provision, a group policy that provides hospital, surgical, or medical expense coverage delivered or issued for delivery in this state to a religious employer, as defined in paragraph five of subsection (cc) of this section, may exclude coverage for abortion only if the insurer:

(A) obtains an annual certification from the group policy holder that the policy holder is a religious employer and that the religious employer requests a contract without coverage for abortion;

(B) issues a rider to each certificate holder at no premium to be charged to the certificate holder or religious employer for the rider, that provides coverage for abortions subject to the same rules as would have been applied to the same category of treatment in the policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer abortion benefits, but that the insurer is issuing a rider for coverage of abortion, and shall provide the insurer's contact information for questions; and

(C) provides notice of the issuance of the policy and rider to the superintendent in a form and manner acceptable to the superintendent.

* (tt) Every contract issued by a medical expense indemnity corporation, hospital service corporation, or health service corporation that provides coverage for a prescription drug shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 USC 223, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied. This subsection only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the

brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective until January 1, 2027

* (tt) Every contract issued by a medical expense indemnity corporation, hospital service corporation, or health service corporation that provides coverage for a prescription drug shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. If under federal law, application of this requirement would result in health savings account ineligibility under 26 USC 223, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the plan deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the plan deductible has been satisfied. This subsection only applies to a prescription drug that is either (A) a brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or (B) a brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or (C) a generic drug the insurer will cover, with or without prior authorization or an appeal process.

* NB Effective January 1, 2027

* NB There are 2 sb (tt)'s

* (tt) Every large group contract issued by a hospital services corporation or a health services corporation which provides medical, major medical, or comprehensive-type coverage shall include coverage for

the cost of pre-exposure prophylaxis (PrEP) for the prevention of HIV and post-exposure prophylaxis to prevent HIV infection. Such coverage may be subject to annual deductibles, coinsurance, and copayments as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract, unless the pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis has in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force.

* NB There are 2 sb (tt)'s

(uu) (1) Every large group contract delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every large group contract which provides major medical or similar comprehensive-type coverage shall provide, upon the prescription of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, coverage for colorectal cancer preventive screenings in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals. The coverage required by this subsection shall also include coverage for all additional colorectal cancer examinations and laboratory tests recommended in accordance with the American Cancer Society Guidelines for colorectal cancer screening of average risk individuals, including an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test. A large group contract shall cover colorectal cancer screenings, examinations, and laboratory tests described in this subsection upon any contract issuance or renewal that occurs six months after the date the guideline described in this subsection is issued.

(2) An enrollee shall not be subject to a deductible, coinsurance, or any other cost-sharing requirements for services consistent with paragraph one of this subsection received from participating providers.

* (vv) Any contract issued by a medical expense indemnity corporation, a hospital service corporation or a health services corporation that provides coverage for antiretroviral prescription drugs for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) shall not subject such drug to

a prior authorization requirement.

* NB There are 3 sb§ (vv)'s

* (vv) (1) Every contract that provides coverage for physician services, medical, major medical or similar comprehensive-type coverage shall, upon the referral of a physician, provide coverage for comprehensive neuropsychological examinations for dyslexia when performed by a health care professional licensed, certified, or authorized pursuant to title eight of the education law and acting within their scope of practice and in accordance with this subsection and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract.

(2) Nothing in this subsection shall be construed to prevent the medical management or utilization review of the services or prevent a contract from requiring that services be provided through a network of participating providers.

* NB There are 3 sb§ (vv)'s

* (vv) (1) Every medical expense indemnity corporation, hospital service corporation and health service corporation which provides major medical or similar comprehensive-type coverage and provides coverage for prescription drugs shall provide coverage for medically necessary epinephrine devices for the emergency treatment of life-threatening allergic reactions. Such coverage may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent; provided however, the total amount that an insured is required to pay out-of-pocket for such devices shall be capped at an amount not to exceed one hundred dollars annually regardless of the insured's deductible, copayment, coinsurance or any other cost-sharing requirement. If under federal law, application of the annual cap would result in health savings account ineligibility under 26 USC 223, such coverage may be subject to the plan's annual deductible, except for with respect to items or services that are preventive care pursuant to 26 USC 223(c)(2)(C), in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under 26 USC 223 has been satisfied.

(2) For the purposes of this subsection, "epinephrine device" shall have the same meaning as provided in paragraph (b) of subdivision one of section three thousand-c of the public health law.

* NB There are 3 sb§ (vv)'s

* (ww) (1) A medical expense indemnity corporation or a health service corporation which provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs shall include coverage for inhalers for the treatment of asthma if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

(2) Coverage shall be provided for one form of rescue and one form of maintenance inhaler that shall not be subject to a deductible, copayment, coinsurance or any other cost-sharing requirement.

(3) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 sb§s (ww)'s

* (ww) (1) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for follow-up screening or diagnostic services for lung cancer upon the recommendation of a health care provider acting within the provider's scope of practice pursuant to title eight of the education law, and as recommended by nationally recognized clinical practice guidelines for the detection of lung cancer.

(2) Notwithstanding any other provision of law, any policy that provides coverage required by this subsection shall not impose patient cost sharing for follow-up screening or diagnostic services for lung cancer.

(3) For the purposes of this paragraph, "nationally recognized clinical practice guidelines" means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits, and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

(4) Nothing in this paragraph shall be construed to prevent medical management or utilization review of the services, including preauthorization, to ensure that such services are consistent with

nationally recognized clinical practice guidelines for the detection of lung cancer.

(5) If the policy is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code of 1986, such coverage may be subject to the plan's annual deductible if application of this requirement would result in ineligibility for a health savings account.

* NB Effective January 1, 2027

* NB There are 2 sb§s (ww)'s

* (xx) With respect to high deductible health plans offered in conjunction with a health savings account, if application of any cost sharing requirements would result in health savings account ineligibility under section two hundred twenty-three of the internal revenue code, such coverage may be subject to the plan's annual deductible.

* NB Effective January 1, 2027

§ 4303-a. Prescription synchronization. (a) Every hospital service corporation and health service corporation providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily pro-rated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

(i) The medications are covered by the policy or plan.

(ii) The medications are used for treatment and management of chronic conditions that are subject to refills.

(iii) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(iv) The medications meet all prior authorization criteria specific to medications at the time of the synchronization request.

(v) The medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(vi) The medications do not have quantity limits or dose optimization

criteria or requirements that would be violated in fulfilling synchronization.

(b) No hospital service corporation or health service corporation providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every hospital service corporation or health service corporation providing prescription drug coverage must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this paragraph shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(i) The prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(ii) The prescriber prescribes a different drug.

§ 4304. Individual contracts. (a) Every corporation subject to the provisions of this article may issue a contract to an individual the premiums for which may be paid to the corporation directly by the individual or by a remitting agent for the group to which the individual belongs. If the premiums for a contract issued pursuant to this section are paid to the corporation by a remitting agent, such contract shall be subject to subsections (k) and (l) of section four thousand two hundred thirty-five of this chapter, and for the purposes of these subsections, the remitting agent shall be treated as the policyholder.

(b)(1) Any such contract shall be for a period not in excess of twelve months, but no contract shall be made providing for the inception of benefits at a date later than one year from the date of the contract.

(2) Any such contract shall provide that it will be automatically

renewed from year to year unless there shall have been one month's prior written notice of termination by the subscriber.

(3) No corporation shall refuse to renew any such contract because of the physical or mental condition or the health of any person covered thereunder. The provisions of this subsection shall in no way diminish the rights of individuals pursuant to section four thousand three hundred seventeen of this article.

(c) Any such contract may be terminated in the following manner:

(1) At the option of the individual to whom the contract is issued, upon not less than one month's prior written notice.

(2) At the option of the corporation, for one or more of the following reasons:

(A) The individual has failed to pay premiums or contributions in accordance with the terms of the contract or the corporation has not received timely premium payments.

(B) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract, upon not less than one month's prior written notice.

(C) (i) Discontinuance of a class of contract upon not less than ninety days' prior written notice. In exercising the option to discontinue coverage pursuant to this item, the corporation must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and must offer to subscribers or group remitting agents, as may be appropriate, the option to purchase all other individual health insurance coverage currently being offered by the corporation to applicants in that market. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this item through the offering of contracts at each level of coverage as defined in subsection (b) of section four thousand three hundred six-h of this article that contains the essential health benefits package described in paragraph three of subsection (e) of section four thousand three hundred six-h of this article by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

(ii) Discontinuance of all hospital, surgical or medical expense coverage in the individual direct payment market in this state upon written notice to the superintendent and to each subscriber not less than one hundred eighty days prior to the date of the expiration of such coverage. In the event of such a withdrawal from the individual direct payment market, the corporation must also provide the superintendent with a written plan to minimize potential disruption in the marketplace occasioned by such withdrawal. In addition, the corporation may not provide for the issuance of any hospital, surgical or medical expense coverage in the individual direct payment market in this state during the five-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

(iii) Discontinuance of all individual hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small group market, or the large group market, or both markets, in this state, in conjunction with a withdrawal from the small group market, or the large group market, or both markets, in this state. Withdrawal from the small group market, or the large group market, or both markets, shall be governed by the requirements of subparagraphs (E) and (F) of paragraph three of subsection (j) of section four thousand three hundred five of this article. For purposes of this item, "withdrawal" from a market means that no coverage is offered or maintained in such market under contracts issued pursuant to this section or contracts issued pursuant to section four thousand three hundred five of this article.

(D) In the case of a corporation that offers health insurance in the market through a network plan, the individual no longer resides, lives or works in the service area (or in an area for which the corporation is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals. For the purposes of this subparagraph, the term "network plan" means health insurance coverage of a corporation organized under this article 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 corporation or another entity that has contracted with the corporation.

(E) In case of a contract for which the premiums are paid by a remitting agent of a group, discontinuance of the individual's membership in such group.

(F) Such other reasons as the superintendent may approve 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, upon not less than one month's prior written notice.

(3) Every notice of termination shall be in a form satisfactory to the superintendent and shall include a statement of the conversion privileges, if any, upon such termination.

(4) In the event of termination of a contract, the corporation shall return the unearned portion of the premium.

(d) (1) (A) No contract issued pursuant to this section shall entitle more than one person to benefits except that a contract issued and marked as a "family contract" may provide that benefits will be furnished to the contract holder, spouse, dependent child or children, or other person chiefly dependent upon the contract holder provided that:

(i) A "family contract" may provide coverage to any child or children not over nineteen years of age, provided that an unmarried student at an accredited institution of learning may be considered a dependent until the child becomes twenty-three years of age, and provided also that the coverage of any such "family contract" may include, at the option of the corporation, any unmarried child until attaining age twenty-five. However, a "family contract" of hospital, medical, surgical, or prescription drug expense insurance that provides coverage for dependent 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 contract holder, student status, or employment.

(ii) The coverage of any such "family contract" shall include any other unmarried child, regardless of age, 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.

(B) In addition to the requirements of subparagraph (A) of this paragraph, every corporation issuing a contract of hospital, medical or surgical expense insurance that provides coverage for children must make available and if requested by the contractholder, extend coverage under the contract 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 corporation. Such coverage shall be made available at the inception of all new contracts, and for group remittance contracts at any anniversary date. Written notice of the availability of such coverage shall be delivered to the contractholder prior to the inception of such contract, and for group remittance contracts annually thereafter.

(C) Notwithstanding any rule, regulation or law to the contrary, any "family contract" shall provide that coverage of newborn infants, including newly born infants adopted by the subscriber if such 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. This provision regarding coverage of newborn infants shall not apply to two person coverage. In the case of individual or two person coverages the corporation must also permit the person to whom the contract 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 remitting agent's plan does not provide coverage for children.

(2) Every "family contract" under which coverage of a dependent spouse or contract holder would terminate upon such spouse or contract holder attaining the age prescribed in subchapter XVIII of the 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 eligible for all of such benefits, for as long as the contract 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 corporation within thirty-one days of the date notice of termination of coverage is mailed by the corporation to the last known address of the such spouse or contract holder.

(3) Coverage of an unmarried dependent 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 the contract holder for support and maintenance, shall not terminate while the contract remains in force and the child remains in such condition, if the contract holder has within thirty-one days of such child's attainment of the limiting age submitted proof of such child's incapacity as described herein.

(e) (1) (A) If any such contract is terminated in accordance with the provisions of paragraph one of subsection (c) of this section, or any such contract is terminated because of a default by the remitting agent in the payment of premiums not cured within the grace period and the remitting agent has not replaced the contract with similar and continuous coverage for the same group whether insured or self-insured, or any such contract is terminated in accordance with the provisions of subparagraph (E) of paragraph two of subsection (c) of this section, or if an individual other than the contract holder is no longer covered under a "family contract" because the individual is no longer within the definition set forth in the contract, or a spouse is no longer covered under the contract because of divorce from the contract holder or

annulment of the marriage, or any such contract is terminated because of the death of the contract holder, then such individual, former spouse, or in the case of the death of the contract holder the surviving spouse or other dependents of the deceased contract holder covered under the contract, as the case may be, shall be entitled to convert, without evidence of insurability, upon application therefor and the making of the first payment thereunder within sixty days after the date of termination of such contract, to a contract that contains the essential health benefits package described in paragraph three of subsection (e) of section four thousand three hundred six-h of this article.

(B) The corporation shall offer one contract at each level of coverage as defined in subsection (b) of section four thousand three hundred six-h of this article. The individual may choose any such contract offered by the corporation. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this paragraph through the offering of contracts that comply with this paragraph by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

(C) The effective date of the coverage provided by the converted direct payment contract shall be the date of the termination of coverage under the contract from which conversion was made.

(2) The corporation shall not be required to issue any such converted individual direct payment contract if its issuance would result in overinsurance or duplication of benefits according to standards on file with the superintendent and approved by the superintendent with regard to such contracts.

(3) In addition to the right of conversion herein, the employee or member insured under a contract for which the premiums are paid by a remitting agent of a group shall at his option, as an alternative to conversion, be entitled to have his coverage continued under the group remittance contract in accordance with the conditions and limitations contained in subsection (k) of this section, and have issued at the end of the period of continuation an individual direct payment conversion contract subject to the terms of this subsection. The effective date for the conversion contract shall be the day following the termination of

insurance under the group remittance contract, or if there is a continuation of coverage, on the day following the end of the period of continuation.

(4) For purposes of this subsection, the term "dependent" shall include a child as described in subsection (d) of this section.

(f) No such corporation shall require as a condition for renewal or for failure to cancel any individual contract any rider, endorsement or other attachment which shall limit the nature or extent of the benefits thereunder, except that a corporation may at any time upon at least thirty days' prior written notice amend such contract to provide a different level of benefits thereunder if approved by the superintendent on finding, upon application by the corporation at least four months before the proposed effective date, that such level would exceed, in the aggregate, the level of benefits theretofore provided and would be in the best interests of the corporation and the persons covered under such contracts.

(g) The provisions of this section with respect to limitations on the termination of an individual contract shall not apply to a contract or an endorsement or rider thereto which is issued by a corporation subject to the provisions of this article pursuant to a plan providing for experimentation in new forms of benefits in the field of health insurance protection, which plan shall be submitted in writing to the superintendent. The superintendent shall approve such plan if he finds that the benefits are of the type heretofore described and that the issuance of such contract, endorsement or rider is in the public interest. Approval of such contract, rider or endorsement shall be subject to any conditions which may be prescribed by the superintendent, including, but not limited to, the maximum period during which the exemption from the provisions of this section with respect to termination shall continue. The superintendent may, for good cause shown, extend such period of exemption. Any termination of such contract, rider or endorsement during the period of exemption, other than for non-payment of premium and fraud in applying for the contract, shall be subject to the approval of the superintendent. Upon termination of such contract, or termination of a rider or endorsement providing experimental benefits, as aforesaid, the contract holder thereunder who has at the time of such termination been covered continuously

immediately preceding such termination for a period of two years or more under one or more contracts of the corporation shall be entitled to have issued to him by the corporation, without evidence of insurability, upon application therefor and the making of the first payment thereunder within thirty-one days after the date of termination, an individual direct payment contract of the type and class which the superintendent shall determine provides benefits most nearly comparable to those currently provided other individuals. If the corporation does not terminate such contract or a rider or endorsement thereto providing experimental benefits as aforesaid during the period of exemption, or any extended period provided herein, such contract shall thereafter be subject to the provisions of this section with respect to termination as of the original effective date of such contract.

(h) Any contract, 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 CONTRACT 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."

(i) Any persons covered by the contract who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon written request, to have their coverage suspended during a period of active duty as described herein. The contract shall provide that the insurer will refund any unearned premiums for the period of such suspension. Persons covered by the contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within sixty days after the date of termination of the period of active duty, with no limitations or conditions imposed as a result of such period of active duty except as set forth in paragraphs one and two herein. Coverage shall be retroactive to the date of termination of the period of active duty. Such right of resumption provided for herein shall be in addition to other existing rights granted pursuant to state and federal laws and regulations and shall not be deemed to qualify or limit such rights in

any way. No exclusion or waiting period may be imposed in connection with coverage of a health or physical condition of a person entitled to such right of resumption, or a health or physical condition of any other person who is covered by the contract unless:

(1) 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

(2) 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.

(j) To be entitled to the right defined in subsection (i) 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:

(1) 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

(2) 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

(3) serves no more than four years of active duty.

(k) A contract for which the premiums are paid by a remitting agent of a group issued by a hospital service, health service or medical expense indemnity corporation shall provide that if all or any portion of the insurance on an employee or member insured under the contract ceases because of termination of employment or membership in the class or classes eligible for coverage under the contract, such employee or member shall be entitled without evidence of insurability upon application to continue his or her insurance for himself or herself and his or her eligible dependents, subject to all of the group remittance contract's terms and conditions applicable to those forms of benefits and to the following conditions:

(1) Continuation shall not be available for: (A) 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 (B) 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 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 or group remittance contract 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 given notice of the right of continuation by either his employer or the group remitting agent.

(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 remitting agent 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 remitting agent 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 remittance contract 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 group remitting agent 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 remittance contract for any person shall terminate at the first to occur of the following:

(A) The date thirty-six months after the date the employee's or member's benefits under the contract 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 contract 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 contract; or

(D) The date on which the group remittance contract with that remitting agent is terminated or, in the case of an employee, the date his employer terminates participation under the group remittance contract. However, if this clause applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group or group remittance contract, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group or group remittance contract, for the balance of the period that he would have remained covered under the prior group remittance contract 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 or group remittance contract shall be the applicable level of benefits of the prior group remittance contract reduced by any benefits payable under that prior group remittance contract, and

(iii) The prior group remittance contract 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) Special enrollment period. An individual who does not have an election of continuation coverage as described in this subsection in effect on the effective date of the American Recovery and Reinvestment act of 2009, but who would be an assistance eligible individual under Title III of such act if such election were in effect, may elect continuation coverage pursuant to this subsection. Such election must be

made no later than sixty days after the date the administrator of the group health plan (or other entity involved) provides the notice required by section 3001(a)(7) of the American Recovery and Reinvestment act of 2009. The administrator of the group health plan (or other entity involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this paragraph within sixty days of the date of enactment of the American Recovery and Reinvestment act of 2009.

(B) Continuation coverage elected pursuant to subparagraph (A) of this paragraph shall commence with the first period of coverage beginning on or after the date of the enactment of the American Recovery and Reinvestment act of 2009 and shall not extend beyond the period of continuation coverage that would have been required if the coverage had instead been elected pursuant to paragraph two of this subsection.

(C) With respect to an individual who elects continuation coverage pursuant to subparagraph (A) of this paragraph, the period beginning on the date of the qualifying event and ending on the date of the first period of coverage on or after the enactment of the American Recovery and Reinvestment act of 2009 shall be disregarded for purposes of determining the sixty-three day period referred to in section four thousand three hundred eighteen of this article.

(6) A contract for which premiums are paid by a remitting agent for a group issued by a hospital service, health service or medical expense indemnity corporation shall offer an employee or member who has exhausted continuation coverage pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300 bb - 1 et seq. the opportunity to continue coverage for up to thirty-six months from the date the employee's or member's continuation coverage began if the employee or member is entitled to less than thirty-six months of continuation benefits.

(7) For purposes of this subsection, the term "dependent" shall include a child as described in subsection (d) of this section.

(l) A corporation shall not offer individual hospital, medical, or surgical expense insurance contracts unless the contracts meet the requirements of subsection (b) of section four thousand three hundred twenty-eight of this article. Such contracts that are offered within the

health benefit exchange established by this state also shall meet any requirements established by the health benefit exchange. To the extent that a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law offers individual hospital, medical, or surgical expense insurance contracts, the contracts shall meet the requirements of subsection (b) of section four thousand three hundred twenty-eight of this article.

(m) (1) As used in this subsection, "child" means an unmarried child through age twenty-nine of an employee or member insured under a group remittance contract of hospital, medical or surgical expense insurance, regardless of financial dependence, who is not insured by or eligible for coverage under any employer health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (e) of this section and the continuation privilege afforded by subsections (e) and (k) of this section, a hospital service, health service or medical expense corporation or health maintenance organization that provides hospital, medical or surgical expense insurance coverage for which the premiums are paid by the remitting agent of a group that provides coverage of a child that terminates at a specified age shall, upon application of the employee, member or child, as set forth in subparagraph (B) of this paragraph, provide coverage to the child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group remittance contract and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a child provided pursuant to this subsection;

(B) An employee, member or child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group contract;

(ii) within sixty days after meeting the requirements for child status set forth in paragraph one of this subsection when coverage for the child previously terminated; or

(iii) during an annual thirty-day open enrollment period as described in the contract.

(C) An employee, member or child electing continuation as described in this subsection shall pay to the group remitting agent or employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group remitting agent or employer within the time periods set forth in subparagraph (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

(D) For any child electing coverage within sixty days of the date the child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation coverage shall be the date coverage would have otherwise terminated. For any child electing to resume coverage during an annual open enrollment period, the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

(E) Coverage for a child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the contract for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any child;

(F) Coverage shall terminate on the first to occur of the following:

(i) the date the child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph (C) of this paragraph; or

(iii) the date on which the group remittance contract is terminated and not replaced by coverage under another group or group remittance contract; and

(G) The corporation or health maintenance organization shall provide

written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; and

(ii) at least sixty days prior to termination at the specified age as provided in the contract.

(3)(A) Corporations and health maintenance organizations shall submit such reports as may be requested by the superintendent to evaluate the effectiveness of coverage pursuant to this subsection including, but not limited to, quarterly enrollment reports.

(B) The superintendent may promulgate regulations to ensure the orderly implementation and operation of the continuation coverage provided pursuant to this subsection, including premium rate adjustments.

§ 4305. Group contracts. (a) A corporation subject to the provisions of this article may issue a group contract, provided the group of persons thereby covered conforms to the requirements of subsections (c) and (d) of section four thousand two hundred thirty-five or of subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter, and provided such contract and the individual certificates issued to members of the group shall comply in substance with this article. A corporation subject to the provisions of this article shall issue to the group contractholder, for delivery to each member of the insured group, a copy of the contract, or a certificate which can be in the form of a booklet setting forth in summary form a statement of the essential features of the insurance coverage. A group contract issued pursuant to this section shall be subject to subsections (k) and (l) of section four thousand two hundred thirty-five of this chapter.

(b) Any such contract which provides for the adjustment of the rate of premium based upon the experience thereunder shall specify the duration of the period of insurance thereunder; such period shall not exceed three years, provided, however, that such contract may provide that, in the absence of one month's prior written notice by either party to the other, it shall be automatically renewed at the termination of any

period thereunder for a succeeding period of not less than one nor more than three years' duration. In any case where such contract is for a period of more than one year, an appropriate additional rate of premium shall be charged therefor. Any such contract may provide for the adjustment of the rate of premium based upon the experience thereunder at the end of the first period of insurance thereunder or at the end of any subsequent period of insurance thereunder and any such adjustment may be made retroactive only for the period of insurance immediately preceding such adjustment.

(c) (1)(A) Any such contract may provide that benefits will be furnished to a member of a covered group, for the member, the member's spouse, child or children, or other persons chiefly dependent upon the member for support and maintenance; provided that:

(i) a contract 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 member, student status, or employment, except a contract 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 a corporation 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 contract under which coverage terminates at a specified age shall, 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 member for support and maintenance, not so terminate while the contract remains in force and the child remains in such condition, if the 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 corporation issuing a group contract of hospital, medical or surgical expense insurance pursuant to this section that provides coverage for children, must make available and if requested by the contractholder, extend coverage under that contract 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 corporation. Such coverage shall be made available at the inception of all new contracts and with respect to all other contracts at any anniversary date. Written notice of the availability of such coverage shall be delivered to the contractholder prior to the inception of such group contract and annually thereafter.

(C) Notwithstanding any rule, regulation or law to the contrary, any contract under which a member elects coverage for the member, the member's spouse, children or other persons chiefly dependent upon the member for support and maintenance shall provide that coverage of newborn infants, including newly born infants adopted by the member if such member 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. This provision regarding coverage of newborn infants shall not apply to two person coverage. In the case of individual or two person coverages the corporation 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.

(2) Any such contract under which coverage of a dependent spouse or group member would terminate upon such spouse or group member attaining the age prescribed in subchapter XVIII of the 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 contract 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 corporation within thirty-one days of the date notice of termination of coverage is sent by first class mail by the corporation to the last known address of the policyholder.

(d) (1) (A) A group contract issued pursuant to this section shall contain a provision to the effect that in case of a termination of coverage under such contract of any member of the group because of (i) termination for any reason whatsoever of the member's employment or membership, or (ii) termination for any reason whatsoever of the group contract itself unless the group contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, the member shall be entitled to have issued to the member by the corporation, without evidence of insurability, upon application therefor and payment of the first premium made to the corporation within sixty days after termination of the coverage, an individual direct payment contract, covering such member and the member's eligible dependents who were covered by the group contract, which provides coverage that contains the essential health benefits package described in paragraph three of subsection (e) of section four thousand three hundred six-h of this article. The corporation shall offer one contract at each level of coverage as defined in subsection (b) of section four thousand three hundred six-h of this article. The member may choose any such contract offered by the corporation. Provided, however, the superintendent may, after giving due

consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this subparagraph through the offering of contracts that comply with this subparagraph by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

(B) The conversion privilege afforded in this paragraph shall also be available: (i) upon the divorce or annulment of the marriage of a member, to the divorced spouse or former spouse of such member; (ii) upon the death of the member, to the surviving spouse and other dependents covered under the contract; and (iii) to a dependent if no longer within the definition in the contract.

(2) The effective date of the coverage provided by the individual direct payment contract shall be the date of the termination of the individual's coverage under the group contract. The corporation shall not be required to issue such individual direct payment converted contract covering any person if it appears that such person shall then be covered by another individual contract providing similar coverage or if it shall appear that such person is covered by or eligible to be covered by a group contract or policy providing similar benefits or is provided with similar benefits required by any statute or provided by any welfare plan or program, which together with the individual direct payment converted contract would result in over-insurance or duplication of benefits according to standards on file with the superintendent of financial services relating to individual contracts.

(3) (A) Each member in the insured group, but not his dependents, shall be given written notice of such conversion privilege provided in paragraph one hereof and its duration within fifteen days after the date of termination of coverage under the group contract, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of coverage under the group contract the time allowed for the exercise of such conversion privilege shall be extended for forty-five days after the giving of such notice. If such notice is not given within ninety days after the date of termination of coverage under the group contract the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days.

(B) Written notice by the contract holder given to the member or sent

by first class mail to the member at his last known address, or written notice by the corporation which issued the group contract sent by first class mail to the member at the last address furnished to the corporation by the contract holder, shall be deemed full compliance with the provisions of this paragraph for the giving of notice.

(C) A group contract issued pursuant to this section may contain a provision to the effect that notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

(4) A group contract to be issued to a social services district pursuant to section three hundred sixty-five of the social services law by a corporation subject to the provisions of this article need not, subject to the approval of the superintendent, provide for the issuance of individual certificates and may omit or modify any of the other provisions required to be contained in such contract, provided that the superintendent deems such omission or modification suitable for the character of the coverage provided.

(5) For purposes of this subsection, the term "dependent" shall include a child as described in subsection (c) of this section.

(e) In addition to the conversion privilege afforded by subsection (d) of this section, a group contract issued by a hospital service, health service or medical expense indemnity corporation 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 insurance for himself or herself and his or her eligible dependents, subject to all of the group contract's terms and conditions applicable to those forms of benefits and to the following conditions:

(1) Continuation shall cease on the date which the employee, member or dependant first becomes, after the date of election: (A) entitled to coverage under title XVIII of the United States Social Security Act (Medicare) as amended or superseded; or (B) covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to

any pre-existing condition of such employee, member or dependent.

(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 contract 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 contract for any person shall terminate at the first to occur of the following:

(A) The date thirty-six months after the date the employee's or member's benefits under the contract 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 contract 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 contract; or

(D) The date on which the group contract is terminated or, in the case of an employee, the date his employer terminated participation under the group contract. However, if this clause applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group contract, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group contract, for the balance of the period that he would have remained covered under the prior group contract 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 contract shall be the applicable level of benefits of the prior group contract reduced by any benefits payable under the prior group contract, and

(iii) The prior group contract shall continue to provide benefits to the extent of its accrued liabilities and extensions 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) The conversion privilege afforded by subsection (d) of this section shall be available upon termination of the continuation of benefits described herein.

(7) This subsection shall not be applicable where a continuation benefit is available to the employee or member pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300 bb - 1 et seq. However, a group contract shall offer an employee or member who has exhausted continuation coverage pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300 bb - 1 et seq. the opportunity to continue coverage for up to thirty-six months from the

date the employee's or member's continuation coverage began if the employee or member is entitled to less than thirty-six months of continuation benefits.

(8)(A) Special enrollment period. An individual who does not have an election of continuation coverage as described in this subsection in effect on the effective date of the American Recovery and Reinvestment act of 2009, but who would be an assistance eligible individual under Title III of such act if such election were in effect, may elect continuation coverage pursuant to this subsection. Such election must be made no later than sixty days after the date the administrator of the group health plan (or other entity involved) provides the notice required by section 3001(a)(7) of the American Recovery and Reinvestment act of 2009. The administrator of the group health plan (or other entity involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this paragraph within sixty days of the date of enactment of the American Recovery and Reinvestment act of 2009.

(B) Continuation coverage elected pursuant to subparagraph (A) of this paragraph shall commence with the first period of coverage beginning on or after the date of the enactment of the American Recovery and Reinvestment act of 2009 and shall not extend beyond the period of continuation coverage that would have been required if the coverage had instead been elected pursuant to paragraph two of this subsection.

(C) With respect to an individual who elects continuation coverage pursuant to subparagraph (A) of this paragraph, the period beginning on the date of the qualifying event and ending on the date of the first period of coverage on or after the enactment of the American Recovery and Reinvestment act of 2009 shall be disregarded for purposes of determining the sixty-three day period referred to in section four thousand three hundred eighteen of this article.

(9) For purposes of this subsection, the term "dependent" shall include a child as described in subsection (c) of this section.

(f) Any contract 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 CONTRACT (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."

(g) In addition to all the rights of conversion and continuation otherwise provided for herein, employees or members insured under the contract 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 (h) of this section, and the employer or group contract holder 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 contract 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 contract holder 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 contract 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 (d) and (e) of this section.

(i) To elect an individual conversion contract pursuant to subsection

(d) 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 (d) of this section, coverage under the supplementary continuation right provided for herein shall terminate.

(ii) To elect continuation of coverage pursuant to subsection (e) 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 contract.

(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 (d) and (e) of this section.

(i) To elect an individual conversion contract pursuant to subsection (d) 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 subsection (e) 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 contract.

(7) A group contract 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 contract ceases because the employee or member insured is ordered to active duty as defined in subsection (h) 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 cease on the date which the employee, member or dependant first becomes, after the date of election: (i) entitled to coverage under title XVIII of the United States Social Security Act (Medicare) as amended or superseded or (ii) 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 contract 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 contract holder 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 contract on the due date of each payment.

(8) The supplementary conversion and continuation rights provided for herein shall apply to:

(A) contracts not covered by Chapter 18 of the Employee Retirement

Income Security Act, 29 U.S.C. section 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq;

(B) contracts covered by Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq or Chapter 6A of the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq, when active duty for reservists and the refusal of an employer to voluntarily maintain coverage for such period of active duty is not considered a qualifying event.

(h) To be entitled to the right defined in subsection (g) 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:

(1) 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

(2) 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

(3) serves no more than four years of active duty.

(j)(1) Except as provided in this section, if a corporation delivers or issues for delivery in this state a group or blanket contract which provides hospital, surgical or medical expense coverage for other than accident only, the corporation must renew or continue in force such coverage at the option of the contract holder.

(2) A corporation may nonrenew or discontinue coverage under such a group or blanket contract based only on one or more of the following:

(A) The contract holder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract or the corporation has not received timely premium payments.

(B) The contract holder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.

(C) The contract holder 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 corporation is ceasing to offer group or blanket contracts in a market in accordance with paragraph three or paragraph six of this subsection.

(E) The contract holder 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 contract 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 a corporation that offers a group or blanket contract 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 operating area of the corporation (or in the area for which the corporation 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 a corporation decides to discontinue offering a particular class of group or blanket contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class may be discontinued by the corporation in accordance with this chapter in such market only if:

(i) the corporation provides written notice to each contract holder provided coverage of this class in such market (and to all employees and member insureds covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage. In addition to any other information required of notices by the superintendent, this written notice shall conspicuously include an explanation, in plain language, of the contract holder's and covered employee's or member insured's rights under this subparagraph and subparagraph (B) of this paragraph, including:

(I) a statement that if the superintendent determines that the covered employee, member insured, or a dependent has a serious medical condition, and the covered employee, member insured or dependent within

the previous twelve months utilized a benefit under; the contrary related to the serious medical condition that is not covered by the replacement coverage offered to the contract holder as a result of the discontinuance, then the superintendent shall require the corporation to offer the contract holder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the contract that the corporation discontinued; and

(II) an explanation as to how to contact the superintendent, and the date by which the superintendent shall be contacted, if the contract holder, covered employee or member insured believes that the covered employee, member insured or a dependent has a serious medical condition, and the covered employee, member insured or dependent within the previous twelve months utilized a benefit related to the serious medical condition that may not be covered by the replacement coverage offered to the contract holder as a result of the discontinuance;

(ii) the corporation offers to each contract holder 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 corporation to a group in such market;

(iii) in exercising the option to discontinue coverage of this class and in offering the option of coverage under item (ii) of this subparagraph, the corporation acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any particular covered employee, member insured or dependent who may become eligible for such coverage, and the corporation is not discontinuing the coverage of this class with the intent or as a pretext to discontinuing the coverage of any such employee, member insured or dependent; and

(iv) at least ninety days prior to the date of discontinuance of such coverage, the corporation provides written notice to the superintendent of such discontinuance, including the reason for the discontinuance, and an officer or director of the corporation certifies to the superintendent that the corporation has complied with items (i), (ii) and (iii) of this paragraph. If such notice does not include the date or dates that the corporation mailed or delivered the notice to all contract holders, covered employers and member insureds, the corporation

shall notify the superintendent of such date within seven days of the completion of the mailing or delivery.

(B) If the superintendent determines that the corporation has not complied with item (iii) of subparagraph (A) of this paragraph, then the superintendent may prohibit the corporation from discontinuing the class of contracts and require the corporation to promptly notify every contract holder, covered employee and member insured that the corporation is not discontinuing the contracts. If the superintendent determines that the corporation wrongfully discontinued the class of contracts pursuant to item (iii) of subparagraph (A), then the superintendent shall require that the corporation take remedial action, including offering to group contract holders the option of reinstating the discontinued contract forms. If the superintendent determines that the corporation discontinued the class of contracts without compliance with items (i), (ii), or (iv) of subparagraph (A), and an employee, member insured or dependent covered under the discontinued contract would have been entitled to relief under this paragraph, then the superintendent may require that the corporation offer replacement coverage to an affected contract holder consistent with item (ii) of subparagraph (C) of this paragraph.

(C) (i) If, within forty-five days after the corporation mails or delivers the written notice of discontinuance required by item (i) of subparagraph (A) of this paragraph, the superintendent is notified by a contract holder or covered employee or member insured that a covered employee, member insured or dependent has a serious medical condition and that a benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition may not be covered by the replacement coverage offered to the contract holder as a result of the discontinuance, then the superintendent shall, within twenty days of the notification, ask the corporation to confirm that the covered employee, member insured or dependent utilized a benefit within the previous twelve months to treat the medical condition that the covered employee, member insured or dependent asserts is a serious medical condition, and that the benefit is not covered by the replacement coverage. The superintendent may request such additional information as the superintendent may require. The corporation shall provide all requested information to the

superintendent within five days of receipt of the request.

(ii) If, within twenty days of the superintendent's receipt of all additional information requested from the corporation, the superintendent determines that (I) the covered employee, member insured or dependent has a serious medical condition; and (II) the benefit utilized by the covered employee, member insured or dependent within the previous twelve months related to the serious medical condition is not covered by the replacement coverage offered to the contract holder as a result of the discontinuance, then the superintendent shall require the corporation to offer to the contract holder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the contract that the corporation discontinued. If the replacement coverage is not available, at the time that the contract would otherwise be discontinued, then the corporation shall keep the existing policy in force for the affected contract holder until the replacement coverage with the substantially similar benefit is available.

(D) The remedies as provided in this paragraph shall be in addition to and not in lieu of any other authority or power of the superintendent to impose monetary or other penalties for violations of this paragraph.

(E) In any case in which a corporation 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 corporation only if:

(i) the corporation provides written notice to the superintendent and to each contract holder (and all employees and member insureds covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

(ii) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market or markets is discontinued and coverage under such contracts 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 corporation shall provide the superintendent with a written plan to minimize potential disruption in the marketplace occasioned by the corporation's withdrawal from the market.

(F) In the case of a discontinuance under subparagraph (E) of this paragraph in a market, the corporation may not provide for the issuance of any group or blanket contract 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 contract not so renewed.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a group or blanket contract offered to a large or small group contract holder so long as such modification is consistent with this chapter and effective on a uniform basis among all small group contract holders with that contract.

(5) For purposes of this subsection the term "network plan" shall mean a health insurance contract 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 corporation or another entity that has contracted with the corporation.

(6) Notwithstanding paragraph three of this subsection, a corporation may discontinue offering a particular class of group or blanket contract of hospital, surgical or medical expense insurance offered in the small or large group market, and instead offer a group or blanket contract of hospital, surgical or medical expense insurance that complies with the requirements of section 2707 of the public health service act, 42 U.S.C. § 300gg-6 that become applicable to such contract as of January first, two thousand fourteen, provided that the corporation:

(A) discontinues the existing class of contract in such market as of either December thirty-first, two thousand thirteen or the contract renewal date occurring in two thousand fourteen in accordance with this chapter;

(B) provides written notice to each contract holder provided coverage of the class in the market (and to all employees and member insureds covered under such coverage) of the discontinuance at least ninety days prior to the date of discontinuance of such coverage. The written notice shall be in a form satisfactory to the superintendent;

(C) offers to each contract holder provided coverage of the class in the market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage

that complies with the requirements of section 2707 of the public health service act, 42 U.S.C. § 300gg-6 that become applicable to such coverage as of January first, two thousand fourteen, currently being offered by the corporation to a group in that market;

(D) in exercising the option to discontinue coverage of the class and in offering the option of coverage under subparagraph (C) of this paragraph, acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any particular covered employee, member insured or dependent, or particular new employee, member insured, or dependent who may become eligible for such coverage, and does not discontinue the coverage of the class with the intent or as a pretext to discontinuing the coverage of any such employee, member insured, or dependent; and

(E) at least one hundred twenty days prior to the date of the discontinuance of such coverage, provides written notice to the superintendent of the discontinuance, including certification by an officer or director of the corporation that the reason for the discontinuance is to replace the coverage with new coverage that complies with the requirements of section 2707 of the public health service act, 42 U.S.C. § 300gg-6 that become effective January first, two thousand fourteen. The written notice shall be in such form and contain such information the superintendent requires.

(k)(1) No corporation delivering or issuing for delivery in this state a group or blanket contract 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 contract 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 corporation may, on the basis of any health status-related factor in relation to the subscriber or dependent of the subscriber, require any subscriber (as a condition of enrollment or continued enrollment under the contract) to pay a premium or contribution which is greater than such premium for a similarly situated subscriber enrolled in the plan.

(4) Nothing in this subsection shall require a corporation to issue a group or blanket contract to a group comprised of fifty-one or more lives exclusive of spouses and dependents.

(5) Where an eligible subscriber or dependent of a subscriber rejects initial enrollment in a group or blanket contract that provides hospital, surgical or medical expense insurance, a corporation shall permit a subscriber or dependent of a subscriber to enroll for coverage under the terms of the contract if each of the following conditions are met:

(A) The subscriber or dependent was covered under another plan or contract at the time coverage was initially offered.

(B)(i) Coverage was provided in accordance with continuation required by federal or state law and was exhausted; or

(ii) Coverage under the other plan or contract 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 contract;

(III) death of the spouse;

(IV) legal separation, divorce or annulment;

(V) reduction in the number of hours of employment; or

(iii) Contract holder 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 contracts 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 four thousand three hundred seventeen of this article.

(7) For purposes of this subsection, the term "dependent" shall include a child as described in subsection (c) of this section.

(l)(1) As used in this subsection, "child" means an unmarried child through age twenty-nine of an employee or member insured under a group contract of hospital, medical or surgical expense insurance, regardless of financial dependence, who is not insured by or eligible for coverage under any employer health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (d) of this section and the continuation privilege afforded by subsection (e) of this section, a hospital service, health service or medical expense corporation or health maintenance organization that provides group hospital, medical or surgical coverage under which coverage of a child terminates at a specified age shall, upon application of the employee, member or child, as set forth in subparagraph (B) of this paragraph, provide coverage to the child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group contract and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a child provided pursuant to this subsection;

(B) An employee, member or child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group contract;

(ii) within sixty days after meeting the requirements for child status set forth in paragraph one of this subsection when coverage for the child previously terminated; or

(iii) during an annual thirty-day open enrollment period, as described in the contract;

(C) An employee, member or child electing continuation as described in this subsection shall pay to the group contractholder or employer, but

not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group contractholder or employer within the time periods set forth in subparagraph (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

(D) For any child electing coverage within sixty days of the date the child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation coverage shall be the date coverage would have otherwise terminated. For any child electing to resume coverage during an annual open enrollment period, the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

(E) Coverage for a child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the contract for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any child;

(F) Coverage shall terminate on the first to occur of the following:

(i) the date the child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph (C) of this paragraph; or

(iii) the date on which the group contract is terminated and not replaced by coverage under another group contract; and

(G) The corporation or health maintenance organization shall provide written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; and

(ii) at least sixty days prior to termination at the specified age as provided in the contract.

(3)(A) Corporations and health maintenance organizations shall submit such reports as may be requested by the superintendent to evaluate the

effectiveness of coverage pursuant to this subsection including, but not limited to, quarterly enrollment reports.

(B) The superintendent may promulgate regulations to ensure the orderly implementation and operation of the continuation coverage provided pursuant to this subsection, including premium rate adjustments.

(m) A health care claim from a subscriber covered under a contract issued pursuant to this section shall be submitted within one hundred twenty days from the date of service; provided, however, that if it was not reasonably possible for the subscriber to submit the claim within that timeframe, then the claim shall be submitted as soon as reasonably possible.

(n) (1) Any corporation subject to the provisions of this article that issues hospital, surgical or medical expense contracts in the small group or large group market in this state shall offer to any employer in this state all such contracts in the applicable market, and shall accept at all times throughout the year any employer that applies for any of those contracts.

(2) The requirements of paragraph one of this subsection shall apply with respect to an employer that applies for coverage either directly from the corporation or through an association or trust to which the corporation has issued coverage and in which the employer participates.

§ 4306. Required contract provisions. Every contract issued by any corporation pursuant to the provisions of section four thousand three hundred four of this article, shall be in writing and shall state the terms and conditions thereof. No such contract shall be made, issued or delivered in this state unless it contains the following provisions:

(a) a statement of the amount payable to the corporation by the individual to whom the contract is issued and the times at which and manner in which such amount is to be paid;

(b) a statement of the nature of the benefits to be furnished and the period during which they will be furnished; and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified;

(c) a statement of the terms and conditions, if any, upon which the

contract may be terminated at the option of the individual, or otherwise terminated at the option of either party as permitted by subsection (b) or (c) of section four thousand three hundred four of this article;

(d) a statement that the contract includes the endorsements thereon and attached papers, if any;

(e) a statement that no statement by the individual in his application for a contract shall avoid the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract, and that no agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions;

(f) a statement that if the individual defaults in making any payment under the contract, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents or by a duly authorized broker shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than ten days after the date of such acceptance;

(g) a statement of the period of grace which will be allowed the individual for making any payment due under the contract which period shall not be less than ten days;

(h) a statement on the first page of the contract or in a notice attached to the contract that during a specified period of time, which shall not be less than ten days nor more than twenty days from the date the contract is delivered to the individual, it may be surrendered to the corporation together with a written request for cancellation of the contract and that in such event the corporation will refund any premium paid therefor including any contract fees or other charges; provided, however, that a contract sold by mail order and a contract providing medicare supplemental insurance or long-term care insurance must contain a provision permitting the individual a thirty day period for such surrender;

(i) the age limit or date or period, if any, after which the coverage provided by the contract will not be effective, or renewed, is stated in a renewal provision set forth on the first page of the contract or as a separate provision bearing an appropriate caption on the first page on the contract or in a brief description in not less than fourteen point

bold face type set forth on the first page of the contract; nothing herein contained shall limit or restrict the right of the corporation to continue the contract after the age or period so stated;

(j) a statement under the caption "CONVERSION PRIVILEGE" which shall set forth in substance the conversion privileges and related provisions required by subsections (d) and (e) of section four thousand three hundred four of this article;

(k) the exceptions of the contract shall appear with the same prominence as the benefits to which they apply;

(l) if the contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the corporation a part of the contract, such portion shall be set forth in full; and

(m) in every such contract made, issued or delivered in this state there shall be a brief description of the contract on its first page and on its filing back.

(n) a statement that a health care claim from a subscriber shall be submitted within one hundred twenty days from the date of service; provided, however, that if it was not reasonably possible for the subscriber to submit the claim within that timeframe, then the claim shall be submitted as soon as reasonably possible.

(o) Every contract delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall provide space on any enrollment, renewal or initial online portal process setup forms required of a subscriber or applicant for coverage, except forms issued by the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of paragraph (a) of subdivision five of section forty-three hundred ten and paragraph (v) of subdivision one of section two hundred six of the public health law, so that the subscriber or applicant for coverage shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment, renewal or initial online portal process setup forms and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

§ 4306-a. Health insurance coverage for full-time students on medical leaves of absence. (a) Every contract issued by a medical expense indemnity corporation, hospital service corporation or health service corporation that provides coverage for dependent children who are full-time students to a higher age than other dependent children shall continue the coverage of a dependent student who takes a leave of absence from school due to illness for a period of twelve months from the last day of attendance at school, provided, however, that nothing in this section shall require coverage of a dependent student beyond the age at which coverage would otherwise terminate.

(b) In order to qualify under this section, the medical necessity of a leave of absence from school must be certified to by the student's attending physician who is licensed to practice in the state of New York. Written documentation of the illness must be submitted to the medical expense indemnity corporation, hospital service corporation or health service corporation.

(c) The rate charged for such extended coverage shall be the same as that charged while the dependent is enrolled as a full-time student.

§ 4306-b. Primary and preventive obstetric and gynecologic care. (a) No corporation subject to the provisions of this article shall by contract, written policy or procedure limit a female subscriber's direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy, provided that: (1) such qualified provider discusses such services and treatment plan with the subscriber's primary care practitioner in accordance with the requirements of the corporation; and (2) such qualified provider agrees to adhere to the corporation's policies and procedures, including any applicable procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan (if any) approved by the corporation.

(b) A corporation shall treat the provision of obstetric and gynecologic care, and the ordering of related obstetric and gynecologic items and services, pursuant to the direct access described in subsection (a) of this section by a participating qualified provider of such services, as the authorization of the primary care provider.

(c) It shall be the duty of the administrative officer or other person in charge of each corporation subject to the provisions of this article to advise each female subscriber, in writing, of the provisions of this section.

§ 4306-c. Grievance procedure and access to specialty care. (a) A corporation, including a municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, that issues a comprehensive contract that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall establish and maintain a grievance procedure consistent with the requirements of section four thousand eight hundred two of this chapter.

(b) A corporation, including a municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, that issues a comprehensive contract that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter and requires that specialty care be provided pursuant to a referral from a primary care provider shall provide access to such specialty care consistent with the requirements of subsections (b), (c) and (d) of section four thousand eight hundred four of this chapter; provided however, that nothing in this section shall be construed to require that a corporation, or a primary care provider on behalf of the corporation, make a referral to a provider that is not in the corporation's network.

(c) A corporation, including a municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, that issues a comprehensive contract that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter shall provide access to transitional care consistent with the requirements of

subsections (e) and (f) of section four thousand eight hundred four of this chapter.

(d) A corporation, including a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter and a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall provide access to out-of-network services consistent with the requirements of subsection (a) of section four thousand eight hundred four of this chapter, subsections (g-6) and (g-7) of section four thousand nine hundred of this chapter, subsections (a-1) and (a-2) of section four thousand nine hundred four of this chapter, paragraphs three and four of subsection (b) of section four thousand nine hundred ten of this chapter, and subparagraphs (C) and (D) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter.

(e) A corporation, including a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter and a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter as added by chapter 246 of the laws of 2012, that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract, as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall establish and maintain procedures for health care professional applications and terminations consistent with the requirements of section four thousand eight hundred three of this chapter and procedures for health care facility applications consistent with section four thousand eight hundred six of this chapter.

§ 4306-d. Choice of health care provider. A corporation that is subject to the provisions of this article and requires or provides for designation by a subscriber of a participating primary care provider shall permit the subscriber to designate any participating primary care provider who is available to accept such individual, and in the case of a child, shall permit the subscriber to designate a physician

(allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the corporation.

§ 4306-e. Prohibition on lifetime and annual limits. (a) A corporation shall not establish a lifetime limit on the dollar amount of essential health benefits in an individual, group or blanket contract of hospital, medical, surgical or prescription drug expense insurance.

(b) A corporation shall not establish an annual limit on the dollar amount of essential health benefits in an individual, group or blanket contract of hospital, medical, surgical or prescription drug expense insurance for contract years beginning on and after January one, two thousand fourteen.

(c) For contract years beginning prior to January one, two thousand fourteen, a corporation may establish restricted annual limits on the dollar amount of essential health benefits in an individual, group or blanket contract of hospital, medical, surgical or prescription drug expense insurance consistent with section 2711 of the Public Health Service Act, 42 U.S.C. § 300gg-11 or any regulations thereunder.

(d) The requirements of subsections (b) and (c) of this section shall not be applicable to any individual contract that is a grandfathered health plan. For purposes of this section, "grandfathered health plan" means coverage provided by a corporation 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).

(e) For purposes of this section, "essential health benefits" shall have the meaning ascribed by section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b).

§ 4306-f. Maternal depression screenings. To the extent a contract provides coverage for maternal depression screening, no corporation subject to this article shall by contract, written policy or procedure limit a patient insured's direct access to screening and referral for maternal depression, as defined in subdivision one of section

twenty-five hundred-k of the public health law, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the patient insured's access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the contract under which the patient insured is covered.

§ 4306-g. Telehealth delivery of services. * (a) (1) A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that a corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the contract. A corporation may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) A corporation that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The superintendent may promulgate regulations to implement the provisions of this section.

(3) A corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically

appropriate.

* NB Effective until April 1, 2028

* (a) A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that a corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the contract. A corporation may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

* NB Effective April 1, 2028

(b) For purposes of this section, "telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.

§ 4306-h. Essential health benefits package and limit on cost-sharing. (a) (1) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(A) ambulatory patient services;

(B) emergency services;

(C) hospitalization;

(D) maternity and newborn care;

* (E) mental health and substance use disorder services, including behavioral health treatment;

* NB Effective until January 1, 2027

* (E) mental health and substance-related and addictive disorder services, including behavioral health treatment;

* NB Effective January 1, 2027

(F) prescription drugs;

(G) rehabilitative and habilitative services and devices;

(H) laboratory services;

(I) preventive and wellness services and chronic disease management; and

(J) pediatric services, including oral and vision care.

(2) A corporation shall not be required to provide coverage for pediatric oral services as an essential health benefit if:

(A) for coverage offered through the exchange established by this state, the exchange has determined sufficient coverage of the pediatric oral benefit is available through stand-alone dental plans certified by the exchange; or

(B) for coverage offered outside the exchange, the corporation obtains reasonable written assurance that the individual or group has obtained a stand-alone dental plan that has been approved by the superintendent as meeting exchange certification standards.

(b) (1) Every individual and small group contract that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan shall provide coverage that meets the actuarial requirements of one of the following levels of coverage:

(A) Bronze Level. A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan;

(B) Silver Level. A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan;

(C) Gold Level. A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan; or

(D) Platinum Level. A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(2) The superintendent may provide for a variation in the actuarial

values used in determining the level of coverage of a plan to account for the differences in actuarial estimates.

(3) Every student accident and health insurance contract shall provide coverage that meets at least sixty percent of the full actuarial value of the benefits provided under the contract. The contract's schedule of benefits shall include the level as described in paragraph one of this subsection nearest to, but below the actual actuarial value.

(c) Every individual or group contract that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan, and every student accident and health insurance contract shall limit the insured's cost-sharing for in-network services in a contract year to not more than the maximum out-of-pocket amount determined by the superintendent for all contracts subject to this section. Such amount shall not exceed any annual out-of-pocket limit on cost-sharing set by the United States secretary of health and human services, if available.

(d) The superintendent may require the use of model language describing the coverage requirements for any form that is subject to the approval of the superintendent pursuant to section four thousand three hundred eight of this article.

(e) For purposes of this section:

(1) "actuarial value" means the percentage of the total expected payments by the corporation for benefits provided to a standard population, without regard to the population to whom the corporation actually provides benefits;

(2) "cost-sharing" means annual deductibles, coinsurance, copayments, or similar charges, for covered services;

(3) "essential health benefits package" means coverage that:

(A) provides for essential health benefits;

(B) limits cost-sharing for such coverage in accordance with subsection (c) of this section; and

(C) provides one of the levels of coverage described in subsection (b) of this section;

(4) "grandfathered health plan" means coverage provided by a corporation 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);

(5) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(6) "student accident and health insurance" shall have the meaning set forth in subsection (a) of section three thousand two hundred forty of this chapter.

§ 4306-i. Coverage for medically fragile children. A corporation that is subject to the provisions of this article shall have procedures for coverage of medically fragile children consistent with section three thousand two hundred seventeen-j of this chapter.

§ 4307. Providers of services. (a) Any hospital service corporation or health service corporation may provide benefits for the rendering of hospital service to persons covered under its contracts (i) by hospitals maintained by the state or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the not-for-profit corporation law, (ii) by such other hospitals, convalescent institutions and nursing homes as shall have been approved by the commissioner of health for such purpose, (iii) with such private or public instrumentalities providing home nursing services as shall have been approved by the commissioner of health for such purpose, and/or (iv) subject to the approval of the superintendent, with similar corporations of other states and hospitals of other states subject to the supervision of such other states.

* (d) In the event a health maintenance organization which is either licensed as a health service corporation under this article or is operating pursuant to a certificate of authority granted in accordance with the provisions of article forty-four of the public health law, or any other health service corporation is deemed insolvent, as provided in subsection (c) of section four thousand three hundred ten of this article, then no individual subscriber or enrollee of, or served by, the health maintenance organization or health service corporation shall be liable to any provider of health care services for any covered services of the insolvent health maintenance organization or health service corporation. No provider of health care services or any representative

of such provider shall collect or attempt to collect from the individual subscriber or enrollee sums owed by a health maintenance organization or health service corporation deemed insolvent, and no provider or representative of such provider may maintain any action at law against an individual subscriber or enrollee to collect sums owed to such provider by such health maintenance organization or health service corporation.

* NB Amended by § 112-a and Repealed by § 143 of 639/96

* § 4307. Providers of services. (a) Any hospital service corporation or health service corporation may provide benefits for the rendering of hospital service to persons covered under its contracts (i) by hospitals maintained by the state or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the not-for-profit corporation law, (ii) by such other hospitals, convalescent institutions and nursing homes as shall have been approved by the commissioner of health for such purpose, (iii) with such private or public instrumentalities providing home nursing services as shall have been approved by the commissioner of health for such purpose, and/or (iv) subject to the approval of the superintendent, with similar corporations of other states and hospitals of other states subject to the supervision of such other states.

(b) All rates of payments to hospitals, nursing homes, convalescent institutions and instrumentalities providing home nursing services made by such corporation pursuant to the contracts provided for in subsection (a) hereof shall prior to payment, (i) in the case of institutions subject to article twenty-eight of the public health law, be certified by the commissioner of health pursuant to the provisions of such article twenty-eight of the public health law and approved by the superintendent, and, (ii) in the case of other institutions, approved as to reasonableness by the superintendent.

(c) Notwithstanding subsections (a) and (b) of this section, approval by the superintendent shall not be required for rates of payment by article forty-three corporations for in-patient hospital services provided after December thirty-first, nineteen hundred eighty-three by general hospitals subject to article twenty-eight of the public health law.

(d) After approval by the superintendent each corporation organized

under this article shall notify each hospital and health related service of its approved rates of payment for out-patient services, in instances where such rates are determined on the basis of a cost based formula, at least thirty days prior to the beginning of each rate year.

* NB Expired January 1, 1986. Remains effective prior to such date. See ch 906/85 § 3

§ 4308. Supervision of superintendent. (a) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate and of all applications, riders and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article and not inconsistent with any other provision of law applicable thereto. The superintendent shall, within a reasonable time after the filing of any such form, notify the corporation filing the same either of his approval or of his disapproval of such form.

(b) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof. The superintendent may refuse such approval if he finds that such premiums, or the premiums derived from the rating formula, are excessive, inadequate or unfairly discriminatory, provided, however, the superintendent may also consider the financial condition of such corporation in approving or disapproving any premium or rating formula. Any adjustments to an approved schedule of premiums or to the approved rating formula for non-community rated contracts shall also be subject to the approval of the superintendent provided, however, such adjustments shall not be subject to the requirements of subsection (c) of this section. Any premium or formula approved by the superintendent shall make provision for such increase as may be necessary to meet the requirements of a plan approved by the superintendent in the manner prescribed in section four thousand three hundred ten of this article for restoration of the statutory reserve fund required by such section.

Notwithstanding any other provision of law, the superintendent, as part of the rate increase approval process, may defer, reduce or reject a rate increase if, in the judgment of the superintendent, the salary increases for senior level management executives employed at corporations subject to the provisions of this article are excessive or unwarranted given the financial condition or overall performance of such corporation. The superintendent is authorized to promulgate rules and regulations which the superintendent deems necessary to carry out such deferral, reduction or rejection.

(c) (1) An increase or decrease in premiums with respect to community rated contracts shall not be approved by the superintendent unless it is in compliance with the provisions of this subsection as well as other applicable provisions of law.

(2) A corporation desiring to increase or decrease premiums for any contract subject to this subsection shall submit a rate filing or application to the superintendent. A corporation shall send written notice of the proposed rate adjustment, including the specific change requested, to each contract holder and subscriber affected by the adjustment on or before the date the rate filing or application is submitted to the superintendent. The notice shall prominently include mailing and website addresses for both the department of financial services and the corporation through which a person may, within thirty days from the date the rate filing or application is submitted to the superintendent, contact the department of financial services or corporation to receive additional information or to submit written comments to the department of financial services on the rate filing or application. The superintendent shall establish a process to post on the department's website, in a timely manner, all relevant written comments received pertaining to rate filings or applications. The corporation shall provide a copy of the notice to the superintendent with the rate filing or application. The superintendent shall immediately cause the notice to be posted on the department of financial services' website. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. The superintendent may modify or disapprove the rate filing or application if the superintendent finds that the premiums are unreasonable, excessive, inadequate, or unfairly discriminatory, and

may consider the financial condition of the corporation in approving, modifying or disapproving any premium adjustment. The determination of the superintendent shall be supported by sound actuarial assumptions and methods, and shall be rendered in writing between thirty and sixty days from the date the rate filing or application is submitted to the superintendent. Should the superintendent require additional information from the corporation in order to make a determination, the superintendent shall require the corporation to furnish such information, and in such event, the sixty days shall be tolled and shall resume as of the date the corporation furnishes the information to the superintendent. If the superintendent requests additional information less than ten days from the expiration of the sixty days (exclusive of tolling), the superintendent may extend the sixty day period an additional twenty days, to make a determination. The application or rate filing will be deemed approved if a determination is not rendered within the time allotted under this section. A corporation shall not implement a rate adjustment unless the corporation provides at least sixty days advance written notice of the premium rate adjustment approved by the superintendent to each contract holder and subscriber affected by the rate adjustment.

(3) (A) The expected minimum loss ratio for a contract form subject to this subsection for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance contract, or, with the approval of the superintendent, an aggregation of contract forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than July thirty-first of each year, every corporation subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the corporation to take corrective action, which may include the submission of a rate filing to reduce future

premiums, or to issue dividends, premium refunds or credits, or any combination of these.

(B) The expected minimum loss ratio for a medicare supplemental insurance contract form shall not be less than eighty percent. No later than May first of each year, every corporation subject to this subparagraph shall annually report the actual loss ratio for each contract form subject to this section for the previous calendar year in a format acceptable to the superintendent. In each case where the loss ratio for the contract form fails to comply with the eighty percent loss ratio requirement, the corporation shall submit a corrective action plan to the superintendent for assuring compliance with the applicable minimum loss ratio standard. The corrective action plan shall be submitted to the superintendent within sixty days of the corporation's submission of the annual report required by this subparagraph. The corporation's plan may utilize premium refunds or credits, subject to the approval of the superintendent.

(4) In case of conflict between this subsection and any other provision of law, this subsection shall prevail.

(d) The superintendent shall order an independent management and financial audit of corporations subject to the provisions of this article with a combined premium volume exceeding two billion dollars annually in order to develop a detailed understanding of such corporation's financial status and to determine the viability of such corporation's products. Such audit shall be performed by an organization upon submission of a program plan in response to a request for proposal approved by the superintendent in consultation with the commissioner of health and the state comptroller. Such audit shall not be performed by any organization that has in any way performed or furnished services of any kind to the corporation within the past five years, unless it is adequately demonstrated that such services would not compromise that organization's performance and objectivity. The audit shall be completed and a report submitted by May first, nineteen hundred ninety-three to the superintendent, the commissioner of health, and the chairs of the senate and assembly committees on health and insurance. The scope of the audit shall include, but not be limited to, financial and competitive position, corporate structure and governance, organization and management, strategic direction, rate adequacy, and the regulatory and

competitive environment in the state of New York. Specifically, the audit shall include, but not be limited to:

(i) determining the corporation's financial and market position, including its reserves, trends in membership, market share, and profitability by market segment;

(ii) evaluating the corporation's product offerings with respect to market requirements and trends, the corporation's responses to the New York health care market, and its management of medical claims costs;

(iii) assessing the effectiveness of the organizational and management structure and performance, including, but not limited to, possible improvement in the size, structure, composition and operation of the board of directors, productivity improvement, information systems, management development, personnel practices, mix and level of skills, personnel turnover, investment practices and rate of return upon investment activities;

(iv) analyzing the corporation's strategic directions, its adequacy to meet competitive, market, and existing regulatory trends, including an evaluation of the use of brokers in marketing products, and the impact of those strategies on the corporation's future financial performance and on the health care system of New York;

(v) evaluating the adequacy of rates for existing products, particularly (but not limited to) small group, medicare supplemental, and direct payment to identify areas that may need immediate remedial attention;

(vi) identifying any changes to the regulatory and legislative environment that may need to be made to ensure that the corporation can continue to be financially viable and competitive;

(vii) identifying and assessing specific transactions such as the procurement of reinsurance, sale of real property and the sale of future investment income to improve the financial condition of the corporation; and

(viii) evaluating and identifying possible improvements in the corporation's managed care strategies, operations and claims handling.

(e) Notwithstanding any other provision of law, the superintendent shall have the power to require independent management and financial audits of corporations subject to the provisions of this article whenever in the judgment of the superintendent, losses sustained by a

corporation jeopardize its ability to provide meaningful coverage at affordable rates or when such audit would be necessary to protect the interests of subscribers. The audit shall include, but not be limited to, an investigation of the corporation's provision of benefits to senior citizens, individual and family, and small group and small business subscribers in relation to the needs of those subscribers. The audit shall also include an evaluation of the efficiency of the corporation's management, particularly with respect to lines of business that are experiencing losses. In every case in which the superintendent chooses to require an audit provided for in this subsection, the superintendent shall have the authority to select the auditor. Any costs incurred as a result of the operation of this subsection shall be assessed on all domestic insurers in the same manner as provided for in section two hundred six of the financial services law.

(f) The results of any audit conducted pursuant to subsections (d) and (e) of this section shall be provided to the corporation and each member of its board of directors. The superintendent shall have the authority to direct the corporation in writing to implement any recommendations resulting from the audit that the superintendent finds to be necessary and reasonable; provided, however, that the superintendent shall first consider any written response submitted by the corporation or the board of directors prior to making such finding. Upon any application for a rate adjustment by the corporation, the superintendent shall review the corporation's compliance with the directions and recommendations made previously by the superintendent, as a result of the most recently completed management or financial audit and shall include such findings in any written decision concerning such application.

(g)(1) Until September thirtieth, two thousand ten, as an alternate procedure to the requirements of subsection (c) of this section, a corporation subject to the provisions of this article desiring to increase or decrease premiums for any contract subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that (A) the anticipated incurred loss ratio for a contract form shall not be less than eighty-two percent for individual direct payment contracts or eighty-two percent for small group and small group remittance contracts, nor, except in the case of individual direct payment contracts with a

loss ratio of greater than one hundred five percent during nineteen hundred ninety-four, shall the loss ratio for any direct payment, group or group remittance contract be more than one hundred five percent of the anticipated earned premium, and (B) the corporation submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that that corporation is in compliance with the provisions of this subsection, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the corporation in establishing premium rates for contracts subject to this section. A corporation shall not utilize the alternate procedure pursuant to this subsection to implement a change in rates to be effective on or after October first, two thousand ten. For purposes of this section, a small group is any group whose contract is subject to the requirements of section forty-three hundred seventeen of this article.

(2) Prior to January first, two thousand, no rate increase or decrease may be deemed approved under this subsection if that increase or decrease, together with any other rate increases or decreases imposed on the same contract form, would cause the aggregate rate increase or decrease for that contract form to exceed ten percent during any continuous twelve month period. No rate increase may be imposed pursuant to this subsection unless at least thirty days advance written notice of such increase has been provided to each contract holder and subscriber.

(h)(1) Each calendar year, a corporation subject to the provisions of this article shall return, in the form of aggregate benefits incurred for each contract form filed pursuant to the alternate procedure set forth in subsection (g) of this section, at least eighty-two percent for individual direct payment contracts or eighty-two percent for small group and small group remittance contracts, but, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent in nineteen hundred ninety-four, for any direct payment, group or group remittance contract, not in excess of one hundred five percent of the aggregate premiums earned for the contract form during that calendar year. Corporations subject to the provisions of this article shall annually report, no later than June thirtieth of each year, the loss ratio calculated pursuant to this subsection for

each such contract form for the previous calendar year.

(2) In each case where the loss ratio for a contract form fails to comply with the eighty-two percent minimum loss ratio requirement for individual direct payment contracts, or the eighty-two percent minimum loss ratio requirement for small group and small group remittance contracts, as set forth in paragraph one of this subsection, the corporation shall issue a dividend or credit against future premiums for all contract holders with that contract form in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits shall equal no less than eighty-two percent for individual direct payment contracts, or eighty-two percent for small group and small group remittance contracts, of the aggregate premiums earned for the contract form in the previous calendar year. The dividend or credit shall be issued to each contract holder or subscriber who had a contract that was in effect at any time during the applicable year. The dividend or credit shall be prorated based on the direct premiums earned for the applicable year among all contract holders or subscribers eligible to receive such dividend or credit. A corporation shall make a reasonable effort to identify the current address of, and issue dividends or credits to, former contract holders or subscribers entitled to the dividend or credit. A corporation shall, with respect to dividends or credits to which former contract holders that the corporation is unable to identify after a reasonable effort would otherwise be entitled, have the option, as deemed acceptable by the superintendent, of prospectively adjusting premium rates by the amount of such dividends or credits, issuing the amount of such dividends or credits to existing contract holders, depositing the amount of such dividends or credits in the fund established pursuant to section four thousand three hundred twenty-two-a of this article, or utilizing any other method which offsets the amount of such dividends or credits. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the dividends and credits, as well as an explanation of the corporation's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing

dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a contract holder or subscriber.

(3) In each case where the loss ratio for a contract form fails to comply with the one hundred five percent maximum loss ratio requirement of paragraph one of this subsection, the corporation shall institute a premium rate increase in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year shall equal no more than one hundred five percent of the sum of the aggregate premiums earned for the contract form in the previous calendar year and the aggregate premium rate increase. The rate increase shall be applied to each contract that was in effect as of December thirty-first of the applicable year and remains in effect as of the date the rate increase is imposed. All rate increases must be imposed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the premium rate increase, as well as an explanation of the corporation's plan to implement the rate increase. The instructions and format for calculating and reporting loss ratios and implementing rate increases shall be specified by the superintendent by regulation.

(i) The alternate procedure described in subsections (g) and (h) of this section shall apply to individual direct payment contracts issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this article on and after January first, nineteen hundred ninety-seven. Such alternate procedure shall not be utilized to implement a change in rates to be effective on or after October first, two thousand ten.

(j) All community rated contracts, other than medicare supplemental insurance contracts, issued or in effect during calendar year two thousand ten shall be subject to a minimum loss ratio requirement of eighty-two percent. Corporations may use the alternate procedure set forth in subsection (g) of this section to adjust premium rates in order to meet the required minimum loss ratio for calendar year two thousand ten. The rate filing or application shall be submitted no later than September thirtieth, two thousand ten.

§ 4309. Limitation on expenses. (a) No corporation subject to the provisions of this article shall, during any one year, disburse more than the percentages hereafter prescribed of the aggregate amount of the premiums received during such year as expenditures for expenses, which, for the purposes of this article, shall include all expenses paid or incurred by the corporation which do not constitute benefit payments made to or on behalf of persons covered under contracts issued by such corporations:

(1) For hospital service corporations: fifteen per centum reduced by one per centum for each five million dollars or fraction thereof above one million dollars of premiums received to ten per centum.

(2) All other corporations: twenty per centum reduced by one per centum for each five million dollars or fraction thereof above one million dollars of premiums received to fifteen per centum except that for any corporation which derives more than fifty per centum of its premiums received from the sale of contracts which provide hospital service benefits: seventeen and one-half per centum reduced by one per centum for each five million dollars or fraction thereof above one million dollars of premiums received to twelve and one-half per centum.

(3) Upon written application, the superintendent may waive the limitations in paragraph one or two of this subsection for any corporation which has not attained the level of enrollment which it needs to attain a break-even position. The break-even position is attained when the amount of annual losses and expenses incurred by the corporation is equal to the amount of premiums earned during this period. Such corporation shall be subject to such limitations in the calendar year following the year in which it attains a break-even position.

(b) If any such corporation shall in any calendar year make or incur expenses as hereinabove defined in excess of its expense limit the superintendent may, upon written application of such corporation and a showing that such corporation has taken steps in accordance with a plan submitted by the corporation and approved by the superintendent which will enable it to comply with the provisions of this section during the next calendar year, suspend the expense limit for such corporation for

the calendar year in which the excess was incurred but the superintendent shall not suspend the expense limit for any such corporation for more than two calendar years in succession.

§ 4310. Investments; financial conditions; reserves. (a) Every corporation subject to the provisions of this article shall annually on or before the first day of March file in the office of the superintendent a statement, verified by at least two of the principal officers of such corporation, showing its condition on the thirty-first day of December then next preceding which shall be in such form and shall contain such matters as the superintendent shall prescribe.

(b) No such corporation shall invest in any securities other than those permitted by the provisions of paragraph two of subsection (a) of section one thousand four hundred three of this chapter, except as provided in paragraphs one and two of this subsection.

(1) A corporation (or two or more such corporations under common management) with admitted assets of greater than eighty million dollars and maintaining cash and reserve investments under subsection (a) of section one thousand four hundred four of this chapter (except paragraphs eight and ten of subsection (a) of such section) free from any lien or pledge, which, when valued in accordance with the provisions of this chapter, seven percent or more of net premium income for the most recent twelve month period, as shown by its last sworn statement, annual or quarterly, on file with the superintendent, may also invest its funds or otherwise acquire or loan upon investments permitted under paragraphs eight and ten of subsection (a) of section one thousand four hundred four of this chapter without having to meet the otherwise applicable qualitative standards and the otherwise applicable aggregate limitation for such investments, provided that the aggregate amount of all such investments shall not exceed the lesser of surplus to policyholders or fifteen percent of its admitted assets as shown by its last statement on file with the superintendent. Any corporation subject to the provisions of this article may jointly exercise control of a subsidiary by acting together with one or more other corporations, provided that such other corporations are either corporations subject to this article, foreign corporations which perform similar functions in

other states or which belong to a national association comprised of similar corporations to which one or more corporations organized under this article also belong, or an institution controlled by any such foreign corporation. No such corporation shall hold a direct or indirect ownership interest in a risk retention group, as defined in article fifty-nine of this chapter, other than in a risk retention group all of whose members are insurance companies. Notwithstanding any other provision of this chapter, including, but not limited to, section one thousand four hundred seven of this chapter, any corporation subject to the provisions of this article may also invest, in the aggregate, not more than three percent of its admitted assets in obligations, shares or other securities (including certificates of deposit) issued by a parent corporation which is organized as a not for profit entity or a corporation which is an affiliate or will be an affiliate after direct or indirect acquisition by the parent corporation; provided, however, that the board of directors of the parent organization is constituted in accordance with the requirements of subsection (k) of section four thousand three hundred one of this article and, provided further however, that the investments of the corporation organized under this article in its own subsidiaries shall not be included in that limitation.

(2) A corporation maintaining cash and reserve investments under subsection (a) of section one thousand four hundred four of this chapter (except paragraphs eight and ten of subsection (a) of such section), free from any lien or pledge, which, when valued in accordance with the provisions of this chapter, equal ten percent or more of net premium income for the most recent twelve month period, as shown by such corporation's last sworn statement, annual or quarterly, on file with the superintendent, may, in addition to the investments permitted by paragraph one of this subsection, invest up to fifteen percent of its admitted assets in investments permitted under paragraph two of subsection (a) of section one thousand four hundred four of this chapter, provided however that such investments need not meet the otherwise applicable qualitative standards of such paragraph two so long as all such investments are rated at BBB or higher (or the equivalent thereto) by a security rating agency recognized by the superintendent.

(c) Any such corporation shall be deemed insolvent whenever it is

presently or prospectively unable to fulfill its outstanding contracts and other liabilities and reserves.

(d) Every such corporation shall maintain a reserve, to be designated as the statutory reserve fund, which shall from time to time during each calendar year be increased in an amount equal to at least one per centum of the net premium income of such corporation during such whole calendar year, provided however, that:

(1) if such corporation reinsures part of its risk under any or all of its contracts by means of reinsurance approved by the superintendent as an appropriate substitute for the statutory reserve fund, then the required increase to the statutory reserve fund at the end of any calendar year shall be reduced by the amount of the premium paid by such corporation for such reinsurance during such calendar year or by one per centum of the net premium income received by such corporation during such calendar year on its contracts so reinsured for the period during which they are so reinsured, whichever amount is the lesser;

(2) the statutory reserve fund at the end of any calendar year shall not exceed twelve and one-half per centum of the net premium income of such calendar year;

(3) every such corporation shall, after the first full calendar year of doing business, accumulate and maintain a statutory reserve fund which shall from time to time during each calendar year be increased in an amount equal to at least five per centum of the net premium income of such corporation during such whole calendar year until such reserve shall be at least equal to fifty thousand dollars and thereafter such reserve shall be accumulated and maintained in the manner prescribed.

(e) (1) Such statutory reserve fund may, after application therefor by the corporation and approval thereof by the superintendent, be reduced below the amount required to be maintained by subsection (d) hereof, provided that no such reduction, except in the event of an epidemic or other catastrophe resulting in extraordinary hospital or medical utilization, shall, in the case of a corporation having a net premium income for the preceding calendar year of (i) less than ten million dollars or (ii) ten million dollars or more, reduce the statutory reserve below an amount equal to seventy-five per centum and fifty per centum, respectively, of the amount required to be maintained by subsection (d) hereof. Any reduction so authorized by the superintendent

shall be restored within a period of not more than three years, or six years in the case of a corporation with a combined premium volume exceeding two billion dollars annually as of December thirty-first, nineteen hundred ninety-six, in accordance with a plan submitted by the corporation and approved by the superintendent which shall provide that such restoration shall be in addition to, and not in lieu of, the increase in the statutory reserve fund hereinabove required, which increase must be made in every year except the year in which a reduction in the statutory reserve fund is authorized by the superintendent.

(2) Any six year plan submitted by a corporation with a combined premium volume exceeding two billion dollars annually as of December thirty-first, nineteen hundred ninety-six shall also be submitted to the special advisory review panel created pursuant to section four thousand three hundred nineteen of this chapter. Within sixty days of its receipt of the six year plan, such panel shall issue a report to the superintendent analyzing the six year plan and recommending any changes it deems appropriate. The superintendent shall hold public hearings regarding any such proposed six year plan and the recommendations of the panel. The superintendent shall consider the findings of the panel and the public hearings held on the six year plan during his approval process for the six year plan.

(f) No such corporation shall invest in any real property, except that any such corporation may, with the approval of the superintendent, invest in such real property as it may reasonably expect will be required for its principal office and the principal office or offices of any other corporation organized under this article which is affiliated with and which shares such principal office or offices with such corporation, or for such purposes as shall be requisite for the convenient accommodation in the transaction of the business of such corporations, but in no event in excess of the aggregate of eight per centum of the net premium income of such corporations and five per centum of the receipts from any governmental agency for which either of such corporations acts as fiscal intermediary during the twelve full months immediately preceding the granting of such approval.

(g) A health service corporation, in addition to the investment in real estate provided in subsection (f) of this section, may, with the approval of the superintendent, purchase an interest in real estate for

the purpose of constructing a hospital or other health facility or center thereon (in accordance with the requirements of chapter seven hundred ninety-five of the laws of nineteen hundred sixty-five), or may purchase an existing hospital or facility for the purpose of providing health services or may make loans to a corporation or corporations under its control for the purposes heretofore described, or for the purpose of organizing, managing or promoting a health maintenance organization, as such term is defined in article forty-four of the public health law primarily for the benefit of persons covered under contracts issued by such corporations, but in no event in excess of an amount equal to ten per centum of its annual net premium income during the twelve full months immediately preceding the granting of such approval. A health service corporation may make expenditures and incur liabilities for the purchase of real estate or for loans in excess of sums provided for in subsection (f) hereof and this subsection as permitted by the superintendent pursuant to paragraph five of subsection (e) of section four thousand three hundred one of this article. A health service corporation, with the approval of the superintendent of financial services, also may enter into agreements for the leasing of hospital facilities.

(h) Notwithstanding any other provisions of this chapter, and in addition to the provisions for the investment of funds and for the purchase of real estate as provided for in this article with the approval of the superintendent, a health service corporation may, with the approval of the superintendent, expend sums including loans to a corporation or corporations under its control to implement the program described herein for the amortization of capital costs for the purchase or construction of facilities in its operations, including a hospital or medical service center, and for the implementation of its program, but not in excess of an amount equal to five percentum of its net premium income during the twelve full months immediately preceding the granting of such approval.

(i) If a loan is made with the approval of the superintendent, to a corporation under the control of a health service corporation, it shall be made on condition that the superintendent may conduct an examination pursuant to sections three hundred nine and three hundred ten of this chapter into the affairs of such corporation.

(j) Every corporation subject to the provisions of this article, including a health service corporation or any of its instrumentalities or any hospital, facility or center directly operated by any such health service corporation, shall be exempt from every state, county, municipal and school tax.

(k) Notwithstanding the provisions of any other law, a corporation subject to the provisions of this article which has admitted assets greater than five hundred million dollars on its last annual report filed with the superintendent may enter into a transaction for an interest rate swap in an amount not to exceed the amount of debt on the books of the corporation on the effective date of this subsection that was incurred within twelve months of the construction of the corporation's home office, provided that such interest rate swap shall provide an initial new interest rate that is at least two hundred basis points lower than the interest rate on the existing debt. The counterparty to this transaction shall meet the qualifications of a qualified counterparty as provided in subparagraph (A) of paragraph three of subsection (f) of section fourteen hundred ten of this chapter except that, notwithstanding clause (iv) of subparagraph (C) of such paragraph, in the event that such counterparty is a qualified bank, such bank shall be rated A or better (or the equivalent thereto) by two independent nationally recognized rating organizations. Any such transaction shall be approved by the corporation's board of directors prior to its implementation.

(l) Notwithstanding any other provisions of this chapter to the contrary, in determining the financial condition of corporations subject to the provisions of this article and not-for-profit corporations authorized pursuant to article forty-four of the public health law, the department shall include real estate, including buildings, property, capital improvements and appurtenances owned and held that are utilized in the ordinary course of the business of such entities, provided that such real estate may be valued by the corporation at either its current amortized book value or at ninety percent of its current market value, as determined by an independent appraisal undertaken annually and in accordance with regulations promulgated by the superintendent.

§ 4312. Employment of solicitors; pension plans. (a) 1. Every corporation subject to the provisions of this article may employ solicitors or accept business from agents and brokers on a commission basis, but all solicitors shall be paid on a salary basis only. It is expressly provided such solicitors are exempt from obtaining a license. Commissions shall be included in the corporation's rate manual and rate filings and commissions payable by health maintenance organizations organized under this article or health maintenance organizations operating as a line of business of corporations organized under this article shall continue to be subject to existing regulations governing commissions payable by health maintenance organizations.

2. Any corporation exercising the authority granted in paragraph one of this subsection shall provide to the superintendent at the time a corporation commences the use of agents and brokers on a commission basis, a detailed plan explaining the purpose for which agents and brokers are to be utilized, the lines of business or products where agents and brokers are to be utilized, the commission scales to be employed in compensating such agents and brokers, and such other information as required by the superintendent.

(b) No corporation subject to the provisions of this article shall hereafter enter into any agreement, directly or indirectly, with an officer, director or salaried employee of such corporation whereby it agrees that for any services rendered or to be rendered he shall receive any salary, compensation or emolument that will extend beyond a period of thirty-six months from the date of such agreement, except that payment of an amount not in excess of twenty percent for the years nineteen hundred eighty-five and nineteen hundred eighty-six and thirty-three and one-third percent for the year nineteen hundred eighty-seven and thereafter of the salary or other compensation of any of its officers or employees, other than a mechanic, workingman or laborer, may by written contract be deferred beyond such period of thirty-six months, which contract may include conditions to be met by such officer or employee before payment will be made. No such corporation shall grant any pension to any officer, director or trustee thereof or to any member of his family after death, except that such corporation may, in pursuance of the terms of a retirement plan adopted

by the board of directors of such corporation and approved by the superintendent, provide for any person who is a salaried officer or employee of such corporation, a pension payable at the time of his retirement by reason of age or disability, and also life insurance benefits payable at his death.

§ 4313. Applicability of other provisions of this chapter. (a) Except as otherwise provided and except as the context otherwise requires, every medical expense indemnity corporation, dental expense indemnity corporation, health service corporation, and hospital service corporation shall be subject to all requirements of this chapter made applicable to insurance companies generally, and to the rules and regulations of the superintendent except in so far as said laws, rules and regulations may be inconsistent with other provisions of this article.

(b) Every such corporation shall be subject to liquidation, dissolution or rehabilitation pursuant to the provisions of article seventy-four of this chapter, and such proceedings shall be under the supervision of the superintendent, who shall have such of the powers granted to him pursuant to the provisions of such article as are applicable to domestic insurance companies.

(c) Every such corporation shall be subject to the provisions of section two thousand six hundred sixteen of this chapter, relating to living organ and tissue donors.

§ 4314. Not to affect provisions of workers' compensation law. No provisions of this article or any contract issued by a corporation subject to the provisions of this article shall in any way affect the operation of the workers' compensation law.

§ 4315. Arbitration; judicial review. (a) Any dispute arising between a hospital service corporation or health service corporation subject to the provisions of this article and any hospital with which such corporation has a contract for hospitalization may, pursuant to an

agreement to that effect in the contract or by subsequent mutual agreement of the parties, be submitted to the commissioner of health for his decision with respect thereto. Any such decision, pursuant to the terms of such submission, shall have the effect of an arbitration award under the provisions of the civil practice law and rules.

(b) Except as provided in subsection (a) of this section, all orders of the superintendent and all final orders or decisions of the commissioner of health made under the provisions of this article shall be subject to judicial review as provided in section three hundred eight of the financial services law.

§ 4316. Individual contracts; premium refund at death of insured. Under individual contracts for which premiums are paid directly to the corporation by the individual, if the death of the insured or a covered dependent occurs during a period for which the premium has been paid, the corporation shall refund the premium or the portion of the premium actually paid by the insured for that person for any period beyond the end of the policy month in which such death occurred.

§ 4317. Rating of individual and small group health insurance contracts. (a) (1) No individual health insurance contract and no group health insurance contract covering between one and fifty employees or members of the group, or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen exclusive of spouses and dependents, including contracts for which the premiums are paid by a remitting agent for a group, hereinafter referred to as a small group, providing hospital and/or medical benefits, including Medicare supplemental insurance, shall be issued in this state unless such contract is community rated and, notwithstanding any other provisions of law, the underwriting of such contract involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual or small group health

insurance coverage including Medicare supplemental insurance, but not including coverage issued on or after January first, two thousand fourteen specified in subsection (l) of section four thousand three hundred four, and section four thousand three hundred twenty-eight of this chapter, must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the corporation to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of coverage for individuals or small groups may be based only on one or more of the reasons set forth in subsection (c) of section four thousand three hundred four or subsection (j) of section four thousand three hundred five of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks of all individuals or small groups covered by the corporation without regard to age, sex, health status, tobacco usage or occupation excluding those individuals of small groups covered by Medicare supplemental insurance. For medicare supplemental insurance coverage, "community rated" means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, tobacco usage or occupation.

(b) (1) The superintendent may set standard premium tiers and standard rating relativities between tiers applicable to all contracts subject to this section. The superintendent may also set a standard relativity applicable to child-only contracts issued pursuant to section 1302(f) of the affordable care act, 42 U.S.C. § 18022(f). The relativity for child-only contracts must be actuarially justifiable using the aggregate experience of corporations to prevent the charging of unjustified premiums. The superintendent may adjust such premium tiers and relativities periodically based upon the aggregate experience of corporations issuing contract forms subject to this section. (2) A corporation shall establish separate community rates for individuals as opposed to small groups. (3) If a corporation is required to issue a contract to individual proprietors pursuant to subsection (f) of this

section, such contract shall be subject to the requirements of subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the corporation in its rate filing so long as the corporation's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the corporation's community rates. (2) Beginning on January first, two thousand fourteen, for every contract subject to this section that provides physician services, medical, major medical or similar comprehensive-type coverage, except for Medicare supplemental insurance, corporations shall use standardized regions established by the superintendent.

(d) * (1) (A) This section shall also apply to a contract issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups having one hundred or fewer employees or members exclusive of spouses and dependents. For a contract issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection. (B) Subparagraph A of this paragraph shall not apply to either the renewal of a contract issued to a group or the issuance, between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of a contract, and any renewal thereof, to a group, provided that the following three requirements are met: (I) the group had been issued a contract that was in effect on July first, two thousand fifteen; (II) the group had member employers, who, on or after July first, two thousand fifteen, have between fifty-one and one hundred employees, exclusive of spouses and dependents; and (III) the group is either: (i) comprised entirely of one

or more municipal corporations or districts (as such terms are defined in section one hundred nineteen-n of the general municipal law); or (ii) comprised entirely of nonpublic schools providing education in any grade from pre-kindergarten through twelfth grade.

* NB Effective until December 28, 2028

* (1) This section shall also apply to a contract issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have one hundred or fewer employees or members exclusive of spouses and dependents. For contracts issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection.

* NB Effective December 28, 2028

(2) If a contract is issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter including association groups, that includes one or more individual or individual proprietor members, then for rating purposes the corporation shall include such members in its individual pool of risks in establishing premium rates for such members.

(3) A corporation shall provide specific claims experience to a municipal corporation, as defined in subsection (f) of section four thousand seven hundred two of this chapter, covered by the corporation under a community rated contract when the municipal corporation requests its claims experience for purposes of forming or joining a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter. Notwithstanding the foregoing provisions, no corporation shall be required to provide more than three years' claims experience to a municipal corporation making this request.

(e) * (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they

purchased insurance, would be subject to this section. No insurer may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. Provided, however, the provisions of this paragraph shall not apply to: (A) the renewal of stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen to small groups covering between fifty-one and one hundred employees or members of the group; and (B) the issuance between January first, two thousand sixteen, and December thirty-first, two thousand sixteen, of stop loss, catastrophic or reinsurance coverage, and any renewal thereof, to a small group covering between fifty-one and one hundred employees or members of the group, provided that such group had stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen.

* NB Effective until December 28, 2028

* (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section.

* NB Effective December 28, 2028

(2) This subsection shall not apply to coverage insuring a plan that was in effect on or before December thirty-first, nineteen hundred ninety-one and was issued to a group that includes member small employers or other member small groups, including but not limited to association groups, provided that (A) acceptance of additional small member employers (or other member groups comprised of fifty or fewer employees or members, exclusive of spouses and dependents) into the group on or after June first, nineteen hundred ninety-two and before April first, nineteen hundred ninety-four does not exceed an amount equal to ten percent per year of the total number of persons covered under the group as of June first, nineteen hundred ninety-two, but nothing in this subparagraph shall limit the addition of larger member employers; (B) (i) after April first, nineteen hundred ninety-four, the

group thereafter accepts member small employers and member small groups without underwriting by any more than the imposition of a pre-existing condition limitation as permitted by this article and the cost for participation in the group for all persons covered shall be the same based on the experience of the entire pool of risks covered under the entire group, without regard to age, sex, health status or occupation; and; (ii) once accepted for coverage, an individual or small group cannot be terminated due to claims experience; (C) the corporation has registered the names of such groups, including the total number of persons covered as of June first, nineteen hundred ninety-two, with the superintendent, in a form prescribed by the superintendent, on or before April first, nineteen hundred ninety-three and shall report annually thereafter until such groups comply with the provisions of subparagraph (B) of this paragraph; and (D) the types or categories of employers or groups eligible to join the association are not altered or expanded after June first, nineteen hundred ninety-two.

(3) A corporation may apply to the superintendent for an extension or extensions of time beyond April first, nineteen hundred ninety-four in which to implement the provisions of this subsection as they relate to groups registered with the superintendent pursuant to subparagraph (C) of paragraph two of this subsection; any such extension or extensions may not exceed two years in aggregate duration, and the ten percent per year limitation of subparagraph (A) of paragraph two of this subsection shall be reduced to five percent per year during the period of any such extension or extensions. Any application for an extension shall demonstrate that a significant financial hardship to such group would result from such implementation.

(f)(1) If the corporation issues coverage to an association group (including chambers of commerce), as defined in subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, then the corporation shall issue the same coverage to individual proprietors who purchase coverage through the association group as the corporation issues to groups that purchase coverage through the association group; provided, however, that a corporation that, on the effective date of this subsection, is issuing coverage to individual proprietors not connected with an association group, may continue to issue such coverage provided that the coverage is

otherwise in accordance with this subsection and all other applicable provisions of law.

(2) For coverage purchased pursuant to this subsection through December thirty-first, two thousand thirteen, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand thirteen, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. Coverage purchased or renewed pursuant to this subsection on or after January first, two thousand fourteen shall be classified in the individual rating category.

(3) The corporation may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance contract, and (C) present a copy of the following documentation to the corporation or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an unincorporated business, the prior year's federal income tax Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an

individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations.

§ 4318. Pre-existing condition provisions. Every individual health insurance contract and every group or blanket accident and health insurance contract issued or issued for delivery in this state which includes a pre-existing condition provision shall contain in substance the following provision or provisions which in the opinion of the superintendent are more favorable to individuals, members of the group and their eligible dependents:

(a) In determining whether a pre-existing condition provision applies to a covered person, the contract shall credit the time the covered person was previously covered under creditable coverage, if the previous creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of the new coverage. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective shall also be credited pursuant to this subsection.

(b) No pre-existing condition provision shall exclude coverage for a period in excess of twelve months following the enrollment date for the covered person and may only relate to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date. For purposes of this section "enrollment date" means the first day of coverage of the individual under the contract or, if earlier, the first day of the waiting period that must pass with respect to an individual before the individual is eligible to be covered for benefits. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period. For

purposes of this section, genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information. No pre-existing condition provision shall exclude coverage in the case of:

(1) an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage as defined in subsection (c) of this section;

(2) a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage as defined in subsection (c) of this section;

(3) pregnancy (except in an individual direct payment contract or a student blanket accident and health insurance contract in which a corporation may exclude coverage, subject to a credit for previous creditable coverage, for a period not to exceed ten months for a pregnancy existing on the enrollment date); or

(4) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage.

Paragraphs one and two of this subsection shall no longer apply to an individual after the end of the first sixty-three day period during all of which the individual was not covered under any creditable coverage.

(c) For purposes of this section, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or B of title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of title 10, United States Code;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under chapter 89 of title 5, United States Code;

(9) A public health plan (as defined in regulations);

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(d)(1) For purposes of applying the credit of such creditable coverage, a corporation shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(2) Alternatively, a corporation may elect to count the period of coverage based on coverage of benefits within each of several classes or categories of benefits as specified in regulations. Such election shall be made on a uniform basis for all subscribers, participants and beneficiaries. Pursuant to such election a corporation shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category. A corporation making such election shall prominently state in any disclosure statement, and shall set forth in any contract or certificate issued in connection with the coverage, that the corporation has made such election. Such disclosure statement shall include a description of the effect of the election with regard to the application of creditable coverage.

(3) Notwithstanding the foregoing paragraph, for purposes of determining the extent to which a pre-existing condition limitation has been satisfied in a contract issued pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this article within thirty days of discontinuance of a class of health maintenance organization direct payment contract for enrollees whose contract was discontinued, a corporation shall credit the coverage of an enrollee under a health maintenance organization direct payment contract issued prior to January first, nineteen hundred ninety-six, without regard to the specific benefits covered under the health maintenance organization contract.

(4) With respect to an "eligible individual", as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. § 300gg-41(b), a corporation may not impose any pre-existing condition exclusion in an individual health insurance contract. For all other covered persons, the pre-existing condition crediting requirement of

subsection (a) of this section shall be applicable.

(e) For the purposes of this section the term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(f) A corporation shall not impose any pre-existing condition exclusion in an individual or group contract of hospital, medical, surgical or prescription drug expense insurance.

§ 4318-a. Certification of creditable coverage by corporations organized under this article. (a) Every corporation subject to the provisions of this article that issues individual health insurance contracts or group or blanket accident and health insurance contracts shall provide covered individuals with written certification, in a form as the superintendent may approve, of:

(1) the period of creditable coverage, as defined in section four thousand three hundred eighteen of this article, of the individual under such contract and under any continuation coverage pursuant to state or federal law; and

(2) any waiting period or affiliation period (if applicable) imposed with respect to the individual for coverage under any such contract.

(b) The corporation shall provide such certification:

(1) at the time an individual ceases to be covered under the contract, including any period of time the individual was covered pursuant to any right of continuation under the contract; and

(2) on the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in paragraph one of this subsection.

(c) In the event of an election by an insurer or a group health plan to count the period of creditable coverage based on coverage of benefits within classes or categories of benefits as provided in state or federal law, if that insurer or group health plan enrolls an individual for coverage under its contract or plan and the individual provides a

certification of coverage of the individual under subsection (a) of this section, then upon request of such insurer or group health plan, any corporation subject to the provisions of this article that issued the certification of coverage provided by the individual shall promptly disclose to such requesting insurer or group health plan information on coverage of classes and categories of health benefits available under the corporation's contract. The corporation may charge the requesting plan or insurer for the reasonable cost of disclosing such information.

(d) A corporation that issues group or blanket accident and health insurance contracts is deemed to have satisfied the requirements of subsection (a) of this section if the contract holder by written agreement with the corporation actually provides the written certification in accordance with this section.

§ 4320. Limitations on administrative services and stop-loss coverage. No insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of a group which denies or limits benefits for a specific disease or condition or for a procedure or treatment unique to a specific disease or condition in a manner which would be inconsistent with this chapter or regulations promulgated by the superintendent had the group purchased insurance. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to groups which deny or limit benefits for a specific disease or condition or for a procedure or treatment unique to a specific disease or condition in a manner which would be inconsistent with this chapter or regulations promulgated by the superintendent had the group purchased insurance. A limit, maximum, or other mechanism that controls total coverage without regard to a specific disease or condition shall not be deemed one that denies or limits benefits for a specific disease or condition, or for a procedure or treatment unique to a specific disease or condition. Nothing herein shall be construed to mandate the inclusion of specified benefits in an employer group plan, if such plan is not subject to the provisions of this chapter.

§ 4321. Standardization of individual enrollee direct payment contracts offered by health maintenance organizations prior to October first, two thousand thirteen. (a) On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer a standardized individual enrollee contract on an open enrollment basis as prescribed by section forty-three hundred seventeen of this article and section forty-four hundred six of the public health law, and regulations promulgated thereunder, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act. On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen, the enrollee contracts issued pursuant to this section and section four thousand three hundred twenty-two of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-two of this article shall also be the only contracts issued by health maintenance organizations for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prevent health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

(b) The standardized individual enrollee direct payment contract shall provide coverage for all health services which an enrolled population in a health maintenance organization might require in order to be maintained in good health, rendered without limitation as to time and cost, except to the extent permitted by this chapter; provided however

that no individual enrollee and no family unit enrolled in such organization shall incur out-of-pocket costs in excess of fifteen hundred dollars and three thousand dollars, respectively, in any calendar year. Such covered services shall be identical to the in-plan covered benefits of the standardized individual direct payment enrollee contract described in section four thousand three hundred twenty-two of this article, except as otherwise provided in subsections (c), (d) and (e) of this section.

(c) The health maintenance organization shall impose a fifteen dollar copayment on all visits to a physician or other provider with the exception of visits for pre-natal and post-natal care, well child visits provided pursuant to paragraph two of subsection (j) of section four thousand three hundred three of this article, preventive health services provided pursuant to subparagraph (F) of paragraph four of subsection (b) of section four thousand three hundred twenty-two of this article, or items or services for bone mineral density provided pursuant to subparagraph (D) of paragraph twenty-six of subsection (b) of section four thousand three hundred twenty-two of this article for which no copayment shall apply. A copayment of fifteen dollars shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. A fifty dollar copayment shall be imposed on emergency services rendered in the emergency room of a hospital; however, this copayment must be waived if hospital admission results. Surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence. A five hundred dollar copayment shall be imposed on inpatient hospital services per continuous hospital confinement. Ambulatory surgical services shall be subject to a facility copayment charge of seventy-five dollars. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.

(d) The provisions of each health maintenance organization contract describing administrative procedures and other provisions not affecting the scope of, or conditions for obtaining, covered benefits, such as, but not limited to, eligibility and termination provisions, may be of the type generally used by the health maintenance organization, as long as the superintendent determines that the terms and description of those

administrative and other provisions are unlikely to affect consumers' determinations of which health maintenance organization's contract to purchase and are not contrary to law. Each contract may also include limitations and conditions on coverage of benefits described in this section provided the superintendent determines the limitations and conditions on coverage were commonly included in health maintenance organization and/or health insurance products covering individuals on a direct payment basis prior to January first, nineteen hundred ninety-six, and are not contrary to law.

(e) The superintendent shall be authorized to modify, by regulation, the copayments, deductibles and coinsurance amounts described in this section, if the superintendent determines such amendments are necessary to moderate potential premiums. On or after January first, nineteen hundred ninety-eight, the superintendent shall be authorized to establish one or more additional standardized individual enrollee direct payment contracts if the superintendent determines, after one or more public hearings, additional contracts with different levels of benefits are necessary to meet the needs of the public.

(f) No contract issued pursuant to this section or section four thousand three hundred twenty-two of this article shall exclude coverage of a health care service, as defined in paragraph two of subsection (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 subsection, 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 subsection

shall be provided subject to the terms and conditions generally applicable to other benefits provided under the policy.

§ 4321-a. Fund for standardized individual enrollee direct payment contracts. (a) The superintendent shall establish a fund from which health maintenance organizations may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations for members covered under standardized individual enrollee direct payment contracts issued pursuant to section four thousand three hundred twenty-one of this article. The fund established by the superintendent pursuant to this section shall be known as the direct payment stop loss fund. Commencing in calendar year two thousand, health maintenance organizations shall be eligible to receive reimbursement from the direct payment stop loss fund for ninety percent of claims paid between twenty thousand and one hundred thousand dollars in a calendar year for any member covered under a contract issued pursuant to section four thousand three hundred twenty-one of this article. For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized direct payment contracts.

(b) The superintendent shall promulgate regulations setting forth procedures for the operation of the direct payment stop loss fund and the distribution of monies therefrom.

(c) Claims shall be reported and funds shall be distributed on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in such calendar year shall be eligible for reimbursement.

(d) Each health maintenance organization shall submit a request for reimbursement from the stop loss fund on a form prescribed by the superintendent. Such request for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement request is being made. The superintendent may require health maintenance organizations to submit such claims data in

connection with the reimbursement request as he deems necessary to enable him to distribute monies and oversee the operation of the direct payment stop loss fund. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis.

(e) The superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement by all health maintenance organizations for a calendar year exceeds funds available for distribution for claims paid by all health maintenance organizations during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations.

(2) In the event that (A) funds available for distribution for claims paid by all health maintenance organizations during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations during that same calendar year, and (B) the total amount requested for reimbursement by all health maintenance organizations from the direct payment out-of-plan stop loss fund exceeds the amount available for distribution from such fund, then any excess funds shall be reallocated for distribution to the direct payment out-of-plan stop loss fund. Otherwise, such excess funds shall be carried forward and will not affect monies appropriated for the direct payment stop loss fund in the next calendar year.

(f) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the direct payment stop loss fund. Such data shall be furnished in a form prescribed by the superintendent.

(g) The superintendent may obtain the services of an organization to administer the direct payment stop loss fund. The superintendent shall establish guidelines for the submission of proposals by organizations for the purposes of administering the fund. The superintendent shall make a determination whether to approve, disapprove or recommend

modification to the proposal of an applicant to administer the fund. An organization approved to administer the fund shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the fund, including, but not limited to an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and assembly ways and means committee. An organization approved to administer the fund shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the direct payment stop loss fund. An organization approved to administer the fund may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

(h) If the superintendent deems it appropriate for the proper administration of the direct payment stop loss fund, the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss fund.

§ 4322. Standardization of individual enrollee direct payment contracts offered by health maintenance organizations which provide out-of-plan benefits prior to October first, two thousand thirteen. (a) On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer to individuals, in addition to the standardized contract required by section four thousand three hundred twenty-one of this article, a standardized individual enrollee direct payment contract on an open

enrollment basis as prescribed by section four thousand three hundred seventeen of this article and section four thousand four hundred six of the public health law, and regulations promulgated thereunder, with an out-of-plan benefit system, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act. The out-of-plan benefit system shall either be provided by the health maintenance organization pursuant to subdivision two of section four thousand four hundred six of the public health law or through an accompanying insurance contract providing out-of-plan benefits offered by a company appropriately licensed pursuant to this chapter. On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen, the contracts issued pursuant to this section and section four thousand three hundred twenty-one of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-one of this article shall also be the only contracts issued by the health maintenance organization for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prohibit health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

(i) On and after January first, two thousand fourteen, each contract that is not a grandfathered health plan shall provide coverage for the essential health benefit package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a); and

(2) "grandfathered health plan" means coverage provided by a corporation 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).

(b) The in-plan and out-of-plan covered benefits for the standardized individual enrollee direct payment contract shall include coverage for all health services which an enrolled population in a health maintenance organization might require in order to be maintained in good health, rendered without limitation as to time and cost, except to the extent permitted by this chapter.

The in-plan and out-of-plan covered services include the following:

(1) Inpatient hospital services, including:

(A) daily room and board;

(B) general nursing care;

(C) special diets; and

(D) miscellaneous hospital services.

(2) Outpatient hospital services including:

(A) diagnostic and treatment services;

(B) x-rays; and

(C) laboratory tests.

(3) Physician services including:

(A) consultant and referral services;

(B) primary and preventive care services;

(C) in-hospital medical services;

(D) surgical services;

(E) anesthetic services; and

(F) second surgical opinion.

(4) Preventive health services including:

(A) periodic physical examinations, including eye and ear examinations to determine the need for vision and hearing correction;

(B) well child care from birth;

(C) pediatric and adult immunizations;

(D) mammography screening, as provided in subsection (p) of section four thousand three hundred three of this article;

(E) cervical cytology screening as provided in subsection (t) of section four thousand three hundred three of this article; and

(F) for a contract that is not a grandfathered health plan, the

following additional preventive health services:

(i) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(v) For purposes of this subparagraph, "grandfathered health plan" means coverage provided by a corporation 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).

(5) Emergency services.

(6) Diagnostic laboratory services.

(7) Therapeutic and diagnostic radiologic services.

(8) Preadmission testing.

(9) Home health services up to two hundred visits per member per calendar year.

(10) Maternity care.

(11) Chemotherapy services.

(12) Hemodialysis services consistent with the provisions of subsection (gg) of section four thousand three hundred three of this article.

(13) Outpatient physical therapy up to ninety visits per condition per calendar year.

(14) Hospice care up to two hundred ten days.

(15) Skilled nursing facility care when preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.

(16) Equipment, supplies and self-management education for the treatment of diabetes.

(17) Inpatient diagnosis and treatment of mental, nervous or emotional disorders or ailments up to thirty days per calendar year combined with inpatient treatment of alcoholism and substance abuse.

(18) Inpatient diagnosis and treatment of alcoholism and alcohol abuse and substance abuse and substance dependence up to thirty days per calendar year for detoxification combined with inpatient treatment of mental, nervous or emotional disorders or ailments.

(19) Outpatient diagnosis and treatment of mental, nervous or emotional disorders or ailments up to thirty non-emergency and three emergency visits per calendar year.

(20) Ambulance services.

(21) Private duty nursing up to five thousand dollars per individual per calendar year up to a ten thousand dollar individual lifetime maximum.

(22) Prosthetics, orthotics, durable medical equipment and medical supplies.

(23) Inpatient physical rehabilitation services.

(24) Blood and blood products.

(25) Prescription drugs, including contraceptive drugs or devices approved by the federal food and drug administration or generic equivalents approved as substitutes by such food and drug administration and nutritional supplements (formulas), whether administered orally or via a feeding tube for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria, obtained at a participating pharmacy under a prescription written by an in-plan or out-of-plan provider. Health maintenance organizations, in addition to providing coverage for prescription drugs at a participating pharmacy, may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician or other provider.

Health maintenance organizations shall impose a one hundred dollar individual deductible and a three hundred dollar family deductible per

calendar year for prescription drugs obtained at a participating pharmacy. Health maintenance organizations may not impose a deductible on prescriptions obtained through the mail order drug program.

In addition to the deductible, a ten dollar copayment shall be imposed on up to a thirty-four day supply of brand name prescription drugs obtained at a participating pharmacy. A five dollar copayment shall be imposed on up to a thirty-four day supply of generic prescription drugs or brand name drugs for which there is no generic equivalent obtained at a participating pharmacy.

If a mail order drug program is utilized, a twenty dollar copayment shall be imposed on a ninety day supply of brand name prescription drugs. A ten dollar copayment shall be imposed on a ninety day supply of generic prescription drugs or brand name drugs for which there is no generic equivalent obtained through the mail order drug program.

In no event shall the copayment exceed the cost of the prescribed drug.

(26) Bone mineral density measurements or tests and, if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes.

In determining appropriate coverage provided by subparagraphs (A), (B) and (C) of this paragraph, the insurer or health maintenance organization shall adopt standards that include the criteria of the federal Medicare program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(A) For purposes of subparagraphs (B) and (C) of this paragraph, bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal Medicare program as well as those in accordance with the criteria, of the national institutes of health, including, as consistent with such criteria dual-energy x-ray absorptiometry.

(B) For purposes of subparagraphs (A) and (C) of this paragraph, bone

mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage consistent with the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, except for a grandfathered health plan under subparagraph (E) of this paragraph, coverage shall be provided for the following items or services for bone mineral density, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for bone mineral density that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; and

(ii) with respect to women, such additional preventive care and screenings for bone mineral density not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, "grandfathered health plan" means coverage provided by a corporation 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).

(27) Services covered under such policy when provided by a comprehensive care center for eating disorders pursuant to article thirty of the mental hygiene law; provided, however, that reimbursement under such policy for services provided through such comprehensive care centers shall, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

(b-1) The in-plan and out-of-plan covered benefits for the standardized individual enrollee direct payment contracts established by this section and section four thousand three hundred twenty-one of this article shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by health maintenance organizations or insurers for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(b-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages for any decision or action pursuant to subsection (b-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(b-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the contracts established by this section and section four thousand three hundred twenty-one of this article for those persons

required to register as sex offenders pursuant to article six-C of the correction law.

(c) The in-plan benefit system shall impose a ten dollar copayment on all visits to a physician or other provider with the exception of visits for pre-natal and post-natal care, well child visits provided pursuant to paragraph two of subsection (j) of section four thousand three hundred three of this article, preventive health services provided pursuant to subparagraph (F) of paragraph four of subsection (b) of this section or items or services for bone mineral density provided pursuant to subparagraph (D) of paragraph twenty-six of subsection (b) of this section for which no copayment shall apply. A copayment of ten dollars shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. A thirty-five dollar copayment shall be imposed on emergency services rendered in the emergency room of a hospital; however, this copayment must be waived if hospital admission results.

(d) The out-of-plan benefit system shall have an annual deductible established at one thousand dollars per calendar year for an individual and two thousand dollars per year for a family. Coinsurance shall be established at twenty percent with the health maintenance organization or insurer paying eighty percent of the usual, customary and reasonable charges, or eighty percent of the amounts listed on a fee schedule filed with and approved by the superintendent which provides a comparable level of reimbursement. Coinsurance of ten percent shall apply to outpatient visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. The benefits described in subparagraph (F) of paragraph three and paragraphs seventeen and eighteen of subsection (b) of this section shall not be subject to the deductible or coinsurance. The benefits described in paragraph nine of subsection (b) of this section shall not be subject to the deductible. The out-of-plan out-of-pocket maximum deductible and coinsurance shall be established at three thousand dollars per calendar year for an individual and five thousand dollars per calendar year for a family. The out-of-plan lifetime benefit maximum shall be established at five hundred thousand dollars for benefits that are not essential health benefits. A lifetime limit on the dollar amount of essential health benefits for any

individual shall not be established. For purposes of this subsection, "essential health benefits" shall have the meaning ascribed by section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b).

(e) The provisions of each contract describing administrative procedures and other provisions not affecting the scope of, or conditions for obtaining, covered benefits, such as, but not limited to, eligibility and termination provisions, may be of the type generally issued by the health maintenance organization and/or insurer, as long as the superintendent determines that the terms and description of those administrative and other provisions are unlikely to affect consumers' determinations of which health maintenance organization's contract to purchase and are not contrary to law. Each contract may also include limitations and conditions on coverage of benefits described in this section provided the superintendent determines the limitations and conditions on coverage were commonly included in the health maintenance organization and/or health insurance products covering individuals on a direct payment basis prior to January first, nineteen hundred ninety-six and are not contrary to law.

(f) A health maintenance organization may offer the required out-of-plan benefits by means of a rider to a contract offering in-plan benefits only.

(g) Day and visit limitations on benefits included in this section are aggregate limitations regardless of whether services are received in-plan or out-of-plan. The five thousand dollar per individual per calendar year limitation and ten thousand dollar lifetime limitation on private duty nursing is also an aggregate limitation for in-plan and out-of-plan benefits combined.

(h) The superintendent shall be authorized to modify, by regulation, the copayments, deductibles and coinsurance amounts described in this section, if the superintendent determines such amendments are necessary to moderate potential premiums. On or after January first, nineteen hundred ninety-eight, the superintendent shall be authorized to establish one or more additional standardized individual enrollee direct payment contracts if the superintendent determines, after one or more public hearings, additional contracts with different levels of benefits are necessary to meet the needs of the public.

(i) On and after January first, two thousand fourteen, each contract

that is not a grandfathered health plan shall provide coverage for the essential health benefit package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a); and

(2) "grandfathered health plan" means coverage provided by a corporation 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).

§ 4322-a. Fund for standardized individual enrollee direct payment contracts which provide out-of-plan benefits. (a) The superintendent shall establish a fund from which health maintenance organizations may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations for members covered under standardized individual enrollee direct payment contracts which provide out-of-plan benefits issued pursuant to section four thousand three hundred twenty-two of this article. The fund established by the superintendent pursuant to this section shall be known as "the direct payment out-of-plan stop loss fund". Commencing in calendar year two thousand, health maintenance organizations shall be eligible to receive reimbursement from the direct payment out-of-plan stop loss fund for ninety percent of claims paid between twenty thousand and one hundred thousand dollars in a calendar year for any member covered under a contract issued pursuant to section four thousand three hundred twenty-two of this article. For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to contracts issued pursuant to section four thousand three hundred twenty-two of this article.

(b) The superintendent shall promulgate regulations that set forth procedures for the operation of the direct payment out-of-plan stop loss fund and the distribution of monies therefrom.

(c) Claims shall be reported and funds shall be distributed on a calendar year basis. Claims shall be eligible for reimbursement only for

the calendar year in which the claims are paid. Once claims paid on behalf of a member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(d) Each health maintenance organization shall submit a request for reimbursement from the stop loss fund on a form prescribed by the superintendent. Such request for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement request is being made. The superintendent may require health maintenance organizations to submit such claims data in connection with the reimbursement request as he deems necessary to enable him to distribute monies and oversee the operation of the direct payment out-of-plan stop loss fund. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis.

(e) The superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement by all health maintenance organizations for a calendar year exceeds funds available for distribution for claims paid by all health maintenance organizations during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's total eligible claims bears to the total eligible claims paid by all health maintenance organizations.

(2) In the event that (A) funds available for distribution for claims paid by all health maintenance organizations during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations during that same calendar year, and (B) the total amount requested for reimbursement by all health maintenance organizations from the direct payment stop loss fund exceeds the amount available for distribution from such fund, then any excess funds shall be reallocated for distribution to the direct payment stop loss fund. Otherwise, such excess funds shall be carried forward and shall not affect the monies appropriated for the direct payment out-of-plan stop

loss fund in the next calendar year.

(f) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the direct payment out-of-plan stop loss fund. Such data shall be furnished in a form prescribed by the superintendent.

(g) The superintendent may obtain the services of an organization to administer the direct payment out-of-plan stop loss fund. The superintendent shall establish guidelines for the submission of proposals by organizations for the purposes of administering the fund. The superintendent shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the fund. An organization approved to administer the fund shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the fund, including, but not limited to, an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and assembly ways and means committee. An organization approved to administer the fund shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the direct payment out-of-plan stop loss fund. An organization approved to administer the fund may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

(h) If the superintendent deems it appropriate for the proper administration of the direct payment out-of-plan stop loss fund, the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss fund.

§ 4323. Marketing materials. (a) All health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall prepare, in conjunction with the superintendent, and shall participate in and share the cost of the publication and dissemination of a consumer's shopping guide for standardized individual health plans issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this article and a separate consumer shopping guide for standardized qualifying individual health insurance contracts and standardized qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. The consumer's shopping guides shall be published annually and shall include the names, addresses and telephone numbers of all health maintenance organizations offering such coverage as well as a description of the plan design and premiums in such a manner that facilitates consumer comparison.

(b) Health maintenance organizations may distribute additional sales or marketing brochures describing the standardized coverage offered subject to review by the superintendent.

(c) All health maintenance organization marketing materials must be sufficiently clear to avoid deception or the capacity or tendency to mislead or deceive and may not disparage competitors.

§ 4324. Disclosure of information. The requirements of this section shall apply to all comprehensive, expense-reimbursed contracts; managed care products; or any other contract or product for which the superintendent deems such disclosure appropriate.

(a) Each health service, hospital service, or medical expense indemnity corporation subject to this article shall supply each subscriber, and upon request each prospective subscriber prior to enrollment, written disclosure information, which may be incorporated into the subscriber contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or

certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

(1) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(2) a description of all prior authorization or other requirements for treatments and services;

(3) a description of utilization review policies and procedures, used by the corporation, including:

(A) the circumstances under which utilization review will be undertaken;

(B) the toll-free telephone number of the utilization review agent;

(C) the time frames under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(D) the right to reconsideration;

(E) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(F) the right to designate a representative;

(G) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;

(H) a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the time frames for such appeals; and

(I) further appeal rights, if any;

(4) a description prepared annually of the types of methodologies the corporation uses to reimburse providers, specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a corporation and a health care provider;

(5) an explanation of a subscriber's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a subscriber's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services;

(6) an explanation, where applicable, of a subscriber's financial responsibility for payment when services are provided by a health care provider who is not part of the corporation's network of providers or by any provider without required authorization;

(7) a description of the grievance procedures to be used to resolve disputes between the corporation and a subscriber, including: the right to file a grievance regarding any dispute between the corporation and a subscriber; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which subscribers may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(8) a description of the procedure for obtaining emergency services. Such description shall include a definition of emergency services, notice that emergency services are not subject to prior approval, and shall describe the subscriber's financial and other responsibilities regarding obtaining such services including when such services are received outside the corporation's service area, if any;

(9) where applicable, a description of procedures for subscribers to select and access the corporation's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) where applicable, a description of the procedures for changing primary and specialty care providers within the corporation's network of providers;

(11) where applicable, notice that a subscriber enrolled in a managed care product or in a comprehensive contract that utilizes a network of

providers offered by the corporation may obtain a referral or preauthorization for a health care provider outside of the corporation's network or panel when the corporation does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral or preauthorization;

(12) where applicable, notice that a subscriber enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that a subscriber enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that a subscriber enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (A) a life-threatening condition or disease, or (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(15) a description of how the corporation addresses the needs of non-English speaking subscribers;

(16) notice of all appropriate mailing addresses and telephone numbers to be utilized by subscribers seeking information or authorization;

(16-a) where applicable, notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan

or for any care related to a pregnancy;

* (17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

* NB Effective until January 1, 2027

* (17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance-related and addictive disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

* NB Effective January 1, 2027

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation;

(19) the method by which a subscriber may submit a claim for health care services;

(20) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the corporation to determine reimbursement for out-of-network health care services;

(B) a description of the amount that the corporation will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

(21) information in writing and through an internet website that reasonably permits a subscriber or prospective subscriber to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the corporation will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services; and

(22) the most recent comparative analysis performed by the corporation to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031 (j), and any amendments to, and federal guidance or regulations issued under, those Acts.

(b) Each health service, hospital service, or medical expense indemnity corporation subject to this article, upon request of a subscriber or prospective subscriber shall:

(1) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the corporation;

(2) provide a copy of the most recent annual certified financial statement of the corporation, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) provide a copy of the most recent individual, direct pay subscriber contracts;

(4) provide information relating to consumer complaints compiled pursuant to section two hundred ten of this chapter;

(5) provide the procedures for protecting the confidentiality of medical records and other subscriber information;

(6) where applicable, to allow subscribers and prospective subscribers

to inspect drug formularies used by such corporation; and provided further, that the corporation shall also disclose whether individual drugs are included or excluded from coverage to a subscriber or prospective subscriber who requests this information;

(7) provide a written description of the organizational arrangements and ongoing procedures of the corporation's quality assurance program, if any;

(8) provide a description of the procedures followed by the corporation in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) provide individual health practitioner affiliations with participating hospitals, if any;

(10) upon written request, provide specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination pursuant to subsection (c-1), subsection (c-2) and subsection (c-3) of section forty-nine hundred three of this chapter, and, where appropriate, other clinical information which the corporation might consider in its utilization review and the corporation may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the corporation, the subscriber or prospective subscriber shall only use the information for the purposes of assisting the subscriber or prospective subscriber in evaluating the covered services provided by the organization. Such clinical review criteria, and other clinical information shall also be made available to a health care professional as defined in subsection (f) of section forty-nine hundred of this chapter, on behalf of an insured and upon written request;

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the corporation for participation in the corporation's network for a managed care product;

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act;

(13) disclose whether a health care provider scheduled to provide a health care service is an in-network provider; and

(14) with respect to out-of-network coverage, disclose the approximate dollar amount that the corporation will pay for a specific out-of-network health care service. The corporation shall also inform the insured through such disclosure that such approximation is not binding on the corporation and that the approximate dollar amount that the corporation will pay for a specific out-of-network health care service may change.

(c) Nothing in this section shall prevent a corporation from changing or updating the materials that are made available to subscribers.

(d) As to any program where the subscriber must select a primary care provider, if a participating primary care provider becomes unavailable to provide services to a subscriber, the corporation shall provide written notice within fifteen days from the time the corporation becomes aware of such unavailability to each subscriber who has chosen the provider as their primary care provider. If a subscriber is enrolled in a managed care product and is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such subscriber, and the corporation is aware of such ongoing course of treatment, the corporation shall provide written notice within fifteen days from the time the corporation becomes aware of such unavailability to such subscriber. Each notice shall also describe the procedures for continuing care pursuant to subsections (e) and (f) of section forty-eight hundred four of this chapter and for choosing an alternative provider.

(e) For purposes of this section, a "managed care product" shall mean a contract which requires that all 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 designated health care provider chosen by the subscriber (i.e. a primary care gatekeeper), and that services provided pursuant to such a referral be rendered by a health care provider participating in the corporation's managed care provider network. In addition, in the case of (i) an individual health insurance contract, or (ii) a group health insurance contract covering no more than three hundred lives, imposing a coinsurance obligation of more than twenty-five percent upon services received outside of the

corporation's managed care provider network, and which has been sold to five or more groups, a managed care product shall also mean a contract which requires that all 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 designated health care provider chosen by the subscriber (i.e. a primary care gatekeeper), and that services provided pursuant to such a referral be rendered by a health care provider participating in the corporation's managed care provider network, in order for the subscriber to be entitled to the maximum reimbursement under the contract.

(f) For purposes of this section, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to this article, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law.

(g) (1) As used in this subsection:

(A) "Pharmacy benefit manager" shall have the meaning set forth in section two hundred eighty-a of the public health law.

(B) "Cost-sharing information" means the amount a subscriber is required to pay to receive a drug that is covered under the subscriber's insurance contract.

(C) "Covered/coverage" means those health care services to which a subscriber is entitled under the terms of the insurance contract.

(D) "Electronic health record" means a digital version of a patient's paper chart and medical history that makes information available instantly and securely to authorized users.

(E) "Electronic prescribing system" means a system that enables prescribers to enter prescription information into a computer prescription device and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network.

(F) "Electronic prescription" shall have the meaning set forth in

section thirty-three hundred two of the public health law.

(G) "Prescriber" means a health care provider licensed to prescribe medication or medical devices in this state.

(H) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (i) is capable of integrating with prescribers' electronic prescribing system and, if feasible, electronic health record systems; and (ii) complies with the technical standards adopted by an American National Standards Institute (ANSI) accredited standards development organization.

(I) "Authorized third party" shall include a third party legally authorized under state or federal law subject to a Health Insurance Portability and Accountability Act (HIPAA) business associate agreement.

(2) The provisions of this section shall not apply to any health plan that exclusively serves individuals enrolled pursuant to a federal or state insurance affordability program, including the medical assistance program under title eleven of article five of the social services law, child health plus under section twenty-five hundred eleven of the public health law, the basic health program under section three hundred sixty-nine-gg of the social services law, or a plan providing services under title XVIII of the federal social security act.

(3) A health service, hospital service, or medical expense indemnity corporation subject to this article or pharmacy benefit manager shall, upon request of the subscriber, the subscriber's health care provider, or an authorized third party on the subscriber's behalf, made to the health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager, furnish the cost, benefit, and coverage data required by this subsection to the subscriber, the subscriber's health care provider, or the authorized third party and shall ensure that such data is: (A) current no later than one business day after any change to the cost, benefit, or coverage data is made; (B) provided through a RTBT when the request is made by the subscriber's health care provider; and (C) in a format that is easily accessible to the requestor.

(4) When providing the data required by paragraph three of this subsection, the health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager shall use established industry content and transport standards published by:

(A) a standards developing organization accredited by the American National Standards Institute (ANSI), including, the National Council for Prescription Drug Programs (NCPDP), ASC X12, Health Level 7; or

(B) a relevant federal or state governing body, including the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology.

(C) another format deemed acceptable to the department which provides the data prescribed in paragraph three of this subsection and in the same timeliness as required by this section.

(5) A facsimile shall not be considered an acceptable electronic format pursuant to this subsection.

(6) Upon a request made pursuant to paragraph three of this subsection, the health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager shall provide the following data for any drug covered under the subscriber's insurance contract:

(A) subscriber-specific eligibility information;

(B) subscriber-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage, and cost-sharing data for the prescribed drug and clinically-appropriate alternatives, when appropriate;

(C) subscriber-specific cost-sharing information that describes variance in cost-sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the insured's benefit; and

(D) applicable utilization management requirements.

(7) A health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term. A health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

(8) A health service, hospital service, or medical expense indemnity corporation and pharmacy benefit manager shall not, except as may be required or authorized by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required; nor shall a health service, hospital service, or medical expense indemnity

corporation or pharmacy benefit manager penalize a health care provider for disclosing such information to a subscriber or legally prescribing, administering, or ordering a lower cost, clinically appropriate alternative.

(9) Nothing in this subsection shall be construed to limit access to the most up-to-date subscriber-specific eligibility or subscriber-specific prescription cost and benefit data by the health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager.

(10) Nothing in this subsection shall interfere with subscriber choice and a health care provider's ability to convey the full range of prescription drug cost options to a subscriber. Health service, hospital service, or medical expense indemnity corporations and pharmacy benefit managers shall not restrict a health care provider from communicating to the subscriber prescription cost options.

§ 4325. Prohibitions. (a) No corporation organized under this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from disclosing to any subscriber, designated representative or, where appropriate, prospective subscriber, (hereinafter collectively referred to as subscriber) any information that such provider deems appropriate regarding:

(1) a condition or a course of treatment with a subscriber including the availability of other therapies, consultations, or tests; or

(2) the provisions, terms, or requirements of the corporation's products as they relate to the subscriber.

(b) No corporation organized under this article shall by contract, written policy, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such corporation which the provider believes may negatively impact upon the quality of or access to patient care. Nor shall a corporation organized under this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to

an appropriate governmental body regarding policies or practices of such corporation which may violate this chapter including subsection (g), (k), (1), (1-1) or (1-2) of section forty-three hundred three of this article.

(c) No corporation organized under this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from advocating to the corporation on behalf of the subscriber for approval or coverage of a particular course of treatment.

(d) No contract or agreement between a corporation organized under this article and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the corporation as opposed to the health care provider.

(e) Contracts entered into between an insurer and a health care provider shall include terms which prescribe:

(1) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(2) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the rates upon which any such payments and adjustments will be made;

(3) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(4) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and

(5) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contract through a proceeding under article seventy-five of the civil practice law and rules.

(f) No contract entered into between an insurer and a health care provider shall be enforceable if it includes terms which transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of section forty-four hundred three of the public health law, or penalize providers for unfavorable case mix so as to jeopardize the quality of or insureds' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(g)(1) No insurer shall implement an adverse reimbursement change to a contract with a health care professional that is otherwise permitted by the contract, unless, prior to the effective date of the change, the insurer gives the health care professional with whom the insurer has directly contracted and who is impacted by the adverse reimbursement change, at least ninety days written notice of the change. If the contracting health care professional objects to the change that is the subject of the notice by the insurer, the health care professional may, within thirty days of the date of the notice, give written notice to the insurer to terminate his or her contract with the insurer effective upon the implementation date of the adverse reimbursement change. For the purposes of this subsection, the term "adverse reimbursement change" shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional, and the term "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law. The notice provisions required by this subsection shall not apply where: (A) such change is otherwise required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or (B) such change is expressly provided for under the terms of the contract by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

(2) Nothing in this subsection shall create a private right of action

on behalf of a health care professional against an insurer for violations of this subsection.

(h) No corporation or insurer organized or licensed under this chapter which provides coverage for prescription drugs shall require, or enter into a contract which permits, a copayment which exceeds the usual and customary cost of such prescribed drug.

(i) Any contract provision, written policy or written procedure in violation of this section shall be deemed to be void and unenforceable.

* (j) If a contract between a corporation and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of such contract, including reimbursement terms, for a period of two months from the effective date of termination or, in the case of a non-renewal, from the end of the contract period. Notice shall be provided to all subscribers potentially affected by such termination or non-renewal within fifteen days after commencement of the two-month period. The commissioner of health shall have the authority to waive the two-month period upon the request of either party to a contract that is being terminated for cause. This subsection shall not apply where both parties mutually agree in writing to the termination or non-renewal and the corporation provides notice to the subscriber at least thirty days in advance of the date of contract termination.

* NB Repealed June 30, 2027

(k) (1) No corporation organized under this article shall by written contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services, observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not comply with certain administrative requirements of such corporation with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and a corporation from agreeing to certain administrative requirements relating to payment for inpatient services, observation services, or emergency department services, including, but not limited to timely notification that medically necessary inpatient services have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely notification; provided,

however that: (A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for services provided on weekends or federal holidays, (B) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not exceed seven and one-half percent of the payment amount otherwise due for the services provided, and (C) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the services were provided.

(3) The provisions of this subsection shall not apply to the denial of a claim: (A) based on a reasonable belief of a corporation of fraud or intentional misconduct resulting in misrepresentation of patient diagnosis or the services provided, or abusive billing by a corporation; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; (C) that is a duplicate claim, is a claim submitted late pursuant to subsection (g) of section thirty-two hundred twenty-four-a of this article, or is for services for a benefit that is not covered under the insured's contract or for a patient determined to be ineligible for coverage; (D) except in the case of medically necessary inpatient services resulting from an emergency admission, where there is not an existing participating provider agreement between such corporation and a general hospital; or (E) where the hospital has repeatedly and systematically, over the previous twelve month period, failed to seek prior authorization for services for which prior authorization was required.

(4) For purposes of this subsection, an "administrative requirement" shall not include requirements: (A) imposed on a corporation or provider pursuant to federal or state laws, regulations or guidance; (B) established by the state or federal government applicable to corporations offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not apply to claims for services for which a request for preauthorization was denied by the corporation prior to delivery of the service.

(l) A corporation organized under this article shall not require a

prior authorization determination for services provided in a neonatal intensive care unit of a general hospital certified pursuant to article twenty-eight of the public health law. Nothing in this subsection shall prohibit a corporation organized under this article from denying a claim for such services if the services are subsequently determined not medically necessary.

(m) At least sixty days prior to the termination of a contract between a hospital and an organization, the parties shall utilize a mutually agreed upon mediator to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

* (n) A contract between a corporation and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the corporation. A health care provider shall submit such provider directory information to a corporation, at a minimum, when a provider begins or terminates a network agreement with a corporation, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the corporation's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective until January 1, 2027

* (n) A contract between a corporation and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the corporation. A health care provider shall submit such provider directory information to a corporation, at a

minimum, when a provider begins or terminates a network agreement with a corporation, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the corporation's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance-related and addictive disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective January 1, 2027

(o) A contract between a corporation and a health care provider shall include a provision that states that the provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the corporation in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the corporation provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the corporation shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Nothing in this subsection shall prohibit a health care provider from requiring in the terms of a contract with a corporation that the corporation remove, at the time of termination of such contract, the provider from the corporation's provider directory or that the corporation bear financial responsibility for providing inaccurate network status information to an insured.

(p) (1) A corporation organized under this article may pay a claim for

reimbursement made by a provider using a credit card, virtual credit card, or electronic funds transfer payment method that imposes on the provider a specifically identified fee or similar charge dedicated to process the payment if in advance of using such reimbursement method:

(A) The corporation notifies the provider of the potential fees or other charges associated with the use of the credit card, virtual credit card, or electronic funds transfer payment;

(B) The corporation offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(C) The provider or a designee of the provider elects to accept payment of the claim using the credit card, virtual credit card, or electronic funds transfer payment method. Such payment type election shall be made by the provider within thirty days of receipt of the notice from the insurer. If the provider fails to make any payment type election within thirty days, the insurer shall pay the provider using the alternative payment method offered in the notice unless the insurer is unable to pay the provider using that alternative method due to the insurer lacking information necessary to make the alternative payment. In that instance, the insurer may use another fee-free method of payment in order to meet the timeframes established in section three thousand two hundred twenty-four-a of this chapter.

(2) A decision pursuant to paragraph one of this subsection shall remain in effect until the provider notifies the corporation, in writing, of a change to the designated payment type.

(3) If a corporation contracts with a vendor to process payments of providers' claims, the insurer shall require the vendor to comply with the provisions of paragraph one of this subsection. This paragraph shall not apply to a vendor used by the provider in order to receive payments from an insurer.

(4) No contract between a corporation organized under this article and provider issued, renewed, modified, altered or amended after the effective date of this subsection shall contain provisions allowing for waiver of the notice requirements contained in this subsection.

(5) For any contract that is in effect on or before the effective date of this subsection or that is entered into, amended or renewed on or after the effective date of this subsection, a corporation that initiates a payment to a provider using, or changes the payment method

to, a health care electronic funds transfers and remittance advice transaction shall not charge a fee solely to transmit the payment to the provider unless the provider elects to accept payment in accordance with subparagraph (C) of paragraph one of this subsection.

(6) For purposes of this subsection, the following terms shall have the following meanings:

(A) "Provider" shall mean a health care professional or a group of health care professionals licensed pursuant to title eight of the education law that has a participating provider contract with a corporation to provide health care services to an insured.

(B) "Virtual credit card" shall mean a single-use series of numbers linked to a fixed dollar amount and provided by a corporation organized under this article to a provider for the purpose of paying a claim for health care services performed by the provider.

§ 4326. Standardized health insurance contracts for qualifying small employers and individuals. (a) A program is hereby established for the purpose of making standardized health insurance contracts available to qualifying small employers as defined in this section. Such program is designed to encourage small employers to offer health insurance coverage to their employees.

(b) Participation in the program established by this section and section four thousand three hundred twenty-seven of this article is limited to corporations or insurers organized or licensed under this article or article forty-two of this chapter and health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article. Participation by all health maintenance organizations is mandatory, provided, however, that such requirements shall not apply to a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law or a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act. On and after January first, two thousand one, all

health maintenance organizations shall offer qualifying group health insurance contracts as defined in this section. For the purposes of this section and section four thousand three hundred twenty-seven of this article, article forty-three corporations or article forty-two insurers which voluntarily participate in compliance with the requirements of this program shall be eligible for reimbursement from the stop loss funds created pursuant to section four thousand three hundred twenty-seven of this article under the same terms and conditions as health maintenance organizations.

(c) The following definitions shall be applicable to the insurance contracts offered under the program established by this section:

(1) (A) A qualifying small employer is an employer with:

(i) not more than fifty employees;

(ii) no group health insurance that provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(iii) at least thirty percent of its employees receiving annual wages from the employer at a level equal to or less than thirty thousand dollars. The thirty thousand dollar figure shall be adjusted periodically pursuant to subparagraph (D) of this paragraph.

(B) The twelve month period set forth in item (ii) of subparagraph (A) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of qualifying group health insurance contracts for other health insurance contracts.

(C) An employer shall cease to be a qualifying small employer if any health insurance that provides benefits on an expense reimbursed or prepaid basis covering an employer's employees, other than qualifying group health insurance purchased pursuant to this section, is purchased or otherwise takes effect subsequent to purchase of qualifying group health insurance under the program established by this section.

(D) The wage levels utilized in subparagraph (A) of this paragraph shall be adjusted annually, beginning in two thousand two. The adjustment shall take effect on July first of each year. For July first, two thousand two, the adjustment shall be a percentage of the annual wage figure specified in subparagraph (A) of this paragraph. For

subsequent years, the adjustment shall be a percentage of the annual wage figure that took effect on July first of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal department of health and human services, for a family unit of four persons for the forty-eight contiguous states and Washington, D.C., changed from the same level established for the prior year.

(2) A qualifying group health insurance contract is a group contract purchased from a health maintenance organization, corporation or insurer by a qualifying small employer that provides the benefits set forth in subsection (d) of this section. The contract must insure not less than fifty percent of the employees.

(d) A qualifying group health insurance contract shall provide coverage for the essential health benefits package as defined in paragraph three of subsection (e) of section four thousand three hundred six-h of this article.

(d-1) Covered services shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by corporations, insurers or health maintenance organizations for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations, corporations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(d-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages for any decision or action pursuant to subsection (d-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(d-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the standardized health insurance contract established by this section for those persons required to register as sex offenders pursuant to article six-C of the correction law.

(e) A qualifying group health insurance contract shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan. The superintendent shall standardize the benefit package and cost sharing requirements of qualified group health insurance contracts consistent with coverage offered through the health benefit exchange established by this state.

(f) The mandated and make-available benefits set forth in sections three thousand two hundred twenty-one of this chapter and four thousand three hundred three of this article shall not be applicable to the contracts issued pursuant to this section.

(g) A health maintenance organization, corporation or insurer must offer the benefit package without change or additional benefits. A qualifying small employer shall be issued the benefit package in a qualifying group health insurance contract.

(h) A health maintenance organization, corporation or insurer shall obtain from the employer written certification at the time of initial application and annually thereafter ninety days prior to the contract renewal date that such employer meets the requirements of a qualifying small employer pursuant to this section. A health maintenance organization, corporation or insurer may require the submission of appropriate documentation in support of the certification.

(i) Applications for qualifying group health insurance contracts must be accepted from any qualifying small employer at all times throughout the year. The superintendent, by regulation, may require health maintenance organizations, corporations or insurers to give preference to qualifying small employers whose employees have the lowest average salaries.

(j) A corporation shall not impose any pre-existing condition limitation in a qualifying group health insurance contract.

(k) A qualifying small employer shall elect whether to make coverage under the qualifying group health insurance contract available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(l) A qualifying small employer must pay at least fifty percent of the premium for employees covered under a qualifying group health insurance contract and must offer coverage to all employees receiving annual wages at a level of thirty thousand dollars or less, and at least one such employee shall accept such coverage. The thirty thousand dollar wage level shall be adjusted periodically in accordance with subparagraph (D) of paragraph one of subsection (c) of this section. The employer premium contribution must be the same percentage for all covered employees.

(m) Premium rate calculations for qualifying group health insurance contracts shall be subject to the following:

(1) coverage must be community rated and the superintendent shall set standard rating tiers for family units and standard rating relativities between tiers applicable to all contracts subject to this section; and

(2) beginning January first, two thousand fourteen, every policy subject to this section shall use standardized regions established by the superintendent; and

(3) claims experience under contracts issued to qualifying small employers must be pooled with the health maintenance organization, corporation or insurer's small group business for rate setting purposes.

(n) A health maintenance organization, corporation or insurer shall submit reports to the superintendent in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance program established by this section.

§ 4327. Stop loss funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals. (a) The superintendent shall establish a fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health

maintenance organizations, corporations or insurers for members covered under qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "small employer stop loss fund".

(b) Health maintenance organizations, corporations or insurers shall be eligible to receive reimbursement for ninety percent of claims paid between five thousand and seventy-five thousand dollars in a calendar year for any member covered under a standardized contract issued pursuant to section four thousand three hundred twenty-six of this article. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the small employer stop loss fund. For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized contracts.

(c) The superintendent shall promulgate regulations that set forth procedures for the operation of the small employer stop loss fund and distribution of monies therefrom.

(d) The superintendent may adjust the level of stop loss coverage specified in subsection (b) of this section.

(e) Claims shall be reported and funds shall be distributed from the small employer stop loss fund on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each health maintenance organization, corporation or insurer shall submit a request for reimbursement from the stop loss fund on forms prescribed by the superintendent. The requests for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement requests are being made. The superintendent may require health maintenance organizations, corporations or insurers to submit such claims data in connection with the reimbursement requests as he deems necessary to enable him to distribute monies and oversee the operation of the small employer stop loss fund. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis.

(g) For the stop loss fund, the superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations, corporations or insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization, corporation or insurer shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's, corporation's or insurer's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations, corporations or insurers.

(2) In the event that funds available for distribution for claims paid by all health maintenance organizations, corporations or insurers during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations, corporations or insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. Such excess funds shall be in addition to the monies appropriated for the stop loss fund in the next calendar year.

(h) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the small employer stop loss fund. Such data shall be furnished in a form prescribed by the superintendent. Each health maintenance organization, corporation or insurer shall provide the superintendent with monthly reports of the total enrollment under the qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. The reports shall be in a form prescribed by the superintendent.

(i) The superintendent shall separately estimate the per member annual cost of total claims reimbursement from each stop loss fund for qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each health maintenance organization, corporation or insurer shall furnish to the superintendent claims experience data for use in such estimations.

(j) The superintendent shall determine total eligible enrollment under qualifying group health insurance contracts. The total eligible enrollment shall be determined by dividing the total funds available for distribution from the small employer stop loss fund by the estimated per member annual cost of total claims reimbursement from the small employer stop loss fund.

(k) The superintendent shall suspend the enrollment of new employers under qualifying group health insurance contracts if the superintendent determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the small employer stop loss fund in excess of the total funds available for distribution from such stop loss fund.

(l) The superintendent shall provide the health maintenance organizations, corporations or insurers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data.

(m) If at any point during a suspension of enrollment of new qualifying small employers, the superintendent determines that funds are sufficient to provide for the addition of new enrollments, the superintendent shall be authorized to reactivate new enrollments and to notify all health maintenance organizations, corporations or insurers that enrollment of new employers may again commence.

(m-1) In the event that the superintendent suspends the enrollment of new individuals for qualifying group health insurance contracts, the superintendent shall ensure that small employers seeking to enroll in a qualified group health insurance contract pursuant to section forty-three hundred twenty-six of this article are provided information on and directed to coverage options available through the health benefit exchange established by this state.

(n) The suspension of issuance of qualifying group health insurance contracts to new qualifying small employers shall not preclude the addition of new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.

(o) The premiums for qualifying group health insurance contracts must factor in the availability of reimbursement from the small employer stop

loss fund.

(p) The superintendent may obtain the services of an organization to administer the stop loss funds established by this section. The superintendent shall establish guidelines for the submission of proposals by organizations for the purposes of administering the funds. The superintendent shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the funds. An organization approved to administer the funds shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the funds, including an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and the assembly ways and means committee. An organization approved to administer the funds shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the stop loss coverage funds. An organization approved to administer the funds may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

(q) If the superintendent deems it appropriate for the proper administration of the small employer stop loss fund, the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss funds established by this section.

(r) The superintendent may access funding from the small employer stop loss fund for the purposes of developing and implementing public education, outreach and facilitated enrollment strategies targeted to small employers without health insurance. The superintendent may contract with marketing organizations to perform or provide assistance

with such education, outreach, and enrollment strategies. The superintendent shall determine the amount of funding available for the purposes of this subsection which in no event shall exceed eight percent of the annual funding amounts for the small employer stop loss fund.

(s) Brooklyn healthworks pilot program and upstate healthworks pilot program. Commencing on July first, two thousand six, the superintendent shall access funding from the small employer stop loss fund for the purpose of support and expansion of the existing pilot program Brooklyn healthworks approved by the superintendent and for the establishment and operation of a pilot program to be located in upstate New York. For the purpose of this subsection, in no event shall the amount of funding available exceed two percent of the annual funding amount for the small employer stop loss fund.

§ 4328. Individual enrollee direct payment contracts offered by health maintenance organization on and after October first, two thousand thirteen. (a) On and after October first, two thousand thirteen, every health maintenance organization issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer an individual enrollee direct payment contract in accordance with the requirements of this section; provided, however, that this requirement shall not apply to a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law, except as otherwise required under subsection (l) of section four thousand three hundred four of this article, or a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal social security act. The superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of this chapter, including a health maintenance organization operated as a line of business of a

health service corporation licensed under this article, offers an individual enrollee direct payment contract that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to the public health law and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of the public health law. The enrollee contracts issued by a health maintenance organization under this section also shall be the only contracts issued by the health maintenance organization for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article.

(b) (1) The individual enrollee direct payment contract offered pursuant to this section shall provide coverage for the essential health benefits package as defined in paragraph three of subsection (e) of section four thousand three hundred six-h of this article.

(2) A health maintenance organization shall offer at least one individual enrollee direct payment contract at each level of coverage as defined in subsection (b) of section four thousand three hundred six-h of this article. A health maintenance organization also shall offer one child-only plan, as required by section 1302(f) of the affordable care act, 42 U.S.C. § 18022(f), at each level of coverage.

(3) Within the health benefit exchange established by this state, a health maintenance organization may offer an individual enrollee direct payment contract that is a catastrophic health plan as defined in section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), or any regulations promulgated thereunder.

(4) (A) The individual enrollee direct payment contract offered pursuant to this section shall have the same enrollment periods, including special enrollment periods, as required for an individual direct payment contract offered within the health benefit exchange established by this state.

(B) In addition to the enrollment periods required in subparagraph (A) of this paragraph, an individual enrollee direct payment contract offered pursuant to this section shall allow for the enrollment of a pregnant individual. Such individual may enroll at any time after a health care professional licensed pursuant to title eight of the

education law and acting within the scope of his or her practice certifies that the individual is pregnant. Such health insurance policy or contract shall not impose a fee or other penalty for special enrollment of the pregnant individual. Upon enrollment, coverage shall be effective as of the first day of the month in which the health care professional certifies that the individual is pregnant, unless the individual elects to have coverage effective on the first day of the month following the date that the individual received certification of the pregnancy.

(5) The individual enrollee direct payment contract offered pursuant to this section shall be issued without regard to evidence of insurability and without an exclusion for pre-existing conditions.

(6) A health maintenance organization offering an individual enrollee direct payment contract pursuant to this section shall not establish rules for eligibility, including continued eligibility, of any individual or dependent of the individual to enroll under the contract 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; or

(H) disability.

(7) The individual enrollee direct payment contract offered pursuant to this section shall be community rated. For purposes of this paragraph, "community rated" means a rating methodology in which the premium for all persons covered by a contract form is the same, based on the experience of the entire pool of risks, without regard to age, sex, health status, tobacco usage, or occupation.

(c) In addition to or in lieu of the individual enrollee direct payment contracts required under this section, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article may offer individual enrollee direct payment contracts within the health benefit

exchange established by this state, subject to any requirements established by the health benefit exchange. If a health maintenance organization satisfies the requirements of subsection (a) of this section by offering individual enrollee direct payment contracts, only within the health benefit exchange, the health maintenance organization, not including a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law, shall also offer at least one individual enrollee direct payment contract at each level of coverage as defined in subsection (b) section four thousand three hundred six-h of this article, outside the health benefit exchange.

(d)(1) Nothing in this section shall be deemed to require health maintenance organizations to discontinue individual direct payment contracts issued prior to October first, two thousand thirteen or prevent health maintenance organizations from discontinuing individual direct payment contracts issued prior to October first, two thousand thirteen. If a health maintenance organization discontinues individual direct payment contracts issued prior to October first, two thousand thirteen, regardless of whether it is a grandfathered health plan, then the health maintenance organization shall comply with the requirements of subsection (c) of section four thousand three hundred four of this article.

(2) For purposes of this subsection, "grandfathered health plan" means coverage provided by a corporation 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).

(e) The superintendent may promulgate regulations implementing the requirements of this section, including regulations that modify or add additional standardized individual enrollee direct payment contracts if the superintendent determines additional contracts with different levels of coverage are necessary to meet the needs of the public.

§ 4329. Prescription drug coverage. * (a) Every corporation subject to the provisions of this article that issues a contract that provides coverage for prescription drugs shall, with respect to the prescription

drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.

* NB Effective until January 1, 2027

* (a) Every corporation subject to the provisions of this article that issues a contract that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds, prospective insureds, health care providers, and other interested parties. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments. A formulary drug list shall only be considered easily accessible if:

(1) it can be viewed on the corporation's public website without requiring an individual to create or access an account or enter a password or to be covered under an insurance policy issued by the corporation; and

(2) an individual can easily discern which formulary drug list applies to which plan, if a corporation offers more than one plan.

* NB Effective January 1, 2027

(b) (1) Every contract issued by a corporation subject to the provisions of this article that provides coverage for prescription drugs shall include in the contract a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, a corporation shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

(2) (A) A corporation shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the contract.

(B) A corporation shall make a determination on a standard exception request that is not based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than seventy-two hours following receipt of the request.

(C) A corporation that grants a standard exception request that is not based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills.

(D) For the purpose of this subsection, "exigent circumstances" means when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary prescription drug.

(3) (A) A corporation shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request an expedited review based on exigent circumstances of a formulary exception for a prescription drug is not covered by the contract.

(B) A corporation shall make a determination on an expedited review request based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than twenty-four hours following receipt of the request.

(C) A corporation that grants an exception based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

(4) A corporation that denies an exception request under paragraph two or three of this subsection shall provide written notice of its determination to the insured or the insured's designee and the insured's prescribing health care provider within three business days of receipt of the exception request. The written notice shall be considered a final

adverse determination under section four thousand nine hundred four of this chapter or section four thousand nine hundred four of the public health law. Written notice shall also include the name or names of clinically appropriate prescription drugs covered by the corporation to treat the insured.

(5) (A) If a corporation denies a request for an exception under paragraph two or three of this subsection, the insured, the insured's designee, or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal agent certified by the superintendent pursuant to section four thousand nine hundred eleven of this chapter in accordance with article forty-nine of this chapter and article forty-nine of the public health law.

(B) An external appeal agent shall make a determination on the external appeal and notify the corporation, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than seventy-two hours following the external appeal agent's receipt of the request, if the original request was a standard exception request under paragraph two of this subsection. The external appeal agent shall notify the corporation, the insured or the insured's designee and the insured's prescribing health care provider in writing of the external appeal determination within two business days of rendering such determination.

(C) An external appeal agent shall make a determination on the external appeal and notify the corporation, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than twenty-four hours following the external appeal agent's receipt of the request, if the original request was an expedited exception request under paragraph three of this subsection and the insured's prescribing health care provider attests that exigent circumstances exist. The external appeal agent shall notify the corporation, the insured or the insured's designee and the insured's prescribing health care provider in writing of the external appeal determination within seventy-two hours of the external appeal agent's receipt of the external appeal.

(D) An external appeal agent shall make a determination in accordance with subparagraph (A) of paragraph four of subsection (b) of section

four thousand nine hundred fourteen of this chapter and subparagraph (A) of paragraph (d) of subdivision two of section four thousand nine hundred fourteen of the public health law. When making a determination, the external appeal agent shall consider whether the formulary prescription drug covered by the corporation will be or has been ineffective, would not be as effective as the non-formulary prescription drug, or would have adverse effects.

(E) If an external appeal agent overturns the corporation's denial of a standard exception request under paragraph two of this subsection, then the corporation shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills. If an external appeal agent overturns the corporation's denial of an expedited exception request under paragraph three of this subsection, then the corporation shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

* (c) (1) Except as otherwise provided in paragraph three of this subsection, a corporation shall not:

(A) remove a prescription drug from a formulary;

(B) move a prescription drug to a tier with a larger deductible, copayment, or coinsurance if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier; or

(C) add utilization management restrictions to a prescription drug on a formulary, unless such changes occur at the time of enrollment, issuance or renewal of coverage.

(2) Prohibitions provided in paragraph one of this subsection shall apply beginning on the date on which a plan year begins and through the end of such plan year.

(3) (A) A corporation with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deductible, copayment or coinsurance if an AB-rated generic equivalent or interchangeable biological product for such prescription drug is added to the formulary at the same time.

(B) A corporation may remove a prescription drug from a formulary if

the federal Food and Drug Administration determines that such prescription drug should be removed from the market, including new utilization management restrictions issued pursuant to federal Food and Drug Administration safety concerns.

(C) A corporation with a formulary that includes two or more tiers of benefits providing for different copayments applicable to prescription drugs may move a prescription drug to a tier with a larger copayment during the plan year, provided the change is not applicable to an insured who is already receiving such prescription drug or has been diagnosed with or presented with a condition on or prior to the start of the plan year that is treated by such prescription drug or is a prescription drug that is or would be part of the insured's treatment regimen for such condition.

(4) A corporation shall provide notice to insureds of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in the upcoming plan year, ninety days prior to the start of the plan year. Such notice of impending formulary and deductible, copayment or coinsurance changes shall also be posted on the corporation's online formulary and in any prescription drug finder system that the corporation provides to the public.

(5) The provisions of this subsection shall not supersede the terms of a collective bargaining agreement, or the rights of labor representation groups to collectively bargain changes to the formularies.

* NB There are 2 sb (c)'s

* (c) Every contract issued by a corporation subject to the provisions of this article that provides coverage for prescription drugs shall include in the contract a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to immediately obtain, on the insured's behalf, an additional thirty-day supply of any current prescription of the insured, except as provided in section two hundred seventy-eight-a of the public health law, at the same level of coverage as a normal refill of such prescription drug upon the declaration of a state disaster emergency pursuant to section twenty-eight of the executive law.

* NB There are 2 sb (c)'s

§ 4330. Discrimination because of sex or marital status in hospital, surgical or medical expense insurance. (a) With regard to a contract issued by a corporation subject to the provisions of this article that provides hospital, surgical, or medical expense coverage or a contract of student accident and health insurance, as defined in subsection (a) of section three thousand two hundred forty of this chapter, no corporation shall because of sex, marital status or based on pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions:

(1) make any distinction or discrimination between persons as to the premiums or rates charged for the contract or in any other manner whatever;

(2) demand or require a greater premium from any person than it requires at that time from others in similar cases;

(3) make or require any rebate, discrimination or discount upon the amount to be paid or the service to be rendered on any contract;

(4) insert in the contract any condition, or make any stipulation, whereby the insured binds his or herself, or his or her heirs, executors, administrators or assigns, to accept any sum or service less than the full value or amount of such contract in case of a claim thereon except such conditions and stipulations as are imposed upon others in similar cases; and any such stipulation or condition so made or inserted shall be void;

(5) reject any application for a contract issued or sold by it;

(6) cancel or refuse to issue, renew or sell such contract after appropriate application therefor;

(7) fix any lower rate or discriminate in the fees or commissions of insurance agents or insurance brokers for writing or renewing such a contract; or

(8) engage in sexual stereotyping.

(b) For purposes of this section, "sex" shall include sexual orientation, gender identity or expression, and transgender status.

ARTICLE 44
EMPLOYEE WELFARE FUNDS

Section 4401. Declaration of policy.

4402. Definitions.
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§ 4401. Declaration of policy. (a) It is declared to be the policy of the state that employee welfare funds are of great benefit to employees and their families and that their growth should be encouraged; that the establishment and management of such funds vitally affect the well-being of millions of people and are in the public interest.

(b) It is further declared that such funds should be supervised by the state to the extent necessary to protect the rights of employees and their families, without imposing burdens on the funds which might discourage their orderly growth and without duplicating the supervisory responsibilities of any state agency.

§ 4402. Definitions. In this article: (a) "Employee welfare fund" or "fund" means any trust fund or other fund established or maintained jointly by one or more employers together with one or more labor organizations, whether directly or through trustees, to provide employee benefits by the purchase of insurance or annuity contracts or otherwise, and to which is paid or contracted to be paid anything, other than income from investments of such fund for the benefit of employees employed in this state, and, if the principal office of the employer is

located outside of the state, for at least twenty such employees; provided, however, that such term shall not include any such fund where its over-all management is vested, alone or jointly with other trustees, in a corporate trustee which is subject to supervision by the supervisor of banks of any state or the comptroller of the currency.

(b) "Employee benefits" means one or more benefits or services for employees or their families or dependents, or for both, including, but not limited to, medical, surgical or hospital care or benefits, benefits in the event of sickness, accident, disability or death, benefits in the event of unemployment, or retirement benefits.

(c) "Trustee" means the person or group of persons who or which is charged with or has the general power of administration over an employee welfare fund and may include a pension board or committee, a board of individual trustees, a board of administration or the like; provided, however, such term shall not include a corporate trustee which is subject to supervision by the supervisor of banks of any state or the comptroller of the currency; nor shall such term include any insurer licensed under the laws of this state or authorized to do business herein.

(d) "Employed in this state" means employed at a place of business maintained by the employer in the state.

(e) "Employer" means all persons part or all of whose employees or members are covered by an employee welfare fund.

(f) "Person" means all individuals (acting alone or in representative capacities), partnerships, associations, corporations, labor unions and other entities.

(g) "Labor organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment or conditions of work.

§ 4403. Registration. (a) The trustees of every employee welfare fund shall register such fund with the superintendent within three months of commencing to do business in this state. Such registration shall be in

such form and shall contain such information relating to the organization, operations and affairs of such fund as may be prescribed by the superintendent.

(b) If it is found that the conditions that originally required registration with the superintendent have ceased to exist and that new conditions exist that would not require the registration of an employee welfare fund with the superintendent, then the superintendent may, on application of the trustees or on the superintendent's own motion, cancel the registration of such fund.

§ 4404. Examinations; requirement. (a) The superintendent may examine into the affairs of any employee welfare fund as often as he deems it necessary, and he shall do so at least once in every five years.

(b) The trustees of every fund shall be responsible for the maintenance of accurate records and books of account in conformance with generally accepted accounting principles and applicable regulations.

§ 4405. Examinations; conduct. (a) Whenever, pursuant to this article, the superintendent shall determine to examine the affairs of any employee welfare fund he shall make an order indicating the scope of the examination and may appoint as examiners one or more competent persons not employed by the trustees of such fund or interested in such fund. A copy of such order shall, upon demand and before the examination begins, be exhibited to the trustees of such fund.

(b) Any examiner authorized by the superintendent shall have convenient access at all reasonable hours to the books, records, files, assets, securities, and other documents of such fund, including those of any affiliated or subsidiary fund thereof, which are relevant to the examination, and shall have power to administer oaths and to examine under oath the trustees of such fund and their officers, agents and employees and any other persons having custody or control of such books, records, files, assets, securities or other documents, regarding any matter relevant to the examination.

(c) The examiner in charge of such examination shall make a report of every examination made by him, verified under oath, which shall comprise

only facts appearing upon the books, records or other documents of the trustees of such fund or as ascertained from the sworn testimony of its trustees, or their officers, agents or employees, or other persons examined concerning its affairs, and such conclusions and recommendations as may reasonably be warranted from such facts.

(d) The superintendent may appoint one or more competent persons as appraisers to appraise any interest in real property which may constitute assets of any such fund. The report of such appraiser shall be a supplement to the report of the examiner in charge.

§ 4406. Examinations; publication. (a) All reports and copies of reports of examinations and investigations of any employee welfare fund, shall be confidential communications, shall not be subject to subpoena and shall not be made public unless, in the judgment of the superintendent, the ends of justice and the public advantage will be served by the publication thereof, in which event he may publish a copy of any such report or any part thereof in such manner as he may deem proper.

(b) In any action or proceeding against the trustees of any fund, or against its other officers, agents, or employees, such report, or any part thereof, if published by the superintendent, shall be admissible in evidence and shall be presumptive evidence of the facts stated therein.

(c) The superintendent may assemble and file for public inspection such information covering:

(1) forms of trust indentures in use;

(2) commission and fee schedules adopted by insurers;

(3) compensation paid to trustees of employee welfare funds; and

(4) such other matters affecting the establishment and administration of such funds as, in his opinion, are in the public interest.

§ 4407. Examinations; expenses. (a) The expenses of every examination of the affairs of any employee welfare fund, including any appraisal of an interest in real property, made pursuant to any provision of this chapter, shall be paid by the employee welfare fund examined.

(b) For any such examination by the superintendent or a deputy

superintendent personally, the charge shall be only for necessary travelling expenses and other actual expenses. In all other cases the expenses of examination shall also include reimbursement for the compensation paid for the services of persons employed by the superintendent or by his authority to make such examination or appraisal.

(c) Notwithstanding the provisions of subsection (a) or (b) hereof:

(1) funds with contributions of less than thirty thousand dollars, as reported in the annual statement filed with the superintendent for the latest fiscal year covered by the examination, the charge shall not exceed three hundred dollars;

(2) funds with contributions between thirty thousand dollars and one hundred fifty thousand dollars the charge shall not exceed one percent of such contributions;

(3) the superintendent, with the approval of the comptroller, may in his discretion for good cause shown remit or reduce such charges.

(d) All charges, including necessary travelling and other actual expenses, as audited and paid by the comptroller to the persons making the examination or appraisal, shall be presented to the trustees of the employee welfare fund in the form of a copy of the itemized bill as certified and approved by the superintendent or by any deputy superintendent or authorized employee of the department. Upon receiving such certified copy, such trustees shall pay the amount thereof to the superintendent, to be paid by him into the state treasury.

§ 4408. Annual statement. (a) The trustees of every employee welfare fund shall file in the office of the superintendent, annually within five months after the close of the fiscal year used in maintaining the records of such fund, a statement, to be known as the annual statement of such fund.

(b) Such statement shall be executed in duplicate, subscribed by its trustee or, if there is more than one trustee, then by at least two of such trustees, and affirmed as true under the penalties of perjury, showing its condition and affairs during such fiscal year. Such fiscal year shall not be changed without the consent of the superintendent.

(c) Such statement shall be in such form and contain such

substantiation by vouchers and otherwise and such other information as the superintendent requires.

(d) The superintendent shall furnish to the trustees of every employee welfare fund required by law to report to him printed forms of the statements and schedules required by him.

§ 4409. Special statements. (a) In addition to any other statements or reports required by this article, the superintendent may make any inquiry to the trustees of any employee welfare fund or to any of its other officers, agents or employees or to any employer or labor organization representing any employees eligible for employee benefits under the fund relating to the transactions or condition of the fund or any related matter.

(b) Every such person shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed and affirmed as true under the penalties of perjury by such individual or individuals as he shall designate.

§ 4410. Annual report. (a) The trustees of every employee welfare fund shall within five months after the close of the fiscal year used in maintaining the records of such fund, annually file a report with the superintendent to be known as the annual report.

(b) Such report shall be subscribed by the trustee of the fund, or if there is more than one trustee it shall be subscribed by at least two trustees, and affirmed by them as true under the penalties of perjury, showing the condition and affairs of the fund during such fiscal year. Such report shall be in such form and contain such matters as the superintendent requires.

(c) Such annual report shall be kept on file with the superintendent and at the principal office of the trustees. The report, or such portion thereof as the superintendent deems appropriate, shall be made available by the superintendent or by the trustees, or both, for inspection by any employer contributing to such fund, by any labor organization which is a party to an agreement establishing such fund, or by any employee covered by such fund. In addition and to such extent that he deems it to be in

the public interest, the superintendent may require the trustees to mail such report or such portions of it to any or all of such parties.

§ 4411. Account statements by insurance companies, service plans and corporate trustees and agents. Every insurance company, hospital, surgical or medical service plan providing benefits under an employee welfare fund, and any corporate trustee or agent holding or administering all or any part of such fund shall, within four months after the end of each policy or fiscal year, furnish to the trustees of the fund a statement of account containing the information relating to the fund as the trustees may need to comply with this article.

§ 4412. Regulation under other laws. (a) Where the trustees of any employee welfare fund are subject to and comply with any law of this state other than this article or the law of any other state or of the United States with respect to registration, filing, examination, statements or reports, such requirements of this article or any of them may be waived by the superintendent with respect to any such fund or trustees to the extent that they are included in such other laws.

(b) Application for such a waiver shall be made in writing to the superintendent on such forms as he may require and any waiver issued by him shall be in writing and filed in his office.

(c) The superintendent may, at any time, revoke any such waiver if, in his opinion, such other laws fail to accomplish adequately the purposes of this article.

§ 4413. Prohibitions. (a) The trustees of every employee welfare fund shall be responsible in a fiduciary capacity for all assets received, managed or disbursed by them, or under their authority, on behalf of such fund.

(b) (1) No such fund and no employer or labor organization representing any employees eligible for employee benefits thereunder, and no trustee or other officer or employee of any such fund, employer or labor organization shall receive, directly or indirectly, any thing

of value from any insurance company, insurance agent, insurance broker or any hospital, surgical, dental or medical service plan, in connection with the solicitation, sale, service or administration of a contract providing employee benefits for such fund. No such employer, labor organization, trustee, officer or employee shall receive any thing of value from such fund, or which is charged against such fund or would otherwise be payable to such fund, either directly or indirectly, except that any such person may receive any employee benefits to which he is otherwise entitled, and any such trustee or other officer or employee of a fund, may receive from such fund reasonable compensation for necessary services and expenses rendered or incurred by him in connection with his official duties as such. Nothing in this subsection shall affect the payment of any dividend or rate credit or other adjustment due under the terms of any insurance or annuity contract.

(2) No insurance company, insurance agent or insurance broker, hospital, surgical, dental or medical service plan, shall directly or indirectly, pay any commission, make any loan or give any thing of value to any employee welfare fund or to any employer or labor organization representing any employees eligible for employee benefits thereunder or to any trustee or other officer or employee of any such fund, employer or labor organization, in connection with the solicitation, sale, service or administration of a contract providing employee benefits for such fund.

(3) The superintendent may, after notice and a hearing, prohibit the trustees of an employee welfare fund from employing or retaining or continuing to employ or retain any person upon finding that such employment or retention involves a conflict of interest which is not in the best interests of the fund or adversely affects the interests of covered employees.

(4) The superintendent may, by regulation or order, and upon such terms and conditions as he requires, authorize or approve any transaction or transactions otherwise prohibited by this subsection upon his finding that the transaction or transactions promote or will promote the best interests of the relevant employee welfare funds, and do not or will not adversely affect the interests of the covered employees.

(c) (1) No person who has been convicted by a court of the United States or by a court of any state or territory thereof of a felony, or

of any crime or offense involving fraudulent or dishonest practices, shall serve, be appointed, designated or employed as a trustee, administrator, officer, agent or employee of any employee welfare fund (other than an employee performing non-discretionary clerical or building maintenance duties exclusively) during or for five years after such conviction or the suspension of sentence therefor or from the date of his unrevoked release from custody by parole, commutation or termination of sentence, whichever event occurs later, unless prior to the expiration of said five year period the conviction is finally reversed by a court of competent jurisdiction or he has been pardoned therefor by the governor or other appropriate authority of the state or jurisdiction in which he was convicted or he has received a certificate of relief from disabilities or a certificate of good conduct pursuant to the provisions of article twenty-three of the correction law which specifically removes the disability herein provided.

(2) If the superintendent, after notice and a hearing, finds that a person has been or is currently serving, appointed, designated or employed in violation of the provisions of this subsection, he shall enter an order removing such person from his position and directing that such person shall be disabled from service, appointment, designation or employment in any of the capacities hereinabove described for a period of five years following the entry of such order. The superintendent may, in addition, impose the penalties provided in subsection (e) of this section for the wilful violation hereof.

(d) (1) No insurance company shall pay any dividend or retrospective rate credit on any covering policy except by check payable to the affected employee welfare fund or by credit memo forwarded to such fund.

(2) No employee welfare fund shall pay any premium on a covering policy except by check payable to the insurance company directly.

(3) No political contributions shall be made directly or indirectly by or from any employee welfare fund.

(e) The superintendent may impose a penalty of not to exceed twenty-five hundred dollars upon any trustee or other officer, agent or employee of any employee welfare fund subject to this article or may remove such trustee, officer, agent or employee from office or employment, or both such penalty and removal, if after notice and a hearing he shall find that he has wilfully failed to comply with the

requirements of this article.

(f) In any case where, after notice and a hearing, the superintendent finds that any employee welfare fund has been depleted by reason of any wrongful or negligent act or omission of a trustee or of any other person, he may transmit a copy of his findings to the attorney general. The attorney general may bring an action in the name of the people of the state, or intervene in an action brought by or on behalf of an employee, to recover the monies of the fund for the benefit of the employees and other persons as may have an interest in the fund.

(g) (1) Any person who wilfully violates or causes or induces the violation of any provision of this article or any regulation issued under it shall be in violation of the provisions of this chapter.

(2) Any person who makes a false statement or representation of a material fact, knowing it to be false, or who knowingly fails to disclose a material fact in any registration, examination, statement or report required under this article or the regulations thereunder shall be guilty of a misdemeanor.

(3) Any person who makes a false entry in any book, record, report, or statement required by this article or any regulation thereunder, to be kept by him for any employee welfare fund, with intent to injure or defraud such fund or any beneficiary thereunder, or to deceive any one authorized or entitled to examine the affairs of such fund, shall be guilty of a misdemeanor.

(4) Nothing in paragraph two or three of this subsection shall be construed in any manner to limit the effect of paragraph one hereof.

§ 4414. Supplementary regulations; extensions of time; service of process; records; loans; compliance. (a) The superintendent may from time to time promulgate appropriate supplementary rules and regulations to carry out the express provisions and purposes of this article.

(b) For good cause shown, the superintendent may grant reasonable extensions of time for doing any act required by this article.

(c) (1) The trustees of any employee welfare fund which has its principal place of business without the state shall, within ten days after registering a fund with the superintendent, file with the secretary of state a designation, subscribed by them and affirmed as

true under the penalties of perjury, irrevocably appointing the secretary of state as their agent upon whom may be served any process directed to such trustees, in any action or proceeding brought pursuant to the provisions of this article arising out of or in connection with any transaction, matter or thing relating to such fund. If the trustees fail to make such designation in the prescribed time and manner they shall be deemed to have irrevocably appointed the secretary of state as such agent.

(2) Service shall be made by serving the secretary of state with a copy of the process and shall be sufficient provided that notice of the service and a copy of the process are sent by the moving party within ten days of the service to the trustees at the office address of the fund, by registered mail with return receipt requested.

(3) In any examination or hearing instituted by the superintendent, service of such process shall be complete ten days after the receipt by the superintendent of a return receipt purporting to be signed by the trustees or their agent or agents in accordance with the rules and customs of the United States postal service, or if acceptance was refused by the trustees or their agents, the original envelope bearing a notation by the postal authorities that receipt was refused.

(4) In any action or proceeding instituted in any court in this state, the moving party shall file with the court in which such action or proceeding is pending an affidavit of compliance herewith, a copy of the process, and either the return receipt or the original envelope bearing a notation of refusal, within thirty days after the return receipt or original envelope is received by the moving party, at which time service of process shall be complete.

(5) Service of any process made in accordance with this subsection shall be deemed to have been made personally within the state and, in the case of a court action or proceeding, within the territorial jurisdiction of the court from which such process issued.

(d) The trustees of every employee welfare fund shall preserve all its records of final entry and all reports and statements required by this article and the regulations issued under it for a period of at least six years from the date of making the same. Preservation of photographic reproduction of records or records in photographic form shall constitute compliance with this subsection.

(e) Subject to the restrictions of this article, any employee welfare fund may lend money to any employees covered by such fund or their children, who are attending or planning to attend college, to assist them in meeting their expenses of higher education and where the loans are guaranteed by the New York higher education services corporation in accordance with the provisions of article fourteen of the education law. In such cases no further security for the repayment of such loans shall be required of the borrowers by such fund.

(f) Nothing in this article shall be construed to relieve the trustees of any employee welfare fund from compliance with any other provision of this chapter or any other applicable laws of this state.

ARTICLE 45
FRATERNAL BENEFIT SOCIETIES

Section 4501. Definitions.
4502. Incorporation and licensing of domestic societies; meeting of supreme governing body.
4503. Licensing of foreign and alien societies.
4504. Amendments to charter, constitution and by-laws; waiver of provisions.
4505. Insurance benefits authorized.
4506. Classes of membership.
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4509. Certificates; applications; effect of changes in corporate documents.
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assessments and other contributions of members.
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4525. Application of other provisions of this chapter.
4526. Investments of fraternal benefit societies.
4527. Optional authority and regulation.
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4529. Subsidiaries authorized.
4530. Optional Investment Authority.

§ 4501. Definitions. In this article:

(a) "Fraternal benefit society" means, except as used in section four thousand five hundred twenty-three of this article, an incorporated society, order or supreme lodge, without capital stock, formed, organized and carried on solely for the benefit of its members and of their beneficiaries and not for profit, operating on a lodge system and having a representative form of government, which obligates itself for the payment of insurance or annuity benefits or both in accordance with this article.

(b) "Society" means any fraternal benefit society.

(c) "Authorized fraternal benefit society" or "authorized society" means any society authorized to do business in this state.

(d) "Lodge system" means a system of organization of a society providing for a supreme governing body and subordinate lodges, by whatever names known, into which members are elected, initiated or

admitted in accordance with the society's constitution, by-laws, rules and regulations, which subordinate lodges shall be required by such constitution or by-laws to hold regular or stated meetings at least once in each month, and either to conduct prescribed ritualistic ceremonies for the initiation of new members or to carry on other altruistic, educational, fraternal or recreational activities.

(e) "Representative form of government" means a form of government providing by its constitution and by-laws, for:

(1) a supreme governing body composed of representatives elected either by the members or by delegates chosen directly or indirectly by the members, together with such other members as may be prescribed by its constitution or by-laws;

(2) the representatives, other than officers, directors and salaried employees, elected directly or indirectly by the members to be a majority of the supreme governing body and to have not less than two-thirds of the votes therein nor less than the votes required to amend its articles of incorporation, constitution and by-laws;

(3) the meetings of the supreme governing body and the election of officers, representatives or delegates to be held as often as once in every four calendar years;

(4) each insurance member to be eligible for election to the supreme governing body;

(5) a board of directors or other executive body, charged with the responsibility for managing the society's affairs between meetings of its supreme governing body, subject to control by its supreme governing body, having powers and duties delegated to it in the constitution and by-laws and required to hold regular meetings at least twice in each calendar year; and

(6) no voting by proxy at any meeting of the supreme governing body.

(f) "Supreme governing body" means a body by whatever name known, organized and functioning as provided in paragraphs one, two, three, four and six of subsection (e) hereof to exercise supreme direction of a society pursuant to the provisions of law and the society's constitution and by-laws. Such name may include, "supreme legislative body" and "supreme legislative convention", and "board of directors" by a society having an executive body with a different name.

(g) "Board of directors" means an executive body by whatever name

known, charged as provided in paragraph five of subsection (e) hereof.

(h) "Life insurance benefits" means those payable under any form of life insurance including endowment insurance.

(i) "Accidental death benefits" means those payable on death caused by accident or accidental means.

(j) "Accidental injury benefits" means those payable as a result of bodily injury caused by accident or accidental means.

(k) "Sickness benefits" means those payable as a result of temporary, total or partial disability due to sickness or bodily infirmity.

(l) "Annuity benefits" means periodical payments either immediate or deferred and continuing during the life or lives of an annuitant or annuitants or during the life or lives of an annuitant or annuitants and for a term of years certain, in an amount which shall not exceed fifteen thousand dollars annually.

(m) "Total and permanent disability benefits" means those payable by the society in the case of total and permanent disability as the result of either disease or accident and which are contained in or supplemental to any life insurance or annuity obligation of the society in amounts which do not exceed the greater of five hundred dollars a month or the amounts permitted by subsection (e) of section three thousand two hundred fifteen of this chapter.

(n) "Monument or tombstone expense benefits" means those payable to reimburse the cost of monuments or tombstones to the memory of deceased members.

(o) "Hospital expense and surgical and medical expense benefits" means those payable for such expenses due to sickness, bodily infirmity or accidental injury.

(p) "Disability income insurance benefits" means periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from sickness or injury, in amounts which do not exceed one thousand two hundred fifty dollars a month.

(q) "Long term care benefits" means those payable to members, or upon application of a member for a member's family and dependents as authorized in section one thousand one hundred seventeen of this chapter.

§ 4502. Incorporation and licensing of domestic societies; meeting of supreme governing body. An authorized domestic society may be organized and licensed in the manner prescribed in this section, and subject to the other requirements of this chapter applicable thereto. The successive steps shall be as follows:

(a) The proposed incorporators, who shall be natural persons, citizens of the United States and a majority of whom shall be citizens of this state, and who shall be not less than fifteen in number, shall submit to the superintendent in writing the proposed name of the society and the county in which its principal office will be located. Such name shall contain a word or words indicating the fraternal character of such society, and shall not contain any of the following words: "insurance", "assurance", "life", "accident", "health", "annuity", "guaranty", "company", "corporation", "indemnity", "endowment", "guarantee", "casualty", "surety", "fidelity", or "underwriters", or any other word or words which in the judgment of the superintendent would be likely to be deceptive or misleading as to the character and purposes of such society. Such proposal shall be subscribed with the name and address of each such incorporator.

(b) If the superintendent approves the proposed name of the society as conforming to the requirements of subsection (g) of section one thousand one hundred two of this chapter and not inconsistent with other requirements of law, he shall so notify the proposed incorporators, or their representative, in writing. Such approval shall become void if within six months from the date thereof the declaration and charter of such society have not been filed pursuant to this section.

(c) The proposed incorporators shall make and subscribe (giving their addresses) and affirm as true under the penalties of perjury, a declaration and charter, both in the English language, and shall file the same with the superintendent, together with duly certified copies of the proposed constitution, by-laws, rules and regulations, all proposed forms of certificates or other evidences of insurance or annuity contracts, or both, all applications therefor and riders or endorsements to be used in connection therewith, all circulars to be issued by the society, and a table or schedule showing the rates of premium or other periodical contribution to be charged by such society for any insurance or annuity benefits to be provided by it. Such declaration shall state

the intention of the proposed incorporators to form a society for the purpose of providing insurance benefits permissible under the provisions of this article, and for other purposes not inconsistent with the provisions of this chapter. The proposed charter shall contain the following:

(1) the name of the proposed society, approved as aforesaid;

(2) the place where such society will have its principal office, which shall be in this state;

(3) the general, fraternal, altruistic, educational, patriotic, recreational and other purposes of such society, and the kinds of insurance benefits to be provided by it, specified in accordance with section four thousand five hundred five of this article;

(4) the mode and manner in which its corporate powers are to be exercised;

(5) the number of directors shall not be less than nine of which at least four must not be officers or employees of the society. The charter of such society shall provide that the number of directors shall be increased to not less than thirteen within one year following the end of the calendar year in which the society exceeded five hundred million dollars in admitted assets. "Number of directors" herein means the total number of directors which the society would have if there were no vacancies;

(6) the times and manner of electing its directors and officers, the manner of filling vacancies in such offices, and a provision that at all times a majority of the directors shall be citizens and residents of this state or of adjoining states, and not less than five thereof shall be residents of this state;

(7) the names and postoffice residence addresses of the directors who shall serve until the first election in accordance with the charter and by-laws;

(8) the duration of its corporate existence which shall be not less than thirty years;

(9) such other particulars as may be necessary to explain the objects, purposes, management and control of such society; and

(10) such additional information as the superintendent may by regulation require.

(d) The superintendent shall transmit such declaration, charter and

accompanying documents to the attorney general. If the same be approved by the attorney general, as conforming to the requirements of law, the superintendent shall thereupon file the declaration and charter in his office, and shall issue a certified copy of each to the proposed incorporators. Such incorporators shall thereupon become a body corporate which shall not be authorized to do an insurance business until it shall have obtained a license therefor as provided in subsection (f) hereof, but it may solicit members for the purpose of completing its organization, collecting from each applicant for insurance an amount not less than one regular monthly premium, in accordance with its table or schedule of rates, issuing to each such applicant a receipt for the amount so collected and providing for the examination of each applicant for life insurance by legally qualified practicing physicians with certificates of such examinations to be duly filed and approved by the chief medical examiner of such society. Before soliciting or receiving any premium or other contribution for insurance benefits of any kind or character, the society shall file with the superintendent a bond in the sum of five thousand dollars, with sureties approved by the superintendent, conditioned upon the return to applicants of the advanced payments, as provided in this section, if the society does not complete its organization and obtain a license to do business within one year from the date of incorporation or within such further time as the superintendent may permit pursuant to subsection (g) hereof. The society shall incur no liability except for the repayment of such advanced payments, nor issue any certificate or other evidence of an insurance or annuity contract, or both, unless and until it shall have obtained a license to do business as hereinafter provided.

(e) Before obtaining a license to do business in this state, such society shall have established not less than ten subordinate lodges or branches, into which not less than five hundred applicants have been initiated and shall have actual bona fide applications for life insurance benefits upon at least five hundred lives each eligible for such insurance, in accordance with the provisions of this article, for at least one thousand dollars on each life and shall have received payments thereunder in the aggregate amount of at least two thousand five hundred dollars. Before obtaining such license such society shall submit to the superintendent, under oath of the president and secretary,

or corresponding officers, a complete list of such applicants, giving their names, addresses, dates of examination, approval and initiation, the name and number of the subordinate lodge or branch of which each applicant is a member, the amount and kinds of insurance benefits to be granted, the rate of periodical insurance contributions of each, which shall conform to the requirements of this article, and the bank or banking institution in which all sums collected from such applicants have been deposited. Such advanced payments or other insurance contributions by applicants shall, during the period of organization and until the issuance of a license to do business, be held in trust on account of such applicants, and no part thereof may be used for expenses; and if a license is not issued within one year from date of incorporation, such advanced payments shall be returned to the applicants who originally made the same.

(f) If the superintendent finds, from the statements of the principal officers of such society, subscribed and affirmed by such officers as true under the penalties of perjury, or from such investigation or examination as he may deem expedient, that such society has complied with the requirements of this section and that the purposes and plan of operation of such society are in accordance with the requirements of law, he may issue to such society a license to do business in this state. Such license shall set forth the name of the society, the location of its principal office, and the kind of insurance or annuity benefits, or both, specified in section four thousand five hundred five of this article, which it is authorized to provide in this state. Thereupon the society shall have such powers as are necessary or properly incidental to carry into effect the lawful objects and purposes of the society.

(g) If any such society shall fail to obtain such license within one year from the date of its incorporation or within such further period, not to exceed one additional year, as the superintendent may in his discretion permit, the superintendent may commence proceedings for the dissolution of such society in accordance with article seventy-four of this chapter.

(h) A domestic society may provide for the meeting of its supreme governing body in any other state, province or territory wherein such society has not less than five subordinate lodges or branches. In all

meetings of the supreme governing body, no member, representative or delegate shall cast more than one vote on any question submitted.

§ 4503. Licensing of foreign and alien societies. (a) The superintendent may issue a license to do business in this state to any foreign or alien society which conforms to the requirements for foreign or alien insurers pursuant to section one thousand one hundred six of this chapter, other than subsection (e) thereof, and which conforms in substance to all other requirements imposed on domestic authorized societies under this chapter. Every such license shall contain the name of the licensee, its home office address, the state or country under whose laws it was incorporated and the term of such license. The superintendent may refuse to issue or renew any such license if in his judgment such refusal will best promote the interests of the people of this state. The superintendent may refuse to renew any such license in addition to, or in lieu of, a proceeding under article seventy-four of this chapter in the circumstances specified in section four thousand five hundred nineteen of this article.

(b) Every license, including every renewal license, issued to a foreign or alien society shall be for a term expiring on April thirtieth following the date of issuance, but such license shall continue in full force until a renewal license shall have been issued or shall have been specifically refused by the superintendent.

(c) No alien society shall be authorized to do business in this state unless it shall at all times maintain trusteed assets, a trusteed surplus and a deposit in the United States pursuant to the provisions of sections one thousand three hundred twelve, one thousand three hundred fifteen, and one thousand three hundred twenty of this chapter, respectively. Such trusteed surplus shall be in an amount not less than four hundred fifty thousand dollars and shall be held in trust for the security of members in the United States admitted to the society on or after January first, nineteen hundred forty. The term "policyholders in the United States" as used in sections one thousand three hundred twelve, one thousand three hundred fifteen and one thousand three hundred twenty of this chapter shall be deemed, in the case of authorized alien societies, to refer to members in the United States

admitted to the society on and after January first, nineteen hundred forty.

§ 4504. Amendments to charter, constitution and by-laws; waiver of provisions. (a) A domestic society may amend its charter and by-laws by a majority vote at any regular meeting or special meeting (called for that purpose) of its supreme governing body, but no such amendment shall take effect unless and until filed with the superintendent and approved by him. The superintendent may approve any such amendment if he finds that it has been duly adopted and is not inconsistent with any requirement of the law or with the character, objects and purposes of such society.

(b) A domestic society may amend its constitution and by-laws, in accordance with the provisions of its constitution, by the action of its supreme governing body at any regular meeting or special meeting thereof, or, if its constitution so provides, by referendum. Such referendum may be held, in accordance with the provisions of the constitution, by the vote of the voting members or by the vote of delegates or representatives of voting members or by the vote of local lodges or branches; but no such amendment shall take effect unless, within six months from the date of submission thereof, a majority of all of the members of such society entitled to vote shall have signified their consent to such amendment. Such amendment to the constitution or by-laws shall be filed with the superintendent within not more than ninety days after the adoption thereof or, in an appropriate case, after such consent of the members. Amendments to the constitution and by-laws may be adopted by the board of directors whenever such amendments, in the opinion of the board, are necessary to meet the requirements of the this chapter, but such amendments shall be submitted for ratification by the supreme governing body of the society at its next regular meeting, or at any special meeting thereof, or if its constitution so provides by referendum and shall be filed with the superintendent within ninety days after such ratification.

(c) Within ninety days from the approval by the superintendent required by subsection (a) hereof, and within ninety days from the filing with the superintendent required by subsection (b) hereof, all

such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official organ of the society.

(d) Every authorized foreign or alien society shall file a certified copy of every amendment to its charter, constitution, and by-laws with the superintendent within not more than ninety days after the same takes effect; and every such society shall, within ninety days from the filing thereof, furnish to all members of the society in this state, a copy of all amendments, or a synopsis thereof, either by mail or by publication in full in the official organ of the society.

(e) If the superintendent finds after notice and hearing, that any authorized society has wilfully violated any of the foregoing provisions of this section relating to the filing of amendments to its charter, constitution, and by-laws, he may, in lieu of any other penalty provided by law, order such society to pay to the people of this state a penalty in a sum not exceeding five hundred dollars for each such offense, and failure of any such society to pay such penalty within thirty days after the making of such order, unless such order is suspended by an order of a court of competent jurisdiction, shall constitute a violation of the provisions of this chapter.

(f) Unless authorized by express provisions in the constitution and by-laws of the society, no subordinate lodge or branch and no officer or member of any authorized society shall have power or authority on behalf of the society to waive or modify any of the provisions of the constitution or by-laws of the society or of any certificate or other evidence of insurance contract issued by such society, nor to waive any violation, forfeiture or default thereof.

(g) Every authorized society shall provide in its constitution or by-laws and in its certificates that if its reserves as to any class of certificates, other than those portions of any certificate that provide variable benefits based on the experience of a separate account, become impaired, its board of directors may require that there shall be paid by the member to the society the amount of the member's equitable proportion of such deficiency as ascertained by its board and that if the payment be not made it shall stand as an indebtedness against the certificate and draw interest not to exceed five percent per annum compounded annually, or the equivalent effective rate of interest if

payable in advance, or in lieu thereof, or in combination therewith, the member may consent to a reduction of the corresponding insurance benefit proportionate to the value of the additional contributions.

§ 4505. Insurance benefits authorized. (a) Any authorized society may obligate itself for the payment of only insurance benefits defined in subsections (h) through (p) of section four thousand five hundred one of this article, except that no benefits may be provided through group insurance. Any benefit defined in subsections (h) through (q) of section four thousand five hundred one or paragraphs one and three of subsection (a) of section four thousand five hundred twenty-seven of this article, or any one or more of such benefits, may be provided in the same or separate certificates, or by rider, subject to the limitations provided for in section four thousand five hundred seven of this article.

(b) An authorized society shall specify in its laws or rules those persons who may receive benefits or be covered by benefits through the society, consistent with providing benefits to members and their dependents. Nothing herein shall alter the insurable interest requirements of section three thousand two hundred five of this chapter.

(c) No authorized society shall undertake to pay a total and permanent disability benefit on any life in excess of two hundred fifty dollars per month exclusive of waived premiums, nor for disability occurring after age sixty except that a society may undertake to pay benefits for disability occurring at any age, in an amount not exceeding the reserve under the life insurance certificate or one-half the amount of such certificate, whichever is greater, if the payment of such benefits is conditioned upon the surrender of, or a proportionate reduction of the amount of, such certificate.

(d) Notwithstanding the foregoing provisions, no policy of industrial life insurance shall be delivered or issued for delivery in this state.

§ 4506. Classes of membership. An authorized society may admit to membership two classes of members: insurance members and social members by whatever name known. Social members shall not be entitled to any of the benefits prescribed by section four thousand five hundred five of

this article, and shall have no voice or vote in the management of the insurance affairs of the society, except that they shall be eligible to be elected as officers and as representatives of insurance members unless such eligibility is prohibited by the society's by-laws. Insurance members may be either adult members or juvenile members.

§ 4507. Juvenile members. (a) An authorized society may admit to adult insurance membership any person not less than fifteen years of age at nearest birthday. Any person so admitted prior to attaining the full age of eighteen years shall be deemed competent to contract for life insurance benefits, and to exercise and enjoy every right, privilege and benefit provided by any life insurance certificate on the life of such minor subject to the limitations contained in section four thousand five hundred eight of this article as to the designation of beneficiary.

(b) Any such society may provide in its constitution or by-laws for the admission, as juvenile insurance members, of children less than eighteen years of age at nearest birthday. They shall have no voice or vote in the management of the insurance affairs of the society. Life insurance benefits may be made payable upon the lives of juvenile members, upon the application of some adult person, in accordance with the by-laws, rules or regulations of such society, and in amounts which shall not exceed the limits specified in section three thousand two hundred seven of this chapter.

(c) Juvenile members insured under certificates issued pursuant to this section, if eligible for adult membership, shall be transferred to and become members of the adult branch of the society upon attaining the minimum age for adult membership under the laws of the society. Upon such transfers made pursuant hereto, the mortuary reserve funds accruing against such certificates and an equitable share of any surplus funds pertaining thereto shall likewise be transferred to the adult mortuary fund.

(d) Any such society may provide in its by-laws that mortuary payments, meaning that portion of contributions allocated to the mortuary fund and to reserves on outstanding contracts, received under new certificates issued on or after January first, nineteen hundred thirty-nine, covering the lives of juvenile members, may be mingled with

the mortuary or reserve funds held on classes of adult certificates on which adequate reserves are maintained not lower than those required by the minimum standards of valuation prescribed by this article for adult certificates issued on or after January first, nineteen hundred thirty-nine. Except as hereinbefore provided, every such society shall maintain the mortuary and reserve funds on insurance on the lives of juvenile members and the accretions thereto, separate and distinct from all other funds of the society, and the same shall be held as a trust fund available exclusively for the payment of benefits under such contracts.

(e) Any such society insuring the lives of juvenile members may provide in its by-laws, rules and regulations for payment on account of the society's juvenile expense fund, and that such payments may be mingled with the general expense funds of the society.

§ 4508. Beneficiaries. (a) The adult owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the authorized society unless the owner waives this right by specifically requesting in writing that the beneficiary designations be irrevocable. Subject to the requirements and limitations of section three thousand two hundred five of this chapter, an authorized society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract. Nothing herein shall prohibit the owner of a certificate from making an absolute assignment of the certificate.

(b) The beneficiaries under contracts of insurance on the lives of children may be designated by the adult person authorized to make application for such insurance. Unless otherwise provided by the constitution or by-laws or the insurance certificate, any such member may, on or after attaining the age of sixteen years, change any such designation.

(c) An authorized society may make provision in its contract for the payment of life insurance or accidental death benefits to such person or

persons as may be equitably entitled thereto by reason of having incurred reasonable expense occasioned by the maintenance, medical attention or burial of the member, provided the amount so paid shall not exceed five thousand dollars.

(d) If at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such proceeds, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner. Notwithstanding any other provision of this chapter to the contrary, any insured member of an authorized society may voluntarily designate the authorized society as the beneficiary of any insurance contract for the purpose of any lawful activity of the authorized society.

§ 4509. Certificates; applications; effect of changes in corporate documents. Every authorized society shall issue to each insured member, except a spouse or children under the age of twenty-one years insured as members pursuant to subsection (b) of section four thousand five hundred five of this article, a certificate specifying the amount or amounts of insurance benefits provided thereby. The application for insurance, and the declaration of insurability, if used in lieu of a medical examination as herein provided, shall be signed by the applicant, and, unless society does not make the application a part of the contract or agreement with the member or applicant, a copy thereof shall be attached thereto, and all statements made by the applicant therein shall be deemed representations and not warranties. Every adult insurance member entitled to life insurance benefits shall, as to each application for life insurance, have furnished evidence of insurability acceptable to the society. The certificate, together with any riders or endorsements attached thereto, the articles of incorporation, constitution and by-laws of the society, and the application and declaration of insurability, if any, attached as aforesaid, shall constitute the entire contract, as of the date of issuance, between the society and the insured member; and copies of the same, certified by the secretary or

corresponding officer of such society, shall be received in evidence to show the terms and conditions of such contract. In the case of certificates that provide that the death benefit or other certificate provisions may be changed by written application or by the written notice of exercise of one or more options provided in the certificate, or automatically by the terms of the certificate, the certificate may also contain a provision that when such written application or notice of exercise of an option is accepted by the society or a notice of any change is issued by the society and, in each case, a copy of such application or notice is returned by mail or delivered to the certificate holder at the certificate holder's last post office address known to the society, such application or notice shall become part of the entire contract between the parties. Any changes, additions or amendments to said articles of incorporation, constitution or by-laws duly made or enacted subsequent to the issuance of any certificate, other than a certificate or contract providing variable benefits pursuant to a separate account, shall bind the member and his beneficiaries, and shall thereafter govern and control the agreement in all respects, except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the members as of the date of issuance.

§ 4510. Life insurance certificates; required and prohibited provisions. (a) No certificate or other evidence of a life insurance contract shall be delivered or issued for delivery in this state by any authorized society unless it contains in substance the following provisions, or provisions which in the opinion of the superintendent are more favorable to the insured members, except that such provisions as are not applicable to single premium or term life insurance shall to that extent not be incorporated in such certificate or contract:

(1) For certificates in which the amount and frequency of premiums may vary, a provision that, after payment of the first premium, the insured is entitled to a grace period of not less than sixty-one days, beginning on the day when the fraternal benefit society determines that the certificate's net cash surrender value is insufficient to pay the total charges necessary to keep the certificate in force for one month from

that day within which to pay sufficient premium to keep the policy in force for three months from the date the insufficiency was determined. During such grace period the certificate shall continue in full force, but in case the certificate becomes a claim, on account of death, maturity or other benefit accrued during such grace period before an amount of premium sufficient to keep the certificate in force is paid, an amount of premium sufficient to keep the policy in force until the day the certificate became a claim may be deducted from any amount payable in any settlement under the certificate. For all other certificates, a provision that the insured is entitled to a grace period of not less than one month or thirty days within which the payment of any premium after the first may be made, and that during such grace period the certificate shall continue in full force, but in case the certificate becomes a claim, on account of death, maturity or other benefit accrued during such grace period before the overdue premiums are paid, the amount of such premium or premiums may be deducted from any amount payable in any settlement under the certificate.

(2) A provision that the certificate shall be incontestable after it has been in force during the lifetime of the insured member for a period of two years from its date of issue, and, if a certificate provides that the death benefit provided by the certificate may be increased, or other certificate provisions changed, upon the application of the certificate holder and the production of evidence of insurability, a provision that the certificate with respect to each such increase or change shall be incontestable after two years from the effective date of such increase or change, except in each case for (i) non-payment of premiums, and (ii) violation of the provisions of the certificate relating to military or naval service, and, at the option of the society, (iii) provisions relating to benefits in the event of total and permanent disability, and (iv) provisions which grant additional insurance against death by accident or accidental means.

(3) A provision that if it shall be found at any time before final settlement under the certificate that the age of the insured (or the age of the beneficiary, if considered in determining the premium) has been misstated, and the discrepancy and the premium payment involved have not been adjusted, the amount payable under the certificate shall be such as the premium would have purchased at the correct age, except that if the

correct age was not an insurable age under the society's charter, constitution or by-laws, and such charter, constitution or by-laws so provide, only the net mortuary payments made thereunder shall be returned or, at the option of the society, the amount payable under the certificate shall be such as the premium would have purchased at the correct age according to the society's promulgated rates and any extension thereof based on actuarial principles.

(4) A provision that the holder of a certificate shall be entitled to have the certificate reinstated at any time within three years from the due date of the premium in default, unless the cash value has been duly paid or the period of extended insurance has expired, upon the production of evidence of insurability and good health satisfactory to the society and the payment of all overdue premiums and any other indebtedness to the society upon such certificate together with interest on such premiums, at a rate not exceeding six percent per annum payable annually and interest on such indebtedness at a rate or rates not exceeding the applicable loan rate or rates determined in accordance with the certificate's provisions. Such provision shall be required only if the certificate provides for termination or lapse in the event of a default in making a regularly scheduled premium. Such provision may give the society the right to contest the reinstated certificate, as to statements made to procure reinstatement, within a period after date of reinstatement not exceeding the period of contestability prescribed in the original certificate with the same exceptions permitted by paragraph two hereof.

(5) In the case of certificates which cause on a basis guaranteed in the certificate unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new certificate, a provision specifying the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the certificate. In the case of all other certificates, a provision specifying the nonforfeiture options available under the certificate in the event of default in a premium payment after premiums have been paid for a specified period, together with a table showing, in figures, the options so available, and also the loan values, if any, available during each of the first twenty years after the issuance of the certificate. Such

options shall conform with the requirements of section four thousand five hundred eleven of this article.

(6) A provision for certificates issued on and after January first, nineteen hundred seventy-five, that after three full years' premiums have been paid or, in the case of certificates that provide that the certificate holder may vary the amount and frequency of premiums to be paid to the society, after three years from the issue of the certificate, if the certificate is in force and not in default, the society will, at any time while the certificate is in force, advance, on proper assignment or pledge of the certificate and on the sole security thereof, a sum equal to, or at the option of the person entitled thereto, less than, the amount of the cash surrender value calculated in accordance with the provisions of section four thousand five hundred eleven of this article; and that the society may deduct from such loan value (in addition to the indebtedness deducted in determining such value) any unpaid balance of the premium for the current certificate year; and that if the loan is made or repaid on a date other than the anniversary of the certificate the society may collect interest for the portion of the current certificate year on a pro rata basis. The certificate shall provide, at the option of the society, either that (i) any such loan shall bear interest at a maximum rate of not more than seven and four-tenths per centum per annum if payable in advance or the equivalent effective rate of interest if otherwise payable, or (ii) any such loan shall bear interest at a rate not in excess of an adjustable maximum rate established from time to time by the society as permitted by law. If the certificate provides for an adjustable rate, the certificate shall specify the regular intervals at which the interest rate is to be determined which shall be at least once every twelve months, but not more frequently than once in any three month period. The certificate may further provide that if the interest on the loan is not paid when due, it shall be added to the existing loan, and shall bear interest at the applicable rate or rates payable on the loan determined in accordance with the provisions of the certificate; and subject to subsection (e) of section three thousand two hundred six of this chapter may further provide that if and when the total indebtedness on the certificate, including interest due or accrued, equals or exceeds the amount of the loan value thereof at such time, and if at least thirty

days' prior notice shall have been given in the manner provided in section three thousand two hundred eleven of this chapter, then the certificate shall terminate and become void. This provision shall not apply to term insurance.

Any certificate which provides for the crediting of additional amounts pursuant to section four thousand five hundred eighteen of this article may also provide that if any indebtedness is owed to the society on any part of the loan value which would otherwise be credited with additional amounts, such additional amounts may be reduced so that the total amounts credited on such part are so credited at a rate that is up to two percent per annum less than the applicable loan interest rate charged or at such other rate as the superintendent, upon the society's demonstrating justification therefor, may allow.

(7) If in the judgment of the superintendent, the charter, constitution or by-laws of the society provide that the violation of any section or sections thereof shall result in the reduction or termination of any benefit payable under the certificate, then a provision which either:

(A) recites fully all such sections,

(B) sets forth the substance of all such sections, or

(C) states in substance that no section of the charter, constitution or by-laws shall be relied upon or be used to reduce or terminate any benefit payable under the certificate unless such section is specifically set forth or referred to in the certificate.

(8) The provision in the constitution or by-laws required by subsection (g) of section four thousand five hundred four of this article.

(9) A provision that in case the by-laws of the society provide for expulsion or suspension of a member, any member so expelled or suspended except for non-payment of a premium or contribution, or within the contestable period for material misrepresentations in his application for membership, shall have the privilege of maintaining his insurance in force by continuing payment of the required premium or contribution payable under the certificates and of such other assessments as may be required of members holding certificates of the same class.

(10) If issued for delivery in this state by any authorized foreign or

alien society, a provision that the rights or obligations of the insured member under such certificate or other evidence of such life insurance contract or of any person rightfully claiming thereunder shall be governed by the laws of this state.

(11) A provision that the society shall annually ascertain and apportion any divisible surplus accruing on the certificate.

(12) In any certificate under which additional amounts may be credited pursuant to section four thousand five hundred eighteen of this article, provisions stating

(A) the guaranteed factors of mortality, expense and interest, and the method used by the society in calculating actual certificate values;

(B) that such additional amount shall be nonforfeitable after the effective date of their crediting except for any charges imposed under the certificate which are not greater than those allowed under subsection (n-1) or any market value adjustment made pursuant to subsection (n-2) of section four thousand two hundred twenty-one of this chapter; and

(C) that the society shall credit any such amounts no less frequently than annually during such period.

(13) Operative on January first, nineteen hundred eighty-five or with respect to certificates issued by any particular society operative on such earlier date as the society may have specified in a written notice filed with the superintendent as the date the society elects to begin compliance with the provisions of this paragraph, a provision that (i) if the death of the insured shall occur within a period for which the premium has been paid, the society shall add to the certificate proceeds a refund of the pro rata portion of premium paid for any period beyond the end of the certificate month in which death occurred, provided such premium was not waived under any waiver of premiums benefit included in the certificate or attached thereto, and (ii) if the death of the insured shall occur within a period for which the premium has not been paid, but within the grace period provided in the certificate, the society may deduct from the certificate proceeds that portion of overdue premium as applies to the period ending with the last day of the certificate month in which death occurred; provided however, that the provisions of this paragraph shall not be applicable to single premium certificates and paid-up certificates.

(b) (1) No such certificate or other evidence of a life insurance contract delivered or issued for delivery in this state shall contain any exclusory or restrictive provisions relating to liability in the event of death caused in a certain specified manner except the following provisions, or provisions which in the opinion of the superintendent are substantially the same or more favorable to holders of such certificate or contracts, excluding or restricting coverage in the event of death:

(A) as a result of war or an act of war, if the cause of death occurs while the insured is serving in the military, naval or air forces of any country, international organization or combination of countries or in any civilian noncombatant unit serving with such forces, provided such death occurs while in such forces or units or within six months after termination of service in such forces or units;

(B) as a result of the special hazards incident to service in the military, naval or air forces of any country, international organization or combination of countries or in any civilian non-combatant unit serving with such forces, if the cause of death occurs while the insured is serving in such forces or units and is outside the home area, provided such death occurs outside the home area or within six months after the insured's return to the home area while in such forces or units or within six months after the termination of service in such forces or units, whichever is earlier;

(C) as the result of war or an act of war, within two years from the date of issue of the certificate, while the insured is not in such forces or units, if the cause of death occurs while the insured is outside the home area; provided such death occurs outside the home area or within six months after the insured's return to the home area;

(D) as a result of suicide within two years from the date of issue of the certificate;

(E) as a result of aviation under conditions specified in the certificate; or

(F) within two years from the date of issue of the certificate as a result of specified hazardous occupations, or while the insured is a resident of a specified foreign country or countries.

(2) The provisions of this paragraph shall apply only to subparagraphs (A), (B) and (C) of paragraph one hereof.

(A) As used in such subparagraphs, "home area" means the states of the

United States, the District of Columbia and Canada; "war" includes, but is not limited to, any war declared or undeclared, and armed aggression resisted by the military, naval or air forces of any country, international organization or combination of countries; "act of war" means any act peculiar to military, naval, or air operations in time of war; and "special hazards incident to service" includes, but is not limited to, those hazards resulting in the insured's death being presumed by reason of being missing or missing in action, and those hazards resulting in death from disease or injury, accidental or otherwise, to which a person serving in, or with, such forces or units is exposed in the line of duty.

(B) In permitting such war exclusions it is the legislative intent that such exclusions are not to be construed or interpreted as exclusions because of the status of the insured as a member of such forces or units or because of the presence of the insured as a civilian in a combat area or area adjacent thereto. Such permissible exclusions shall be construed and interpreted according to the fair import of their terms so as not to exclude deaths due to diseases or accidents which are common to the civilian population and are not attributable to special hazards to which a person serving in such forces or units is exposed in the line of duty.

(C) The superintendent may, by regulation, prescribe reasonable conditions relative to the use of such war exclusion provisions.

(3) In the event of death as to which there is such an exclusion or restriction, the society shall pay the reserve on the face amount of the certificate, computed according to the mortality table and interest rate specified in the certificate, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the certificate, less any indebtedness to the society on the certificate, including interest due or accrued; provided that if the certificate shall have been in force for not more than two years the society shall pay the amount of the gross premiums charged on the certificate less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the society on the certificate; including interest due or accrued.

(4) Nothing contained in this subsection shall apply to any provision in a life insurance certificate for additional benefits in the event of

death by accident or by accidental means.

(5) If a certificate provides that the death benefit may be increased, or other certificate provisions changed, upon the application of the certificate holder and the production of evidence of insurability, the certificate may also provide that the two year exclusions permitted under subparagraph (C), (D) or (F) of paragraph one of this subsection shall run from the date of issue of the certificate except that it shall run from the effective date of each subsequent increase or change with respect to each such increase or change.

(c) No such certificate or other evidence of a life insurance contract shall be issued or delivered in this state by any society if, in substance, any of the following provisions are in any way made a part of the contract:

(1) any provision limiting the time within which any action at law or in equity may be commenced to less than eighteen months after the cause of action shall accrue;

(2) any provision for forfeiture, lapse or termination of any certificate because of failure to repay any loan on the certificate or to pay interest on such loan, while the total unpaid amount of any loan or loans under such certificate, including interest, is less than the loan value thereof; or

(3) any provision whereby the suspension or expulsion of the insured member, or change of occupation, or any other violation of the terms and conditions of the insurance contract shall result in the loss or reduction of the cash surrender value or other withdrawal equity, if any, available by the terms of such certificate.

§ 4511. Life insurance certificates and annuity contracts; nonforfeiture benefits and values; requirements and exceptions. (a) Every certificate of life insurance except certificates for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1958 Standard Ordinary Mortality Table or the Commissioners 1941 Standard Industrial Mortality Table, delivered or issued for delivery in this state prior to January first, nineteen hundred seventy-five by every authorized society shall be subject to the requirements and exceptions of section four thousand two

hundred twenty of this chapter, except that:

(1) the reserve on the certificate shall be determined on the basis of section four thousand five hundred seventeen of this article,

(2) a cash surrender value shall not be required on certificates delivered or issued for delivery prior to January first, nineteen hundred sixty-two, and

(3) the paid-up nonforfeiture benefit shall be on a plan as stipulated in the certificate.

(b) Every certificate of life insurance delivered or issued for delivery in this state prior to January first, nineteen hundred seventy-five, by every authorized society, for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1958 Standard Ordinary Mortality Table or the Commissioners 1941 Standard Industrial Mortality Table shall be subject to the requirements and exceptions of section four thousand two hundred twenty-one of this chapter, and if for any category of ordinary insurance issued on female risks, reserves are calculated according to an age not more than three years younger than the actual age of the insured, adjusted premiums and present values shall be calculated in like manner.

(c) Every certificate of life insurance delivered or issued for delivery in this state on or after January first, nineteen hundred seventy-five, by every authorized society shall be subject to the requirements and exceptions of section four thousand two hundred twenty-one of this chapter provided that with respect to subsection (h) thereof, the society may also elect to calculate adjusted premiums and present values according to the Commissioners 1941 Standard Ordinary Mortality Table or the Commissioners 1961 Standard Industrial Mortality Table provided, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not greater than one hundred thirty percent of the rates of mortality of the Commissioners 1941 Standard Ordinary Mortality Table, if applicable, nor greater than the rates of mortality of the 1961 Industrial Extended Term Insurance Table, if applicable.

(d) Every annuity contract delivered or issued for delivery in this state prior to January first, nineteen hundred eighty-two, by every

authorized society shall be subject to the requirements and exceptions of section four thousand two hundred twenty-one of this chapter.

(e) Every annuity contract delivered or issued for delivery in this state on or after January first, nineteen hundred eighty-two, by every authorized society shall be subject to the requirements and exceptions of section four thousand two hundred twenty-three of this chapter.

§ 4512. Accident and health and disability insurance certificates; compliance with rules and regulations. (a) No certificate or other evidence of any contract of accident insurance, disability income insurance, or health insurance or of any total and permanent disability insurance and no application or rider or endorsement for use in connection therewith shall be delivered or issued for delivery in this state unless it conforms with reasonable rules and regulations prescribed by the superintendent and contains a provision that the rights or obligations of the insured member under any such certificate or other evidence of such contract, or of any person rightfully claiming thereunder, shall be governed by the laws of this state. Pursuant to the foregoing provisions the superintendent shall have power, from time to time to make, alter and supersede reasonable rules and regulations prescribing the required, optional and prohibited provisions in such contracts, and such rules and regulations shall conform, as far as practicable, to the provisions of section three thousand two hundred fifteen of this chapter or of section three thousand two hundred sixteen of this chapter, whichever shall be applicable. Where the superintendent deems inapplicable, either in part or in their entirety, the provisions of the aforesaid sections, he may prescribe the portions, or a summary thereof, of the contract to be printed in the certificate issued to the member.

(b) Anything in this article to the contrary notwithstanding, each certificate of hospitalization expense benefits or surgical or medical expense benefits delivered or issued for delivery in this state to any member individually or as the head of a family shall:

(1) stipulate a premium determined on the basis of the age of the member, which premium shall be subject to change only if the premiums on all outstanding certificates in the same class are changed in accordance

with the standards which shall have been established prior to the issuance of the certificate for the determination of the increase or decrease in the premiums and are on file with and approved by the superintendent,

(2) contain the following provisions under the caption "Incontestable and Guaranteed Renewable":

"After this certificate has been in force for a period of one year from the date of issue, it shall become incontestable as to the statements contained in the application and the member shall have the right to continue the same in force, subject to the timely payment of premiums and the conditions of the certificate relating to military service;" and

(3) in the case of such certificates written at issue age above sixty-five years, contain the following provision:

"No claim for benefits provided in this certificate shall be reduced or denied on the ground that a disease or physical condition had existed prior to the effective date of coverage of this certificate, except only such disease or physical condition which is specifically eliminated by rider, attached to this certificate, a copy which shall have been furnished to the member and its receipt evidenced by a signed amendment to the application for such certificate."

§ 4513. Annuity certificates; compliance with rules and regulations. No certificate or other evidence of any annuity contract and no application or rider or endorsement for use in connection therewith, shall be delivered or issued for delivery in this state unless it conforms with reasonable rules and regulations prescribed by the superintendent. Pursuant to the foregoing the superintendent shall have power, from time to time to make, alter and supersede reasonable rules and regulations prescribing the required, optional and prohibited provisions in such contracts, and such rules and regulations shall conform, as far as practicable with the provisions of section three thousand two hundred nineteen of this chapter.

§ 4514. Creation and maintenance of separate funds; premiums;

assessments and other contributions of members. (a) Every authorized society shall create a separate fund or funds for the payment of all insurance benefits as defined in section four thousand five hundred one of this article, under all certificates or other contracts issued by it or under any provisions of its constitution or by-laws which require payment of premiums or other contributions as consideration for such benefits. All such funds shall be known as the insurance funds of such society. In addition to such insurance funds, any such society may create, maintain, invest, disburse and apply, separate and independent from such insurance funds, any general, expense, emergency, patriotic, relief or other similar funds in accordance with its constitution and by-laws. Except as provided in subsection (g) hereof, all such funds of any such society may be invested only as permitted by paragraph two of subsection (a) of section one thousand four hundred three of this chapter. All such funds shall be held, invested and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein, or become entitled to any apportionment or the surrender of any part thereof, except in accordance with the terms and provisions of an insurance or annuity contract made by such society.

(b) In a provision of its by-laws relating to the payment of premiums or other required periodical contributions by insured members, every such society shall distinctly indicate the amount or portion of such premium or contribution which is to be used for insurance benefits, to be known as the insurance contribution, and the amount or portion which may be used for expenses and other purposes. The amount of such insurance contributions shall be not less than that required by the standard of valuation applicable to such certificate or contract in accordance with the provisions of this chapter. Every such insurance contribution shall without any deduction be paid into the insurance funds of such society.

(c) No authorized society shall issue or deliver in this state or elsewhere any certificate which does not require stated periodical premiums or contributions at least equal to those required according to the minimum valuation standards set forth in subsection (c) of section four thousand five hundred seventeen of this article; nor shall such society insure in this state or elsewhere members for temporary or

permanent disability benefits or for hospital expense or surgical and medical expense unless the rates thereof are adequate upon the basis of tables based upon reliable experience with an interest assumption not higher than three percent per annum.

(d) The insurance funds of every such society shall consist of the insurance contributions and of all interest or other income on investments in such funds and all other accretions to such funds. Such insurance funds may be used for the payment of benefits under any insurance or annuity contract and for the payment of expenses of investment of such funds. No part of such insurance funds shall be used for any other expenses or other purposes, except that any such society having admitted assets, as shown by its last annual statement filed with the superintendent, in excess of one hundred five percent of its entire liabilities, including its required reserves computed on a net tabular basis, may transfer or allocate such excess insurance funds to the expense or other funds of the society, in accordance with its constitution and by-laws; but the amount so transferred in any calendar year shall not exceed whichever is the smaller of (i) five percent of the total contributions to the mortuary fund or funds of such society during the next preceding calendar year or (ii) seventy-five per centum of the sum of

(1) the savings in mortality during the preceding calendar year under certificates issued on rates creating and maintaining reserves in accordance with the table of mortality used, and

(2) the excess interest earnings over and above the interest requirements to maintain reserves, after deducting from such sum the dividends, if any, paid to members, as determined by the valuation report and annual statement required by this chapter, but no society shall make any such transfer or allocation within the limits herein described which pays or agrees to pay a first year commission in excess of fifty-five percent of the year's premium on any life insurance certificate or annuity contract issued by such society. In addition to any transfer or allocation made within the limits herein described, a society may transfer or allocate from the mortuary fund or funds to the general or expense fund, surrender charges, if any, provided for under terminated life insurance contracts on a legal reserve basis.

(e) Any such society may ascertain and distribute any divisible

surplus accruing under its certificates on an equitable basis, provided that any apportionment of such surplus shall be only on an annual basis.

(f) Whenever any authorized society heretofore organized in or licensed to do business in this state has substantially separate groups or classes of certificates in force on which premiums or assessments are payable according to substantially different tables of rates, the superintendent may require such society to file a separate accounting in its annual report of such major classifications of certificates.

(g) Any such society, for the accomplishment of any lawful purpose provided for in its charter or constitution, may own, hold or lease personal and real property located within or without this state, with necessary buildings thereon; but no such personal or real property shall be deemed an admitted asset of such society, within the meaning of this chapter, except the home office building of such society to an amount not exceeding that permitted by paragraph seven of subsection (a) of section one thousand four hundred four of this chapter. Any such real or personal property may be acquired and maintained only out of the general or expense fund of such society, any voluntary contributions which it may receive therefor, and such reasonable charges as may be made for the facilities or services furnished thereby.

(h) Every authorized society shall at all times maintain a surplus not less than the minimum amount established by rule of the superintendent.

§ 4515. Conditions for avoiding separate funds. (a) Any authorized society which maintains reserves, including deficient premium reserves, at least equal to those required by the minimum standards of valuation hereinafter specified and which does not exceed the expense limits hereinafter specified shall not be required, if its constitution or by-laws so permit, to create or maintain a separate fund or funds, for the payment of insurance benefits as required by subsection (a) of section four thousand five hundred fourteen of this article nor to comply with the provisions of subsections (b) and (d) of such section and subsection (d) of section four thousand five hundred seven of this article.

(b) (1) Such minimum standards of valuation shall be:

(A) as to all contracts for life insurance benefits issued prior to

January first, nineteen hundred forty-eight, the American Experience Table of Mortality or the American Men Ultimate Table of Mortality with interest at three and one-half per centum,

(B) as to all contracts for life insurance benefits issued on and after January first, nineteen hundred forty-eight, and prior to January first, nineteen hundred fifty-six, the American Experience Table of Mortality or the American Men Ultimate Table of Mortality with interest at three per centum, and

(C) as to all contracts for life insurance benefits issued on and after January first, nineteen hundred fifty-six, the applicable mortality tables as specified in subsection (c) of section four thousand five hundred seventeen of this article.

(2) The deficient premium reserve as to all such contracts issued prior to January first, nineteen hundred forty-eight, shall be determined in the manner prescribed in subsection (b) of section four thousand five hundred seventeen of this article and as to all such contracts issued on and after January first, nineteen hundred forty-eight, shall be determined in the manner prescribed in section four thousand two hundred eighteen of this chapter.

(3) Such minimum standard of valuation as to all contracts for annuity benefits issued on and after January first, nineteen hundred forty-eight, shall be the 1937 Standard Annuity Mortality Table with interest at three per centum.

(c) No such society shall, except as provided for in subsection (f) hereof, make or incur in any calendar year, or permit to be made or incurred on its behalf or under any agreement with it, total life insurance expenses as defined in subsection (d) hereof in excess of the total life insurance expense limit as defined in subsection (e) hereof.

(d) The total life insurance expenses of any such society within the meaning of this section, shall include all expenses, made or incurred on its behalf with its permission or under any agreement with it, in the business of fraternal life insurance, except:

(1) taxes, licenses and fees,

(2) disbursements for altruistic, educational, fraternal or recreational activities which are made from funds collected solely for such purposes and in addition thereto disbursements for like purposes in an amount not exceeding one and one-half per centum of the premiums

received for life insurance contracts during such calendar year,

(3) that portion of its total investment expenses not exceeding one-fourth of one per centum of the mean amount of its total invested assets during such calendar year,

(4) taxes and other outlays exclusively in connection with real estate and commissions, or salaries and expenses in lieu of commissions, on mortgage loans, and

(5) outlays representing the accrued liability for services rendered by the society's employees prior to coverage under employees pension plans.

(e) The total life insurance expense limit, within the meaning of this section, shall be the sum of the following items:

(1) seven per centum of all life insurance premiums received by such society during such calendar year,

(2) thirty-five per centum of all first year life insurance premiums received by such society during such calendar year,

(3) one hundred seventy-five one thousandths of one per centum of the aggregate amount of life insurance of such society in force at the beginning of such calendar year and of the aggregate amount of such insurance issued during, and in force at the end of, such calendar year,

(4) three-tenths of one per centum of the aggregate amount of life insurance of such society in force at the beginning of such calendar year and of the aggregate amount of such insurance issued during, and in force at the end of, such calendar year, and

(5) thirty-five one hundredths of one per centum of the aggregate amount of life insurance of such society issued during, and is in force at the end of, such calendar year, exclusive of additional insurance purchased by the application of certificate dividends.

(f) The total life insurance expense limit of any such society which has in force at the end of the next preceding calendar year less than one million dollars of life insurance shall be increased by one hundred per centum; and for any other such society, such limits shall be increased by one hundred per centum less two-tenths of one per centum for each one million dollars of life insurance in excess of one million dollars of life insurance until the extra margin is sixty per centum of said limit, and thereafter said extra margin shall decrease by one-third of one per centum for each ten million dollars of life insurance in

force at the end of the next preceding calendar year until the extra margin is fifty per centum; and thereafter said extra margin shall decrease by one-half of one per centum for each ten million dollars of life insurance in force at the end of the next preceding calendar year until such extra margin is reduced to zero.

(g) The amounts of life insurance referred to in this section shall not include additional benefits payable for accidental death or for total and permanent disability.

(h) No such society, and no person, firm or corporation, on its behalf or under any agreement with it, shall pay or allow to any agent, broker, employee or other person, for services in procuring an application for life insurance, for collecting any premium thereon or for any other service performed in connection therewith, any compensation greater than that which has been determined by agreement made in advance of the rendering of such service.

(i) The superintendent may, in his discretion, accept satisfactory approximations of the figures required in this section. If any such society shall in any calendar year make or incur total life insurance expenses in excess of the total life insurance expense limit, the superintendent may, upon written application of such society, suspend such limit for such society for the calendar year in which such excess was incurred.

(j) Notice of intention to comply with the provisions of this section shall be given in writing to the superintendent by any such society, accompanied by a certified copy of the authorizing resolution of the board of directors.

§ 4516. Annual statement; valuation report; power of superintendent. (a) Every authorized society shall make special reports in compliance with section three hundred eight of this chapter, shall file its annual statement in conformity with the requirements of section three hundred seven of this chapter, and on or before the first day of March of each year, shall file with the superintendent a valuation report of its insurance certificates or other insurance obligations in force at last year-end in form and content prescribed by the superintendent. Every authorized alien society shall also make and file the trusteed surplus

statement required by section one thousand three hundred twelve of this chapter.

(b) The superintendent shall annually make or cause to be made valuations of all outstanding certificates and other insurance obligations of every domestic society, in accordance with the provisions of this article. The superintendent may make such valuation, or cause the same to be made, by groups of certificates using approximate averages for fractions of a year and otherwise. The superintendent may, in his discretion, make or cause to be made a similar valuation of the outstanding certificates and other insurance obligations of any authorized foreign or alien society, or he may accept in lieu thereof the valuation made or accepted by the insurance department or insurance supervisory official of the state, province or country in which such society is domiciled.

(c) Every domestic society, if it has an official publication or newspaper, shall publish therein a synopsis of its annual statement and valuation report within sixty days after the same have been filed with the superintendent.

(d) Every authorized society shall submit such reports as may be required by the superintendent to demonstrate the activity of its lodge system, its expenditures for altruistic, educational, fraternal, patriotic or recreational purposes and other expenses of maintaining fraternal character.

(e) The superintendent is authorized to engage outside resources and take such other actions he or she deems necessary and appropriate to ensure compliance with the requirements of this article and to provide assistance to and oversight of authorized societies.

§ 4517. Standard of valuation reserves. (a) The legal minimum standard of valuation for all life insurance certificates issued by an authorized society prior to January first, nineteen hundred fifty-seven shall be in accordance with provisions of law applicable thereto as of December thirty-first, nineteen hundred fifty-six, including the setting aside and maintenance of the required statutory contingency reserve on such of its certificates as are valued on an interest assumption in excess of three and one-half percent per annum. The legal minimum standard of

valuation for all annuity contracts, and disability benefits and accident and sickness benefits in all certificates and contracts shall be in accordance with the provisions of law applicable thereto as of December thirty-first, nineteen hundred fifty-six.

(b) In every valuation report of every authorized society and in every valuation of reserves made or caused to be made by the superintendent or accepted by him in lieu of such valuation, the reserve liability on all certificates issued on and after January first, nineteen hundred fifty-seven shall be determined on a basis of the net tabular value of the reserves on such certificates, not including any value for the right to make extra payments or to require additional insurance contributions. Such tabular values shall not be less than the reserve determined according to the commissioners reserve valuation method as defined in this subsection. If the premium charged is less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in such premiums, as determined in the manner prescribed in section four thousand two hundred eighteen of this chapter, shall be set up and maintained as a liability; provided that, in the case of any society which is not qualifying with the provisions of section four thousand five hundred fifteen of this article, the deficiency reserve shall be determined on the basis of the difference between the net insurance contribution, as in practice actually collected for life insurance benefits, and the tabular net premium. The reserve liability shall be properly adjusted in the event that the mid-year or tabular values are not appropriate.

(1) Reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such certificates, over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the certificate, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the certificate and the excess of:

(A) a net level premium equal to the present value, at the date of issue, of such benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annuity of one dollar per annum payable on the first and each subsequent anniversary of such certificate on which a premium falls due; provided however, that such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such certificate, over

(B) a net one-year term premium for such benefits provided for in the first certificate year.

(2) Reserves according to the commissioners reserve valuation method for (i) life insurance certificates providing for varying amounts of benefits or requiring the payment of varying premiums, (ii) annuity and pure endowment benefits, (iii) disability and accidental death benefits in all certificates and contracts, and (iv) all other benefits, except life insurance and endowment benefits, shall be calculated by a method consistent with the principles of this subsection (b), except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

(c) (1) The minimum standard for the valuation of life insurance and annuity certificates issued on and after January first, nineteen hundred fifty-seven, but prior to July first, nineteen hundred seventy-two, shall be three percent interest and for life insurance and annuity certificates issued on and after July first, nineteen hundred seventy-two, but prior to January first, nineteen hundred eighty, shall be three and one-half percent interest, and the following tables:

(A) for certificates of life insurance issued prior to January first, nineteen hundred seventy-five -- American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or, with the consent of the superintendent, the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1958 Standard Ordinary Mortality Table or the Commissioners 1941 Standard Industrial Table of Mortality; provided that for any category of ordinary insurance issued on female risks, all modified net premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured; and for certificates issued on and after January

first, nineteen hundred seventy-five, -- the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1958 Standard Ordinary Mortality Table or the Commissioners 1961 Standard Industrial Table of Mortality;

(B) for annuity certificates, including life annuities provided or available under optional modes of settlement in such certificates -- the 1937 Standard Annuity Table or, at the option of the society, the Annuity Mortality Table for 1949, Ultimate, or any modification of either table approved by the superintendent;

(C) for disability benefits issued in connection with life benefit certificates -- Hunter's Disability Table, which, for active lives, shall be combined with a mortality table permitted for calculating the reserves on life insurance certificates, except that the table known as Class III Disability Table (1926) modified to conform to the contractual waiting period, or, at the option of the society, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefits, shall be used in computing reserves for disability benefits under a contract which presumes that total disability shall be considered to be permanent after a specified period; and

(D) for accidental death benefits issued in connection with life benefit certificate -- the Inter-Company Double Indemnity Mortality Table or, at the option of the society, the 1959 Accidental Death Benefits Table. Either such table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates.

(2) The minimum standard for the valuation of life insurance and annuity certificates issued on and after January first, nineteen hundred eighty, shall be subject to the requirements and exceptions of section four thousand two hundred seventeen of this chapter, provided that a society may also elect to use the Commissioners 1941 Standard Ordinary Mortality Table or the Commissioners 1961 Standard Industrial Table.

(3) The superintendent may, in his discretion, accept other standards for valuation if he finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The superintendent may, in his discretion, vary the standards of mortality applicable to all

certificates of insurance on substandard lives or other extrahazardous lives by any society authorized to do business in this state. Whenever the mortality experience under all certificates valued on the same mortality table is in excess of the expected mortality according to such table for a period of three consecutive years, the superintendent may require additional reserves when deemed necessary in his judgment on account of such certificates.

(4) Any society, with the consent of the superintendent and under any conditions he may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

(d) Every society shall maintain reserves for all individual accident and health insurance certificates which shall place a sound value on its liabilities under such certificates and which shall not be less than the reserves according to the standards set forth in regulations issued by the superintendent and, in no event, less than the pro rata gross unearned premium reserve for such certificates. Prior to the issuance of any regulation provided for in this subsection the superintendent shall give at least ten days notice thereof to each society licensed to write accident and health insurance in this state, by ordinary mail addressed to its principal place of business, and provide an opportunity for hearing on such proposed action.

(e) All of the foregoing valuations, in any valuation report filed by a society as required by the provisions of this article, shall either be certified by a competent actuary, or, at the request and expense of the society be verified by an actuary of the insurance department of the state, province or country in which the society is domiciled.

(f) Any authorized society which issues certificates or other obligations providing for benefits in case of death or disability resulting solely from accident, or in case of temporary disability resulting from sickness, or hospital expense or surgical and medical expense benefits shall maintain reserves for unearned premiums and for disabled lives in accordance with standards prescribed from time to time by the superintendent, which standards shall conform as nearly as practicable to those required for similar reserves of accident and health insurance companies under the laws of this state.

§ 4518. Amounts credited on life insurance certificates. Any individual life insurance certificate may provide that in addition to any minimum benefits guaranteed in the certificate, additional amounts may be credited to the certificate. No such additional amounts shall be guaranteed or credited except upon reasonable assumptions as to investment income, mortality, persistency and expenses. The declaration of such additional amounts by a society must be made prospectively; no such additional amounts shall be credited retroactively to apply to any period prior to such declaration. No such additional amounts are required to be credited to any certificate with respect to the period after the termination or lapse of such certificate by reason of default in payment of any premium, installment or interest on any certificate loan and before the reinstatement of such certificate, if it is reinstated. Any such additional amounts shall be credited on a basis equitable to all certificate holders of a given class and shall be based on written criteria approved by the board of directors of the society or a committee thereof.

§ 4519. Impairment of reserves and surplus; order to make good deficiency. (a) Whenever the superintendent determines that the admitted assets of an authorized society will be less than the sum of its required reserves, accrued liabilities, and minimum surplus within a period of five years or less, the superintendent may, in his or her discretion, require submission of reports, business plans or other information demonstrating the steps the society is taking to address the deficiency and require that such society take such actions as the superintendent deems necessary and appropriate to maintain the minimum surplus amount, including, but not limited to, prohibiting such society from issuing any new contracts of insurance in this state, and in the case of a domestic society, from issuing any new contracts in this state or elsewhere.

(b)(1) Whenever the superintendent determines that the admitted assets of an authorized society are less than the sum of its required reserves, accrued liabilities, and minimum surplus, he or she shall determine the amount of such deficiency and issue a written requisition to such

society to remove, repair or make good such deficiency within such period as he or she shall designate, not less than thirty days nor more than six months from the service of such requisition, except that if he or she believes the interests of the certificate holders of such society will best be served by extending such period of time, he or she may do so for such period or periods of time as he or she, in his or her discretion deems best. He or she may also prohibit such society, while such deficiency exists, from issuing any new contracts of insurance in this state, and in the case of a domestic society, from issuing any new contracts in this state or elsewhere. If such society shall fail or be unable to make good such deficiency within such period as so extended, the superintendent shall proceed against such society under the provisions of article seventy-four of this chapter on the ground that its further transaction of business will be hazardous to its policyholders, its creditors or the public.

(2) In the event that the superintendent determines that the admitted assets of a domestic society are less than the sum of its required reserves, accrued liabilities, and minimum surplus, the superintendent shall have the power and authority to require that the society merge or otherwise consolidate with another willing authorized society or that the society cede any individual risk or risks, in whole or in part, to a willing society or life insurer.

(c) An authorized society may assess members as described in subsection (g) of section four thousand five hundred four of this article only after such assessment is filed with the superintendent and approved by him or her, or, in the case of a foreign or alien society, after approval of the insurance department of the state of domicile and upon notice to the superintendent. The superintendent shall have the authority to prohibit any foreign or alien society that has assessed its members from issuing any new contracts of insurance in this state.

§ 4520. Non-liability of officers and members. Officers and members of the supreme or any subordinate body of any authorized society shall not be individually liable for the payment of any benefits provided for in the laws and agreements of such society, but the same shall be payable only out of the funds of such society and in the manner provided by its

laws.

§ 4521. Grounds for revocation or suspension of license. The superintendent may revoke or suspend the license to do business in this state of any domestic, foreign or alien society, if, after notice to and hearing of such society in accordance with sections three hundred four, three hundred five and three hundred six of the financial services law, the superintendent finds any one or more of the following grounds therefor:

(a) that such society has exceeded its powers under its charter or under its license to do business;

(b) that such society has failed to comply with any requirement of this chapter applicable thereto;

(c) that such society is conducting its insurance business fraudulently or in a way hazardous to its members, its creditors or the public;

(d) that such society is not carrying out its contracts in good faith; and

(e) in the case of a foreign or alien society, that the society is not conforming in substance to all of the requirements imposed on domestic societies, and in such a case, the revocation may be in addition to, or in lieu of, a proceeding under article seventy-four of this chapter in the circumstances specified in section four thousand five hundred nineteen of this article.

§ 4522. Exemptions of certain organizations. (a) Except as provided in subsection (b) hereof the following societies, corporations, unincorporated associations, and other organizations shall be exempt from the provisions of this chapter requiring the obtaining of a license to do an insurance business and from all other requirements of this chapter except those provided in subsections (c) and (d) hereof and except section three thousand two hundred nine and the provisions of article seventy-four of this chapter:

(1) Organizations of workmen of the same trade or of several allied trades maintained for the purpose of securing by united action the most

favorable conditions as regards wages, hours and conditions of labor, and the protection of their individual rights in the prosecution of their trade or trades.

(2) Organizations which limit their membership to the employees of a particular city or town, or of a designated business corporation or firm, or of one or more business corporations or firms having business interests in common, except as otherwise provided in subsection (f) of section one thousand one hundred eight of this chapter. Any such organization which limits its membership to the employees of a corporation having more than five thousand employees may provide for hospital, surgical and medical benefits for the employee, his or her spouse, and his or her child or children not over eighteen years of age.

(3) Organizations of a religious, charitable, benevolent or fraternal character, which are not organized or maintained primarily for the purpose of providing insurance benefits, and which have not more than fifteen hundred members who are or may be entitled to any insurance benefits unless the organization obligates itself to pay a death benefit of more than five hundred dollars on the death of any one member, or disability benefits of more than three hundred fifty dollars to any one person in any one year, or both.

(4) Organizations which limit their membership to persons engaged in one or more occupations in the same or similar lines of business and which, together with their legal predecessors or affiliated bodies continuously paid or provided for the payment of death or disability benefits to their members for a period of not less than fifteen years prior to January first, nineteen hundred forty.

(5) Any organization of a religious, charitable, benevolent or fraternal character, which is not organized or maintained primarily for the purpose of providing insurance benefits, which have furnished hospital benefits to its members under a plan where the maximum charge for such benefits is not in excess of two dollars per annum and which was in operation for ten years prior to March first, nineteen hundred forty-one, or which obligates itself to pay a death benefit of not more than one hundred dollars on the death of any one member, and has been in operation for more than twenty-five years prior to March first, nineteen hundred fifty.

(6) Organizations which limit their membership to members of a

fraternal benefit society organized under the provisions of this chapter and which provide either cemetery benefits, or funeral benefits not in excess of seventy-five dollars for any one interment, or both, for such member, his or her spouse or his or her child or children not over twenty-one years of age.

(b) The foregoing exemptions shall not apply to:

(1) any organization which is incorporated or organized under the laws of, or has its principal office or headquarters in, any province or country outside of the United States,

(2) any organization, except one specified in paragraph two of subsection (a) hereof, which makes or issues annuity contracts,

(3) any organization of any of the kinds specified in paragraph two, three or five of subsection (a) hereof if it gives or allows, or promises to give or allow, to any person any compensation for procuring new members, or

(4) any subordinate lodge of any society providing insurance benefits to its members.

(c) The superintendent may require from any organization claiming exemption under subsection (a) hereof, by examination in accordance with section three hundred ten of this chapter, or otherwise, such information as will enable him to determine whether such organization is exempt under this section.

(d) No organization of the kinds hereinbefore specified which obligates itself to pay life insurance or accident or health or disability insurance benefits to its members shall make, issue or deliver in this state any certificate or other written evidence of such obligation unless the same shall have conspicuously printed on the first page thereof in bold-faced type not smaller than ten point the following statement: "This organization does not operate under the supervision of the New York State Department of Financial Services."

§ 4523. Soliciting membership in unauthorized societies; penalties. (a) Any person, firm, association or corporation who or which shall solicit a member or members for, or in any way assist in procuring a member or members for, or collect payments or dues for or in connection with the membership of, any fraternal benefit society that is not

licensed to do business in this state and that is not exempted under the provisions of section four thousand five hundred twenty-two of this article shall be guilty of a misdemeanor, and in addition, such person, firm, association or corporation shall be liable to a penalty of one hundred dollars for each person so solicited or so procured to become a member in such unauthorized society, and may in addition to either of the foregoing, be enjoined from doing any such unlawful acts, in the manner specified in section three hundred nine of the financial services law.

(b) The provisions of subsection (a) hereof shall not apply to the conduct of a designated representative acting under the authority of an unlicensed fraternal benefit society which was heretofore licensed to do business in this state and has obtained a certificate from the superintendent authorizing designated representatives to act for such society in the collection of payments or dues from members or perform any act incident to existing membership but not to solicit members or assist in procuring members. The application for such certificate shall be on such form or forms and supplements thereto, and shall contain such information, as the superintendent may prescribe. There shall be attached to such forms a statement by such society stating that such society has satisfied itself that the proposed designated representative is trustworthy and competent to act as such designated representative and that the society will appoint him to act as its designated representative. Such statement shall be subscribed by an officer of such society and affirmed by such officer as true under the penalties of perjury. The superintendent may revoke the superintendent's authorization of any designated representative after notice and hearing and on the grounds enumerated in subsection (a) of section two thousand one hundred ten of this chapter.

§ 4524. Exemption from taxation. Every society organized or licensed under this article is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax, other than taxes on real estate and office equipment.

§ 4525. Application of other provisions of this chapter. Every authorized society shall be subject to the provisions of this article but shall not be subject to other provisions of this chapter except:

(a) those specified in this article as applicable to such societies;

(b) articles one, two, three, thirteen, fourteen, twenty-four, seventy-one and seventy-four;

(c) section one thousand one hundred one, subsections (a) and (g) of section one thousand one hundred two, sections one thousand one hundred three, one thousand one hundred five, one thousand one hundred six, one thousand one hundred eight, one thousand one hundred twelve, paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen, sections one thousand two hundred five, one thousand two hundred twelve, one thousand two hundred seventeen, and one thousand three hundred twenty-two, subsections (a), (b), (d) and (e) of section two thousand one hundred one, subsection (a) of section two thousand one hundred two, subsection (a) and subsections (c) through (m) of section two thousand one hundred three, subsections (a) through (e) of section two thousand one hundred nine, subsections (a), (b) and (d) through (f) of section two thousand one hundred ten, sections two thousand one hundred twelve, two thousand one hundred fourteen and two thousand one hundred sixteen, subsections (a), (b), (c) and (e) through (h) of section two thousand one hundred seventeen, subsections (a) and (c) of section two thousand one hundred twenty, sections two thousand one hundred twenty-two, two thousand one hundred twenty-three, and two thousand one hundred twenty-four, subsection (b) of section two thousand three hundred seven, sections three thousand one hundred three, three thousand one hundred five, three thousand one hundred six, three thousand one hundred ten, three thousand two hundred one, three thousand two hundred two, three thousand two hundred five, three thousand two hundred seven, three thousand two hundred nine through three thousand two hundred twelve, three thousand two hundred fourteen, four thousand two hundred thirteen, four thousand two hundred twenty-six, four thousand two hundred forty-one, seven thousand three hundred one, seven thousand three hundred three and seven thousand three hundred four; and

(d) any other section which specifically applies to fraternal benefit societies.

§ 4526. Investments of fraternal benefit societies. (a) For purposes of investments made pursuant to the provisions of section one thousand four hundred four of this chapter, the term "institution" shall only include a corporation, a joint-stock association, and a business trust and the term "obligations" shall only include bonds, debentures, notes, or other evidences of indebtedness. Notwithstanding the provisions set forth in items (ii) and (iv) of subparagraph (A) of paragraph two of subsection (a) of such section, a society is authorized to invest, in an amount not to exceed thirty-three percent of its admitted assets as shown by its last statement on file with the superintendent, in obligations of American institutions which:

(1) are rated BBB or higher (or the equivalent thereto) by a securities rating agency recognized by the superintendent, or if not so rated, are similar in structure and in all material respects to other obligations of the same institution which are so rated, or

(2) have been given at least the second highest quality designation by the Securities Valuation Office of the National Association of Insurance Commissioners.

(b) Investments in loans secured by real property and investments in real property made pursuant to the provisions of paragraphs four and five of subsection (a) of such section shall be permitted only to the extent that such investments are acquired or held directly by such society.

(c) Foreign investments made pursuant to the provisions of paragraph six of such subsection shall only consist of the following:

(1) Investments in Canada which are substantially of the same kinds, classes and investment grades as those eligible for investment under other provisions of such subsection. The aggregate amount of such investments held at any time shall not exceed the greater of ten percent of the society's admitted assets as shown by its last statement on file with the superintendent or the amount, if any, permitted pursuant to paragraph two hereof.

(2) Investments in a foreign country or in a possession of the United States if the society is authorized to do business therein, or if the society has outstanding insurance, annuity or reinsurance contracts on

lives or risks resident or located therein; provided such investments are substantially of the same kinds, classes and investment grades as those eligible for investment under other provisions of such subsection. The aggregate amount of such investments and of cash in the currency of such country or possession at any time held shall not, except as permitted by paragraph one hereof, exceed the amount which such society is required by law to invest in such country or possession or one and one-half times the amount of its reserves and other obligations under such contracts, whichever is greater.

(3) Investments in any foreign country, in addition to investments permitted under paragraphs one and two hereof, which are substantially of the same kinds, classes and investment grades, and in the same proportions, as those eligible for investment under other provisions of such subsection and subsection (a) of this section. The aggregate amount of such investments made pursuant to this paragraph shall not exceed four percent of the society's admitted assets as shown by its last statement on file with the superintendent and provided that a society shall not make any investment in any foreign country pursuant to this paragraph, if such investment, together with all other investments in the same foreign country so made and then held by such insurer, would exceed one percent of the society's admitted assets as shown by its last statement on file with the superintendent.

(d) Investments in equity interests made pursuant to paragraph eight of such subsection shall be limited to investments in common shares and shall not include investments in partnership interests or other equity interests.

§ 4527. Optional authority and regulation. (a) An authorized fraternal benefit society subject to this article and meeting the requirements of this section may obligate itself for the payment of the following benefits in addition to those authorized in section four thousand five hundred five of this article;

(1) Long term care benefits as defined in subsection (q) of section four thousand five hundred one of this article.

(2) Variable life insurance benefits and variable annuity benefits issued pursuant to separate accounts that are approved by the

superintendent and established in compliance with section four thousand two hundred forty of this chapter, except that item (vi) of subsection (a) of section four thousand two hundred forty of this chapter shall not apply to accounts established under this section.

(3) Annuity benefits as defined in subsection (l) of section four thousand five hundred one of this chapter in amounts exceeding fifteen thousand dollars annually.

(4) Disability income insurance benefits as defined in subsection (p) of section four thousand five hundred one of this article in amounts exceeding one thousand two hundred fifty dollars a month.

(b) In addition to other requirements of this article, an authorized fraternal benefit society obligating itself for the payment of benefits described in this section shall, notwithstanding section four thousand five hundred twenty-five of this article or subsection (g) of section two thousand one hundred three and subsection (b) of section two thousand one hundred thirty-two of this chapter, only retain as agents persons who are licensed pursuant to section two thousand one hundred three of this chapter and who:

(1) take the personal written examination required by subsection (f) of section two thousand one hundred three of this chapter if seeking the original issuance of a license under section two thousand one hundred three of this chapter on or after January first, nineteen hundred ninety-seven; and

(2) comply with the provisions of section two thousand one hundred thirty-two of this chapter regarding agents continuing education for the biennial licensing period beginning on or after January first, nineteen hundred ninety-eight.

§ 4528. New business limitations. Every authorized society shall limit the issuance of new life insurance certificates and new annuity contracts in accordance with requirements for new life insurance policies and new annuity contracts under section four thousand two hundred twenty-seven of this chapter, except that:

(a) No such limitations shall apply to new life insurance certificates or new annuity contracts issued by the society before January first, nineteen hundred ninety-eight; and

(b) Limitations equal to one hundred fifty percent of the limitations established in section four thousand two hundred twenty-seven of this chapter shall apply to new life insurance certificates and new annuity contracts issued by the society after January first, nineteen hundred ninety-eight but before January first, two thousand; and

(c) The limitations established in section four thousand two hundred twenty-seven of this chapter shall fully apply to all new life insurance certificates and all new annuity contracts issued by the society on or after January first, two thousand.

§ 4529. Subsidiaries authorized. (a) A domestic fraternal benefit society may invest in subsidiaries as authorized in article seventeen of this chapter for domestic life insurance companies, provided such society meets the requirements of subsection (b) of section forty-five hundred twenty-seven or section four thousand five hundred thirty of this article.

(b) A domestic fraternal benefit society may create, maintain and operate, or may establish organizations to operate, not-for-profit institutions to provide one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious benefits to members. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in the society's annual statement.

§ 4530. Optional Investment Authority. (a) An authorized society meeting the requirements set forth in this section is authorized to invest its funds in, or otherwise acquire, or loan upon, the types of investments specified in sections one thousand four hundred two, one thousand four hundred three, one thousand four hundred five, one thousand four hundred six, one thousand four hundred ten, and four thousand two hundred forty of this chapter, subject to the limitations contained therein. The provisions of section one thousand four hundred four of this chapter shall not have any application to investments of such societies, except to the extent provided in paragraph four of

subsection (b) of section one thousand four hundred two of this chapter.

(b) In addition to other requirements of this article, an authorized society investing pursuant to this section shall meet the following requirements:

(1) Prior to investing pursuant to this section, the society shall submit notice to the superintendent that the board of directors of the society has approved investment pursuant to this section and that the society meets the requirements of this section and intends to invest hereunder;

(2) The society shall: (A) have been in continuous operation for a minimum of five years; and (B) have total admitted assets of at least two billion dollars for a period of five continuous years as of the immediately preceding calendar year; and

(3) For each calendar year during which this section applies to the society, the society shall have, as of the end of the immediately preceding calendar year:

(A) had a risk based capital level of at least six times authorized control level RBC as defined by the provisions of section one thousand three hundred twenty-two of this chapter; and

(B) maintained a minimum claims-paying, financial strength or equivalent rating from at least one nationally recognized statistical rating organization in one of the organization's three highest rating categories for the time period during which this section applies to the society provided that the rating shall not depend on a guarantee or other credit enhancement from another entity; and shall not be modified or otherwise qualified to show dependence of the rating on the performance or a contractual obligation of, or the society's affiliation with, another society.

(c) Whenever a society fails to meet the requirements set forth in this section, the superintendent may, in his or her discretion, prohibit or limit the society from engaging in new investments under this section.

ARTICLE 46

RETIREMENT SYSTEMS

Section 4601. Definitions.

4602. Creation of retirement systems.
4603. Benefits.
4604. Contributions.
4605. Reinsurance.
4606. Reserves.
4607. Exemption from taxation; trusts; higher education loans.
4608. Application.

§ 4601. Definitions. In this article:

(a) "Employees" means the employees, officers, and agents of any person, firm or corporation or of one or more corporations having business interests in common.

(b) "Employer" means the person, firm, corporation or one or more corporations having business interests in common, and includes any organization of such employers.

(c) "Retirement system" or "system" means a non-profit corporation or trust formed for the purpose of providing pension benefits.

(d) "Pension benefits" means benefits provided by a retirement system for members retiring by reason of age or length of service, or both, and benefits permitted by section four thousand six hundred three of this article.

§ 4602. Creation of retirement systems. (a) The employees, an employer, or the employees and employer jointly, may create a retirement system by filing in the office of the superintendent a declaration of their intention to do so, in a form approved by the superintendent, subscribed and affirmed as true under the penalties of perjury by two provisional trustees or officers of such system, and an authenticated copy of the constitution, by-laws or declaration of trust adopted to regulate the affairs of the system.

(b) Upon such filing the superintendent may, if satisfied that the rates of contribution are adequate and that the plan of operation is sound and equitable, issue a license, subject to the provisions of section one thousand one hundred two of this chapter, authorizing the retirement system to do the business described in the plan.

(c) A system shall have trustees who shall choose officers or agents to carry on the business of the system. The by-laws or declaration of trust of such a system shall prescribe the manner in which and the officers or agents by whom the system may be conducted and the manner in which its funds shall be collected and disbursed.

(d) The funds and investments of a system shall be held independently of the funds and investments of the employer and of any other person. The manner of investment of the funds of a system shall be limited in every respect as in the case of the funds of a domestic life insurance company, except that investments shall be made under section one thousand four hundred four not section one thousand four hundred five of this chapter and shall be subject to the provisions of section one thousand four hundred four of this chapter that relate specially to retirement systems.

(e) A system shall not issue or deliver any certificate or contract providing for or promising to pay any benefit until a copy of its form has been filed with the superintendent and approved by him. Such certificate or contract shall conform to the provisions of this article and, insofar as practicable, to the other provisions of this chapter applicable to similar policies or contracts.

§ 4603. Benefits. (a) A system providing retirement benefits by agreement with an employer may also provide in the same agreement for withdrawal equities and benefits on account of disability or death.

(b) A system may provide pension benefits by entering into agreements with an employer or group of employers having a common retirement plan which has been approved by the superintendent to receive funds which are to be accumulated at interest and, subject to the conditions agreed upon, to apply the accumulated funds to provide pension benefits for the employees of the employer or group of employers as each employee retires.

(c) No agreement shall be entered into with an employer or group of employers having less than twenty-five employees who are eligible for retirement benefits under the agreement.

(d) The accumulation of any funds contributed by an employee shall be used for his exclusive benefit.

§ 4604. Contributions. (a) The participating employees, or the employer, or both may contribute to the funds of the system and the rates of contribution shall be fixed by the trustees upon the basis of actuarial recommendations and shall be adequate to support the benefits granted.

(b) The trustees may, with the approval of the superintendent, increase or decrease the rates of contribution whenever such action is deemed by them necessary to preserve the solvency and equity of the system.

§ 4605. Reinsurance. (a) All or any part of the pension benefits of a system may be reinsured in an insurance company authorized to insure such risks in this state, as may be provided for in the by-laws or declaration of trust of the retirement system.

(b) The reinsurance contract may be terminated by agreement between the reinsurer and the ceding retirement system or a successor and the assets supporting such agreement may be transferred to such system or its successor in one sum or over a period of years in accordance with terms and conditions approved by the superintendent. In such event, the funds transferred in one sum or the present value of sums to be transferred over a period of years shall become an admitted asset of such system or its successor.

§ 4606. Reserves. (a) A system shall, except to the extent that its benefits are reinsured by an insurance company authorized to transact such business in this state, create and maintain reserves, calculated to be adequate to cover the liabilities on account of benefits payable under its contracts, by-laws, or declaration of trust.

(b) The calculation shall be made on the basis of mortality, disability, and other experience tables based on reliable experience for such or a similar group of employees and approved by the superintendent, and of interest at a rate which is approved by the superintendent and is not in excess of the maximum rate permitted to domestic life insurance

companies under section four thousand two hundred seventeen of this chapter for the valuation of group annuities, for all participating employees in the system upon application by the system and a showing that such rate can be supported by the income from the investments of the system.

(c) The reserves required in respect of service rendered or benefits granted prior to the date of organization or creation of such system under this chapter may be accumulated on a basis calculated to produce a balance between the actuarial present value of the assets and of the liabilities of the system within a period of not exceeding thirty years from the date of the incorporation or creation thereunder.

§ 4607. Exemption from taxation; trusts; higher education loans. (a) The property of a system, the portion of wages or salary of an employee deducted or to be deducted, the right of an employee to a pension benefit, and all his rights in the funds of the system, shall be exempt from taxation and from the operation of any law relating to bankruptcy or insolvency, except as provided in section four thousand six hundred eight of this article and subject to the provisions of section three thousand two hundred twelve of this chapter.

(b) No trust created pursuant to this article shall be deemed invalid as violating any existing laws against perpetuities or suspension of the power of alienation of title to property; and the income arising from any property, real or personal, held in such trust may be permitted to accumulate until the fund shall be sufficient in the opinion of its trustee or trustees to accomplish the purposes of such trust.

(c) Any system may lend money to any of its participating employees or their children, who are attending or planning to attend college, to assist them in meeting their expenses of higher education, where such loans are guaranteed by the New York higher education services corporation in accordance with the provisions of article fourteen of the education law. In such cases no further security for the repayment of such loans shall be required of the borrowers by such system.

§ 4608. Application. (a) Every system organized or created under this

chapter shall be subject to the provisions of this article, to subsection (g) of section one thousand one hundred two of this chapter, to the appropriate provisions of articles one, three and seventy-four of this chapter, and to articles thirteen and fourteen of this chapter, insofar as applicable to the assets and investments of a domestic life insurance company, except that the provisions of section one thousand four hundred four (and the provisions therein that relate specially to retirement systems) shall be applicable instead of the provisions of section one thousand four hundred five of this chapter.

(b) Article seventeen of this chapter is applicable to any such system for the purpose of investing in the stock of a domestic life insurance company organized on a restricted plan pursuant to the provisions of subsection (b) of section four thousand two hundred two of this chapter and for investing in or otherwise acquiring subsidiaries of the types described in section one thousand seven hundred four of this chapter.

(c) Section four thousand two hundred forty of this chapter shall be applicable to any such system in which the total present value of benefits provided by the employer for members in active service exceeds fifty million dollars, subject to such modifications in the application of the provisions of such section as the superintendent may prescribe by rules and regulations not inconsistent with the provisions of this chapter, as may be appropriate to carry out the purposes of this article.

ARTICLE 47

MUNICIPAL COOPERATIVE HEALTH BENEFIT PLANS

Section 4701. Legislative findings.
4702. Definitions.
4703. Application for certificate of authority.
4704. Conditions for issuance of certificate of authority.
4705. Municipal cooperation agreements.
4706. Reserve and surplus requirements.
4707. Stop-loss requirements.
4708. Contingent liability.
4709. Plan benefits and disclosure.
4710. Additional filing requirements and annual report.

4711. Examinations.
4712. Suspension or revocation of certificate of authority.
4713. Plan dissolution.
4714. Transition.

§ 4701. Legislative findings. (a) Cooperative health risk-sharing agreements allow public entities to: share, in whole or part, the costs of self-funding employee health benefit plans; provide municipal corporations, school districts and other public employers with an alternative approach to stabilize health claim costs; lower per unit administration costs; and enhance negotiating power with health providers by spreading such costs among a larger pool of risks.

(b) Appropriate safeguards are necessary to help keep self-funded municipal cooperative health benefits plans from exposing municipalities and their taxpayers to unpredictable and potentially catastrophic liabilities. Minimum standards regarding benefits and participation can better assure that self-funded municipal cooperative health benefit plans will continue to act responsibly and provide coverage for high-cost conditions and high-cost individuals.

(c) It is the policy of this state to expand the alternatives available to public employers by permitting the development of municipal cooperative health benefit plans while, at the same time, establishing appropriate standards designed to promote fair competition and sound operation of such plans on an ongoing basis.

(d) It is the legislative intent that the superintendent implement a workable system of authorization and regulation of municipal cooperative health benefit plans in this state, in order to assure that such plans are:

(1) operated on an actuarially sound basis with appropriate financial and other standards to protect plan participants and their beneficiaries as well as local taxpayers; and

(2) not unduly disruptive of the regulated insurance market and public health programs.

§ 4702. Definitions. As used in this article: (a) "Community rating"

means a rating methodology in which the premium equivalent rate for all persons covered under a municipal cooperative health benefit plan is the same, based upon the experience of the entire pool of risks covered under the plan, without regard to age, sex, health status or occupation and such that refunds, rebates, credits or dividends based upon age, sex, health status or occupation are not permitted.

(b) "Fully-insured" means that all benefits payable pursuant to a municipal cooperative health benefit plan are guaranteed under a contract or policy of insurance delivered in this state and issued by an insurance company authorized to do accident and health insurance business in this state, an article forty-three corporation, or a health maintenance organization.

(c) "Governing board" means the group of persons, designated in the municipal cooperation agreement establishing the municipal cooperative health benefit plan, to be responsible for administering the plan.

(d) "Municipal cooperation agreement" means an appropriate cooperative agreement authorized by article five-G of the general municipal law.

(e) "Municipal cooperative health benefit plan" or "plan" means any plan established or maintained by two or more municipal corporations pursuant to a municipal cooperation agreement for the purpose of providing medical, surgical or hospital services to employees or retirees of such municipal corporations and to the dependents of such employees or retirees.

(f) "Municipal corporation" means within the state of New York, a city with a population of less than one million or a county outside the city of New York, town, village, board of cooperative educational services, school district, a public library, as defined in section two hundred fifty-three of the education law, or district, as defined in section one hundred nineteen-n of the general municipal law.

(g) "Plan document" means the group contract issued by the municipal cooperative health benefit plan to participating municipal corporations describing the terms and conditions of coverage.

(h) "Premium equivalent" or "contribution" means the amount contributed by participating municipal corporations to cover expected claims and expenses thereon, required reserves, surplus, stop-loss insurance, and other expenses associated with the operations of the municipal cooperative health benefit plan.

(i) "Qualified actuary" means an actuary who is a member in good standing of the American Academy of Actuaries or Society of Actuaries, with experience in establishing rates for self-insured trusts providing health benefits or other similar experience.

(j) "Summary plan description" means the certificate of coverage or booklet delivered to employees or retirees enrolled in the plan, summarizing the essential terms and conditions of coverage for employees or retirees and their dependents.

§ 4703. Application for certificate of authority. (a) No municipal corporation shall establish, maintain or otherwise participate in a municipal cooperative health benefit plan in this state which provides benefits, in whole or part, on a shared-funding basis, unless the municipal cooperative health benefit plan:

(1) obtains and maintains a certificate of authority from the superintendent pursuant to the provisions of this article; or

(2) is an employee welfare fund, as defined in article forty-four of this chapter that is administered by equal representation of employees and employers; or

(3) is exempt from the requirement of obtaining a license; or

(4) is, and continues to be, a fully-insured municipal cooperative health benefit plan.

(b) The governing board shall file an application for a certificate of authority on such form as the superintendent may prescribe, and shall provide to the satisfaction of the superintendent the following:

(1) a list of every participating municipal corporation, the names, addresses and official titles of the members of the plan's governing board, and name and principal address of the plan's attorney-in-fact designated pursuant to the municipal cooperation agreement;

(2) evidence that the plan's chief fiscal officer is adequately bonded in a manner acceptable to the superintendent, who may accept or consider for this purpose any bond required under the applicable provisions of the education law, general municipal law or public officers law;

(3) a copy of the municipal cooperation agreement and all other documents describing the rights and obligations of the municipal corporations participating in the municipal cooperative health benefit

plan;

(4) a copy of all documents, including the summary plan description, furnished to the participating municipal corporations and their employees or retirees describing plan benefits;

(5) a copy of all agreements between the plan and each service provider, including any contract administrator;

(6) a qualified actuary's opinion, in form and substance satisfactory to the superintendent, accompanied by a memorandum, also in form and substance satisfactory to the superintendent, describing the calculations, assumptions and methodology made in support of such opinion, that the municipal cooperative health benefit plan is actuarially sound and that premium equivalent rates have been established at a level sufficient to maintain reserves as required by section four thousand seven hundred six of this article;

(7) a statement, certified by the governing board, that aggregate and specific stop-loss coverage shall be obtained and maintained, to the extent required by section four thousand seven hundred seven of this article, and a copy of the written commitment, binder or stop-loss policy or policies;

(8) a proposed plan of operation and funding for the municipal cooperative health benefit plan, setting forth:

(A) the current or proposed premium equivalent rates to provide for the payment of all expected obligations, including surplus requirements, under the municipal cooperative health benefit plan for a twelve-month period, taking into account the plan's expected coverage and experience;

(B) a statement of the costs incorporated in such premium equivalent rates, including an itemization of the amounts for claims, administration, stop-loss insurance, reserves, surplus adjustments, and other expenses associated with the operation of the municipal cooperative health benefit plan for the same twelve-month period;

(C) the expected number of employees, retirees, and dependents covered under the municipal cooperative health benefit plan;

(D) claims handling and dispute resolution procedures and timeframes, including the manner in which claim denials can be appealed;

(E) method of selecting service providers, including any contract administrator; and

(F) current and projected financial statements, including statement of

assets, liabilities and surplus, statement of operations (income and expenses), and cash flow statement; and

(9) such other information as may be required by the superintendent.

(c) The superintendent shall have the powers to conduct such investigation as the superintendent may deem necessary and to examine under oath any person interested in or connected with the municipal cooperative health benefit plan.

§ 4704. Conditions for issuance of certificate of authority. (a) The superintendent shall issue a certificate of authority to a municipal cooperative health benefit plan if all of the following conditions, after examination and investigation, have been met to the superintendent's satisfaction:

(1) a complete application has been filed with the superintendent in accordance with section four thousand seven hundred three of this article;

(2) except for any plan that provided medical, surgical and hospital services on or before January first, nineteen hundred ninety-three pursuant to a municipal cooperation agreement, the number of municipal corporations participating in the municipal cooperative health benefit plan shall be at least three;

(3) except for any plan that provided medical, surgical and hospital services to at least three hundred fifty covered employees (including retirees and not including dependents) on or before January first, nineteen hundred ninety-three pursuant to a municipal cooperation agreement, the number of covered employees (including retirees and not including dependents) of municipal corporations participating in the municipal cooperative health benefit plan shall be at least two thousand;

(4) the municipal cooperative health benefit plan is or shall be operated pursuant to a municipal cooperation agreement satisfying the requirements set forth in section four thousand seven hundred five of this article;

(5) the municipal cooperative health benefit plan has within its own organization adequate facilities and competent personnel to service the plan or, in order to provide such services, in whole or part, has

contracted with a contract administrator or other service provider, determined by the governing board to be qualified based upon written documentation furnished to the governing board, provided that such documentation shall be made available to the superintendent upon request;

(6) the municipal cooperative health benefit plan possesses a written commitment, binder or policy for stop-loss insurance issued by an insurance company authorized to do business in this state, to the extent required by section four thousand seven hundred seven of this article;

(7) the municipal cooperative health benefit plan establishes premium equivalent rates sufficient to meet its contractual obligations and to satisfy the reserve and surplus requirements set forth in section four thousand seven hundred six of this article;

(8) the municipal cooperative health benefit plan has established a fair and equitable process for claims review, dispute resolution and appeal procedures including arbitration of rejected claims, and procedures for handling claims for benefits in the event of plan dissolution, which are satisfactory to the superintendent;

(9) the municipal cooperative health benefit plan has delivered to the superintendent such bond, deposit or security for protection of the employees and retirees and their dependents covered by the plan as the superintendent shall require in the event that the plan's chief fiscal officer is not otherwise adequately bonded under the provisions of the education law, general municipal law or public officers law;

(10) the municipal cooperative health benefit plan provides to covered employees and retirees of participating municipal corporations written notice disclosing the information required by section four thousand seven hundred nine of this article; and

(11) all plan documents, including the summary plan description, and amendments thereto, have been filed with and approved by the superintendent in accordance with section four thousand seven hundred nine of this article.

(b) The superintendent shall refuse to grant a certificate of authority to an applicant that fails to meet the requirements of this section. Notice of refusal shall be in writing and shall set forth the basis for the refusal. If the applicant submits a written request within thirty days after receipt of the notice of refusal, the superintendent

shall promptly conduct a hearing to give the applicant the opportunity to show cause why the refusal should not be made final.

(c) After any municipal cooperative health benefit plan receives a certificate of authority, it may be joined by additional municipal corporations that execute a municipal cooperation agreement identical with the instruments in effect at that time and which the other participating municipal corporations have executed.

§ 4705. Municipal cooperation agreements. (a) The municipal cooperation agreement, under which the municipal cooperative health benefit plan is established and maintained, and any amendment thereto, shall be approved by each participating municipal corporation by majority vote of each such corporation's governing body, and shall:

(1) specify all municipal corporations participating in the municipal cooperative health benefit plan and describe the form or type of municipal corporations eligible for participation;

(2) state that all participating municipal corporations agree to share the costs of and assume the liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan to the covered employees (including retirees) and their dependents of all participating municipal corporations;

(3) state that each participating municipal corporation agrees to pay on demand such municipal corporation's share of any assessment ordered by the governing board of the municipal cooperative health benefit plan or by the superintendent under this article or article seventy-four of this chapter;

(4) specify the eligibility requirements for membership in and coverage by the municipal cooperative health benefit plan, including reasonable geographic boundaries (if any) of such plan, provided that no municipal cooperation agreement shall include any provision restricting or otherwise limiting the right to participate in the plan of a municipal corporation of the same type which provides satisfactory proof of its financial responsibility and which is located within the geographic region in which the municipal cooperative health benefit plan operates;

(5) not include any provision restricting or otherwise limiting the

right of eligible employees (including retirees and dependents) of a participating municipal corporation to enroll for coverage in the plan;

(6) designate the fiscal officer of a participating municipal corporation to be the chief fiscal officer of the municipal cooperative health benefit plan;

(7) designate the plan's attorney-in-fact to receive service of summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving such municipal cooperative health benefit plan; and

(8) establish a governing board to be responsible for the management, control and administration of the municipal cooperative health benefit plan, provided any municipal cooperative agreement to establish such a plan which is entered into after the effective date of this article shall provide that unions which are the exclusive collective bargaining representatives of employees who are covered by such health benefit plan shall be entitled to representation on such governing board.

(b) The municipal cooperation agreement shall provide that the plan's chief fiscal officer:

(1) shall have custody of all moneys received by the municipal cooperative health benefit plan or made available for expenditure under the plan;

(2) shall, notwithstanding any provision of the general municipal law, make payment in accordance with procedures developed by the plan's governing board and acceptable to the superintendent;

(3) may invest moneys not required for immediate expenditure in the types of investment specified in the general municipal law or the education law (as applicable) for temporary investments or as otherwise expressly permitted by the superintendent; and

(4) shall receive no remuneration, except that the participating municipal corporation employing the chief fiscal officer may be reimbursed for reasonable expenses incurred in connection with the duties of such fiscal officer in connection with the plan.

(c) A municipal cooperation agreement shall include a provision:

(1) describing the composition, number and procedures under which governing board members are chosen, provided that, for those agreements entered into after the effective date of this article, the governing board shall include representation by unions which are the exclusive

collective bargaining representatives of employees covered by the plan, and that such unions shall establish and agree to the procedures by which the member or members of the governing board which represent unions are selected;

(2) designating one governing board member to have custody of all reports, statements and other documents of the plan; and

(3) that the governing board shall meet at least annually at a time and place in this state designated in accordance with the agreement.

(d) The municipal cooperation agreement shall provide that the governing board:

(1) shall design the plan of benefits provided by the municipal cooperative health benefit plan and prepare the plan document and summary plan description in accordance with section four thousand seven hundred nine of this article;

(2) may enter into an agreement with a contract administrator or other service provider, determined by the governing board to be qualified, to receive, investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that:

(A) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts as required in subdivision six of section ninety-two-a of the general municipal law;

(B) payment for contracted services shall be made only after such services are rendered;

(C) no member of the plan's governing board or any member of such member's immediate family shall be an owner, officer, director, partner, or employee of any contract administrator retained by the plan; and

(D) all such agreements shall comply with the requirements of subdivision six of section ninety-two-a of the general municipal law.

(3) shall be authorized to purchase stop-loss insurance, to the extent required by section four thousand seven hundred seven of this article, on behalf of the municipal cooperative health benefit plan;

(4) shall be authorized to establish a joint fund or funds to finance all plan expenditures, including claims, reserves, surplus, administration, stop-loss insurance and other expenses;

(5) shall prepare an annual budget for the municipal cooperative

health benefit plan to determine the premium equivalent rates for participating municipal corporations to be deposited in the plan's joint fund or funds during the fiscal year, provided that:

(A) the governing board shall designate the bank or trust company in which joint funds, including reserve funds, are to be deposited and which shall be located in this state, duly chartered under federal law or the laws of this state; and

(B) the governing board shall establish premium equivalent rates for participating municipal corporations on the bases of a community rating methodology filed with and approved by the superintendent and, in determining the annual premium equivalent rates, the governing board:

(i) may contract for necessary actuarial services to estimate expected plan expenditures during the fiscal year;

(ii) shall maintain reserves in amounts equal to or exceeding the minimum amounts required by section four thousand seven hundred six of this article; and

(iii) shall maintain a stop-loss policy or policies, to the extent required by section four thousand seven hundred seven of this article;

(6) shall be authorized to assess participating municipal corporations for additional contributions, if actual losses due to benefits paid out, administrative expenses and reserve and surplus requirements exceed amounts held in the plan's joint funds; and

(7) shall be authorized to refund amounts in excess of reserves and surplus required by section four thousand seven hundred six of this article and anticipated expenses in the plan's joint funds to participating municipal corporations, or to retain such excess amounts or a portion thereof and apply such amounts in preparing the plan's budget for the following year.

(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of employees covered by the plan and to the superintendent:

(1) an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan;

(2) an annual report and quarterly reports describing the plan's current financial status; and

(3) an annual independent actuarial opinion on the financial soundness of the plan, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current year and projected for the next fiscal year.

(f) The municipal cooperation agreement shall specify the rights and obligations of a municipal corporation withdrawing from a municipal cooperative health benefit plan to any contribution (or premium equivalent) refund or reserve fund or for any contingent assessment liability or other obligation.

(g) Every municipal cooperation agreement shall contain a provision stating that nothing contained in such agreement shall be construed to waive any right a covered person possesses with respect to the confidentiality of medical records and that such right may only be waived upon the written consent of such covered person.

§ 4706. Reserve and surplus requirements. (a) Notwithstanding any provision of law, the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan's chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(1) a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate;

(2) a reserve for unearned premium equivalents;

(3) a claim stabilization reserve;

(4) a reserve for other obligations of the municipal cooperative health benefit plan; and

(5) a surplus account, established and maintained for the sole purpose of satisfying unexpected obligations of the municipal cooperative health benefit plan in the event of termination or abandonment of the plan,

which shall not be less than:

(A) five percent of the annualized earned premium equivalents during the current fiscal year of a municipal cooperative health benefit plan which consists of five or more participating municipal corporations and covers two thousand or more employees and retirees; or

(B) seven percent of the annualized earned premium equivalents during the current fiscal year of the municipal cooperative health benefit plan which consists of four or fewer participating municipal corporations or covers fewer than two thousand employees and retirees.

(b) The moneys in the plan's reserve funds and surplus account shall be deposited in one or more banks or trust companies designated by the governing board in accordance with the municipal cooperation agreement, in one or more separate segregated accounts, subject to investment in obligations specified in the general municipal law or education law (as applicable) for investment of moneys in reserve funds or as otherwise expressly permitted by the superintendent. Any such bank or trust company shall be located in this state and shall be duly chartered pursuant to federal law or the laws of this state. Any interest earned or capital gain realized on the money so deposited or invested shall accrue to and become part of the plan's reserve funds or surplus account, as applicable.

(c) The plan's chief fiscal officer shall account for the plan's reserve funds separate and apart from all other funds of the municipal cooperative health benefit plan, and such accounting shall show:

(1) the purpose, source, date and amount of each sum paid into the fund;

(2) the interest earned by such funds;

(3) capital gains or losses resulting from the sale of investments of the plan's reserve funds;

(4) the order, purpose, date and amount of each payment from the reserve fund; and

(5) the assets of the fund, indicating cash balance and schedule of investments.

(d) The plan's chief fiscal officer, within ninety days of the end of each fiscal year, shall furnish a detailed report of the operations and condition of the plan's reserve funds to the governing board.

(e) An expenditure from the plan's reserve funds shall be made only

for the payment of benefits and other obligations of the municipal cooperative health benefit plan or expenses incurred in administering such plan.

(f) If the municipal cooperative health benefit plan ceases to provide plan benefits on a shared-funding basis, the moneys remaining in the plan's reserve funds not needed to satisfy plan liabilities incurred prior to such cessation shall be disposed of in the manner provided in the municipal cooperation agreement.

(g) If a municipal corporation withdraws from a municipal cooperative health benefit plan operating under a certificate of authority, the governing board shall, in accordance with the municipal cooperation agreement, determine the amount, if any, of the plan's reserve funds attributable to such municipal corporation, after considering all plan liabilities, and dispose of such amount in the manner provided in the municipal cooperation agreement.

§ 4707. Stop-loss requirements. (a) The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:

(1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; and

(2) specific stop-loss coverage with a specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current fiscal year.

(b) Upon application of the governing board, the superintendent may waive the requirement for the stop-loss insurance, in whole or part, or modify the maximum retention amounts or attachment points for stop-loss insurance, provided that:

(1) the plan maintains reserves and surplus equal to or greater than one hundred fifty percent of the amounts specified in paragraphs one and five of subsection (a) of section four thousand seven hundred six of this article; or

(2) the superintendent is satisfied that such waiver or modification of retention amounts or attachment points would not be detrimental to the plan's solvency and stability, after considering such factors as availability and affordability of stop-loss insurance, the plan's past and expected experience, plan size, reserves, surplus, and premium equivalent rates, and the contingent liability of participating municipal corporations.

(c) As an alternative to suspension or revocation pursuant to section four thousand seven hundred twelve of this article, the superintendent may reduce the aggregate or specific stop-loss retention amounts or attachment points specified in subsection (a) of this section for any municipal cooperative health benefit plan that fails to maintain required reserves and surplus.

§ 4708. Contingent liability. (a) The municipal cooperation agreement and the plan document delivered to each participating municipal corporation shall provide that every municipal corporation participating in the municipal cooperative health benefit plan shall be liable in the event of an order issued pursuant to subsection (b) of this section for an assessment, in addition to the amount of premium equivalent paid or payable.

(b) If the municipal cooperative health benefit plan does not have admitted assets, as defined in section one hundred seven of this chapter, at least equal to the aggregate of its liabilities, reserves and minimum surplus required by this article, the governing board of such plan shall, within thirty days thereafter, order an assessment for the amount that will provide sufficient funds to remove such impairment and collect from each municipal corporation a pro rata share of such assessed amount.

(c) Every municipal corporation that participated in the municipal cooperative health benefit plan at any time during the two-year period prior to the issuing of an assessment order by the plan's governing board shall, if notified of such assessment, pay its pro rata share of such assessment within ninety days after the issuance of that assessment order.

(d) A municipal corporation's pro rata share of any assessment shall

be determined by applying the ratio of the total assessment to the total contributions or premium equivalents earned during the period covered by the assessment on all municipal corporations subject to assessment to the contribution or premium equivalent earned during such period attributable to such municipal corporation.

(e) The contingent liability of municipal corporations for additional premium equivalents or assessments shall not be included as an asset in the financial statements of the municipal cooperative health benefit plan.

§ 4709. Plan benefits and disclosure. (a) The governing board of the municipal cooperative health benefit plan shall deliver or cause to be delivered the plan document to all participating municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the plan and the summary plan description to every employee or retiree of participating municipal corporations covered by the plan.

(b) The summary plan description shall be subject to regulation as if it were a health insurance subscriber certificate, provided that the superintendent may modify or suspend any provision of this chapter or regulation promulgated thereunder pertaining to scope or type of coverage, if the superintendent determines:

(1) such provision of this chapter or regulation to be inappropriate for municipal cooperative health benefit plans;

(2) such modification or suspension not to be prejudicial to the interests of covered employees, retirees or dependents; and

(3) such modification or suspension not to be destructive of competition.

(c) Conspicuously printed on the first page of the plan document and summary plan description, in at least ten point bold-face type, shall be the following statement:

"This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of financial services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability."

§ 4710. Additional filing requirements and annual report. (a) The governing board of the municipal cooperative health benefit plan shall:

(1) file for approval with the superintendent a description of material changes in any information provided in the application for certificate of authority in the form and manner prescribed by the superintendent;

(2) annually, not later than one hundred twenty days after the close of the plan year, file a report with the superintendent showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) as of the end of the preceding plan year, in such form and providing such other information as the superintendent may prescribe and in compliance with section three hundred seven of this chapter; and

(3) file a report each quarter with the superintendent describing the plan's current financial status and providing such information as the superintendent may prescribe.

(b) The plan's annual report shall be furnished to all municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the municipal cooperative health benefit plan and shall be made available for inspection by any employee or retiree covered under the plan.

§ 4711. Examinations. (a) The superintendent may examine the affairs of a municipal cooperative health benefit plan as often as deemed necessary, but not less than once in every three years, except that the superintendent may extend the three-year interval to no more than five years upon determining that the three-year requirement is not necessary to safeguard the interests of the public or covered persons.

(b) In connection with such examinations, the superintendent may exercise the powers set forth in sections three hundred six, three hundred eight, three hundred ten, three hundred eleven, and three hundred twelve of this chapter and subsection (f) of section two hundred six and sections three hundred five and three hundred six of the financial services law, and may also require special reports from a

municipal cooperative health benefit plan as specified in section three hundred eight of this chapter.

(c) The governing board of every municipal cooperative health benefit plan shall be responsible for the maintenance of accurate records and books of account in regard to the plan.

§ 4712. Suspension or revocation of certificate of authority. (a) The superintendent may suspend or revoke a certificate of authority issued to a municipal cooperative health benefit plan under the following circumstances:

(1) for any cause that would be a basis for denial of an initial application for such a certificate, provided that the superintendent shall not suspend or revoke such certificate solely due to the size or composition of the plan unless the plan ceases to cover a minimum of three hundred fifty employees and retirees; or

(2) failure to maintain the reserves and surplus required by section four thousand seven hundred six of this article, provided that the superintendent shall not suspend or revoke such certificate if the plan has implemented a remediation plan acceptable to the superintendent; or

(3) the superintendent finds that the municipal cooperative health benefit plan has refused to produce its accounts, records, and files for examination or any member of the governing board of the municipal cooperative health benefit plan has refused to cooperate or give information with respect to the affairs of the plan or to perform any other legal obligation relating to such an examination when required by the superintendent.

(b) In the case of suspension or revocation of a certificate of authority, the superintendent shall send a copy of such decision to the governing board of the municipal cooperative health benefit plan by certified mail at the plan's address. Upon the request of the governing board, or any party that would be prejudiced by the suspension or revocation, filed within sixty days of the mailing of the superintendent's decision, the superintendent shall schedule a hearing on such decision by written notice, sent by certified mail to the governing board or party requesting the hearing. Such notice shall set forth a specific date, time and place for the hearing, which shall

commence within sixty days of the mailing of the notice.

(c) Any certificate of authority suspended or revoked under this section shall be surrendered to the superintendent, and the plan's governing board shall notify all participating municipal corporations of that decision in such form and manner as the superintendent may prescribe, not later than ten days after receipt of notice of the superintendent's decision requiring suspension or revocation.

(d) The superintendent shall publish all final decisions to suspend or revoke the certificate of authority in regard to a municipal cooperative health benefit plan.

§ 4713. Plan dissolution. (a) In any case in which the governing board of a municipal cooperative health benefit plan determines that there is reason to believe that the plan will terminate, the governing board shall so inform the superintendent and submit a plan for the superintendent's approval for winding up the plan's affairs in an orderly manner designed to result in timely payment of all benefits, in such form and manner as the superintendent may prescribe.

(b) No part of any funds of the municipal cooperative health benefit plan shall be subject to the claims of general creditors of any participating municipal corporation until all plan benefits and other plan obligations have been satisfied.

(c) The superintendent may maintain a proceeding under article seventy-four of this chapter to rehabilitate or liquidate the business of a municipal cooperative health benefit plan, which shall be considered an insurer for such purpose under section seven thousand four hundred one of this chapter.

§ 4714. Transition. For municipal cooperative health benefit plans that provided medical, surgical or hospital services on or before January first, nineteen hundred ninety-three pursuant to a municipal cooperation agreement authorized under article five-G of the general municipal law, the reserve and surplus requirements in section four thousand seven hundred six of this article may be phased in over a period of up to five plan years, provided that:

(a) the amount for the reserve described in paragraph one of subsection (a) of section four thousand seven hundred six of this article:

(1) at the end of the first plan year on or after the effective date of this article shall not be less than twelve percent of expected incurred claims and expenses thereon for such plan year; and

(2) at the end of each subsequent plan year during the phase-in period shall not be less than the actual percentage amount in the previous year, plus an amount equal to the difference between such actual percentage amount and the percentage amount otherwise required under section four thousand seven hundred six of this article, divided by the number of years remaining in the phase-in period;

(b) the amount of surplus:

(1) at the end of the first plan year on or after the effective date of this article shall not be less than two percent of the annualized earned premium equivalents during such plan year; and

(2) at the end of each subsequent plan year shall not be less than the actual percentage amount in the previous plan year, plus an amount equal to the difference between such actual percentage amount and the percentage otherwise required under section four thousand seven hundred six of this article, divided by the number of years remaining in the phase-in period; and

(c) the superintendent may reduce the aggregate or specific stop-loss retention amounts or attachment points, referred to in section four thousand seven hundred seven of this article, during the phase-in period for any municipal cooperative health benefit plan which consists of fewer than five municipal corporations or which covers less than two thousand employees and retirees.

ARTICLE 48

MANAGED CARE HEALTH INSURANCE CONTRACTS

Section 4801. Application.
4802. Grievance procedure.
4803. Health care professional applications and terminations.
4804. Access to specialty care.
4805. Access to end of life care.

4806. Health care facility applications.

§ 4801. Application. The provisions of this article shall apply to all managed care products, as defined in subsection (c) of this section, which are delivered or issued for delivery in this state by insurers licensed under this chapter; provided, however, that none of the provisions of this article shall apply to any health maintenance organization lines of business of such insurers or to health maintenance organizations certified under article forty-four of the public health law or licensed under article forty-three of this chapter, which are subject to the provisions of article forty-four of the public health law. For purposes of this article:

(a) an "insured" shall mean a person covered under a managed care health insurance contract.

(b) an "insurer" shall mean an insurance company subject to article thirty-two of this chapter, or a corporation subject to article forty-three of this chapter.

(c) a "managed care health insurance contract" or "managed care product" shall mean a contract which requires that all 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 designated health care provider chosen by the insured (i.e. a primary care gatekeeper), 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, in the case of (i) an individual health insurance contract, or (ii) a group health insurance contract covering no more than three hundred lives, imposing a coinsurance obligation of more than twenty-five percent upon services received outside of the insurer's provider network, and which has been sold to five or more groups, a managed care product shall also mean a contract which requires that all 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 designated health care provider chosen by the insured (i.e. a primary care gatekeeper), 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.

(d) "in-network benefits" shall mean benefits covered and received under a managed care product from a health care provider participating in the insurer's managed care provider network pursuant to a referral from the insured's participating primary care gatekeeper.

§ 4802. Grievance procedure. (a) An insurer which offers a managed care product shall establish and maintain a grievance procedure with regard to such managed care product. Pursuant to such procedure, insureds shall be entitled to seek a review of determinations by the insurer with regard to such managed care product, other than determinations subject to the provisions of article forty-nine of this chapter.

(b) (1) An insurer shall provide to all insureds written notice of the grievance procedure in the contract and at any time that the insurer denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an insurer denies a service as an adverse determination as defined in article forty-nine of this chapter, the insurer shall inform the insured or the insured's designee of the appeal rights provided for in article forty-nine of this chapter.

(2) The notice to an insured describing the grievance process shall explain:

(i) the process for filing a grievance with the insurer;

(ii) the timeframes within which a grievance determination must be made; and

(iii) the right of an insured to designate a representative to file a grievance on behalf of the insured.

(3) The insurer shall assure that the grievance procedure is reasonably accessible to those who do not speak English.

(c) (1) The insurer may require an insured to file a grievance in writing, by letter or by a grievance form which shall be made available by the insurer, and which shall conform to applicable standards for readability.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, an insured may submit an oral grievance in connection with (i) a denial of, or failure to pay for, a referral; or (ii) a determination as to whether a benefit is covered pursuant to the terms of the insured's contract. In connection with the submission of an oral grievance, an insurer may require that the insured sign a written acknowledgment of the grievance, prepared by the insurer summarizing the nature of the grievance. Such acknowledgment shall be mailed promptly to the insured, who shall sign and return the acknowledgment, with any amendments, in order to initiate the grievance. The grievance acknowledgment shall prominently state that the insured must sign and return the acknowledgment to initiate the grievance. If an insurer does not require such a signed acknowledgment, an oral grievance shall be initiated at the time of the telephone call.

(3) Upon receipt of a grievance, the insurer shall provide notice specifying what information must be provided to the insurer in order to render a decision on the grievance.

(4) (i) An insurer shall designate personnel to accept the filing of an insured's grievance by toll-free telephone no less than forty hours per week during normal business hours and, shall have a telephone system available to take calls during other than normal business hours and shall respond to all such calls no less than one business day after the call was recorded.

(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, an insurer may, in the alternative, designate personnel to accept the filing of an insured's grievance by toll-free telephone no less than forty hours per week during normal business hours and, in the case of grievances subject to subparagraph (1) of subsection (d) of this section, on a twenty-four hour a day, seven day a week basis.

(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(1) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's

health;

(2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and

(3) forty-five days after the receipt of all necessary information in all other instances.

(e) The insurer shall designate one or more qualified personnel to review the grievance; provided further, that when the grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals.

(f) The notice of a determination of the grievance shall be made in writing to the insured or to the insured's designee. In the case of a determination made in conformance with subparagraph (1) of subsection (d) of this section, notice shall be made by telephone directly to the insured with written notice to follow within three business days.

(g) The notice of a determination shall include:

(1) the detailed reasons for the determination;

(2) in cases where the determination has a clinical basis, the clinical rationale for the determination; and

(3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.

(h) An insured or an insured's designee shall have not less than sixty business days after receipt of notice of the grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by the insurer.

(i) Within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the insurer to respond to the appeal and what additional information, if any, must be provided in order for the insurer to render a decision.

(j) The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who

made the grievance determination.

(k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:

(1) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health; and

(2) thirty business days after the receipt of all necessary information in all other instances.

(l) The notice of a determination on an appeal shall include:

(1) the detailed reasons for the determination; and

(2) in cases where the determination has a clinical basis, the clinical rationale for the determination.

(m) An insurer shall not retaliate or take any discriminatory action against an insured because an insured has filed a grievance or appeal.

(n) An insurer shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the insured's acknowledgment of the grievance, if any; the determination made by the insurer including the date of the determination, and the titles and, in the case of a clinical determination, the credentials of the insurer's personnel who reviewed the grievance. If an insured files an appeal of the grievance, the file shall include the date and a copy of the insured's appeal, the determination made by the insurer including the date of the determination and the titles and, in the case of clinical determinations, the credentials of the insurer's personnel who reviewed the appeal.

(o) An insurer shall have procedures for obtaining an insured's, or insured's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the superintendent. Written and telephone notification to an insured or the insured's designee under this section may be provided by electronic means where the insured or the insured's designee has informed the insurer in advance of a preference to receive such notifications by electronic means. An insurer shall permit the insured and the insured's designee to change the preference at any time. The insurer shall retain documentation of preferred notification methods and

present such records to the superintendent upon request.

(p) The rights and remedies conferred in this article upon insureds shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.

§ 4803. Health care professional applications and terminations. (a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to: (A) whether he or she is credentialed; or (B) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(2) If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state, who joins a group practice of health care professionals each of whom participates in the in-network portion of an insurer's network, is neither approved nor declined within sixty days of submission of a completed application pursuant to paragraph one of this subsection, such health care professional shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network;

provided, however, that a provisionally credentialed physician may not be designated as an insured's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the sixtieth day of receipt of the completed application and shall last until the final credentialing determination is made by the insurer. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the insurer in writing that, should the application ultimately be denied, the health care professional or the group practice: (A) shall refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the insured's contract with the insurer; and (B) shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of this chapter shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent an insurer from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. An insurer shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

(3) A newly-licensed physician, a physician who has recently relocated to this state from another state and has not previously practiced in this state, or a physician who has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which such physician's services are billed for and who previously had a participation contract with the insurer immediately prior to the event that changed his or her corporate relationship, who becomes employed by a general hospital or diagnostic and treatment center licensed pursuant to article twenty-eight of the public health law, or a facility licensed under article sixteen, article

thirty-one or article thirty-two of the mental hygiene law which has a participating provider contract with an insurer, and whose other employed physicians participate in the in-network portion of an insurer's network, shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network during this time period upon: (A) the insurer's receipt of the hospital and physician's completed sections of the insurer's credentialing application; and (B) the insurer being notified in writing that the health care professional has been granted hospital privileges pursuant to the requirements of section twenty-eight hundred five-k of the public health law. However, a provisionally credentialed physician shall not be designated as an insured's primary care physician until such time as the physician has been fully credentialed by the insurer. Notwithstanding any other provision of law, an insurer shall not be required to make any payments to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the service provided by a provisionally credentialed physician, until and unless the physician is fully credentialed by the insurer, provided, however, that upon being fully credentialed, the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall be paid for all services provided by the physician for up to sixty days after submission of the completed application that the credentialed physician provided to the insurer's subscribers or members from the date the physician fully met the requirements to be provisionally credentialed pursuant to this paragraph. Should the application ultimately be denied by the insurer, the insurer shall not be liable for any payment to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the services provided by the provisionally credentialed health care professional that exceeds any out-of-network benefits payable under the insured's contract with the insurer; and the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall not pursue

reimbursement from the insured, except to collect the copayment or coinsurance or deductible amount that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network.

(b) (1) An insurer shall not terminate a contract with a health care professional for participation in the in-network benefits portion of the insurer's network for a managed care product unless the insurer provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(2) The notice of the proposed contract termination provided by the insurer to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by the insurer;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing or review; and

(iv) a time limit for a hearing date which must be held within not less than thirty days after the date of receipt of a request for a hearing.

(3) The hearing panel shall be comprised of three persons appointed by the insurer. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(4) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the insurer, provisional reinstatement subject to conditions set forth by the insurer or termination of the health care professional. Such decision shall be provided in writing to

the health care professional.

(5) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of subsection (e) of section four thousand eight hundred four shall apply to such termination.

(6) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

(c) Either party to a contract for participation in the in-network benefits portion of an insurer's network for a managed care product may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

(d) An insurer shall develop and implement policies and procedures to ensure that health care providers participating in the the in-network benefits portion of an insurer's network for a managed care product are regularly informed of information maintained by the insurer to evaluate the performance or practice of the health care professional. The insurer shall consult with health care professionals in developing methodologies to collect and analyze provider profiling data. Insurers shall provide any such information and profiling data and analysis to these health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of such a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each such health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the professional's profile and to work cooperatively with the insurer to improve performance.

(e) No insurer shall terminate or refuse to renew a contract for participation in the in-network benefits portion of an insurer's network

for a managed care product solely because the health care professional has (1) advocated on behalf of an insured; (2) has filed a complaint against the insurer; (3) has appealed a decision of the insurer; (4) provided information or filed a report pursuant to section forty-four hundred six-c of the public health law; or (5) requested a hearing or review pursuant to this section.

(f) Except as provided herein, no contract or agreement between an insurer and a health care professional for participation in the in-network benefits portion of an insurer's network for a managed care product shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination and the opportunity for a hearing concerning such termination.

(g) Any contract provision in violation of this section shall be deemed to be void and unenforceable.

(h) For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

§ 4804. Access to specialty care. (a) If an insurer offering a managed care product determines that it does not have a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, the insurer shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the non-participating provider and the insured or the insured's designee, at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

(b) An insurer offering a managed care product shall have a procedure by which an insured enrolled in such managed care product who needs ongoing care from a specialist may receive a standing referral to such specialist. If the insurer, or the primary care provider in consultation with the insurer and the specialist, determines that such a standing referral is appropriate, the insurer shall make such a referral to a specialist. In no event shall an insurer be required to permit an insured to elect to have a non-participating specialist, except pursuant

to the provisions of subsection (a) of this section. Such referral shall be pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the specialist, and the insured or the insured's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(c) An insurer shall have a procedure by which a new insured upon enrollment in a managed care product, or an insured in a managed care product upon diagnosis, with (1) a life-threatening condition or disease or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer, or primary care provider in consultation with the insurer and the specialist, if any, determines that the insured's care would most appropriately be coordinated by such a specialist, the insurer shall refer the insured to such specialist. In no event shall an insurer be required to permit an insured to elect to have a non-participating specialist, except pursuant to the provisions of subsection (a) of this section. Such referral shall be pursuant to a treatment plan approved by the insurer, in consultation with the primary care provider if appropriate, the specialist, and the insured or the insured's designee. Such specialist shall be permitted to treat the insured without a referral from the insured's primary care provider and may authorize such referrals, procedures, tests and other medical services as the insured's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If an insurer refers an insured to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

(d) An insurer offering a managed care product shall have a procedure by which an insured enrolled in such managed care product with (1) a life-threatening condition or disease or (2) a degenerative and

disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the insurer, or the primary care provider or the specialist designated pursuant to subsection (c) of this section, in consultation with the insurer, determines that the insured's care would most appropriately be provided by such a specialty care center, the insurer shall refer the insured to such center. In no event shall an insurer be required to permit an insured to elect to have a non-participating speciality care center, unless the insurer does not have an appropriate specialty care center to treat the insured's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the insurer, in consultation with the primary care provider, if any, or a specialist designated pursuant to subsection (c) of this section, and the insured or the insured's designee. If an insurer refers an insured to a specialty care center that does not participate in the insurer's managed care provider network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network. For purposes of this subsection, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(e) (1) If an insured's health care provider leaves the insurer's in-network benefits portion of its network of providers for a managed care product for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph one of subsection (b) of section forty-eight hundred three of this chapter, the insurer shall provide written notice to the insured of the provider's disaffiliation and permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of: (A) ninety days from the later of the date of the notice to the insured of the provider's disaffiliation from the

insurer's network or the effective date of the provider's disaffiliation from the insurer's network; or (B) if the insured is pregnant at the time of the provider's disaffiliation, the duration of the pregnancy and post-partum care directly related to the delivery.

(2) During the transitional period the health care provider shall: (A) continue to accept reimbursement from the insurer at the rates applicable prior to the start of the transitional period, and continue to accept the in-network cost-sharing from the insured, if any, as payment in full; (B) adhere to the insurer's quality assurance requirements and provide to the insurer necessary medical information related to such care; and (C) otherwise adhere to the insurer's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer.

* (f) If a new insured whose health care provider is not a member of the insurer's in-network benefits portion of the provider network enrolls in the managed care product, the insurer shall permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of up to sixty days from the effective date of enrollment, if (1) the insured has a life-threatening disease or condition or a degenerative and disabling disease or condition or (2) the insured has entered the second trimester of pregnancy at the time of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an insured elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the insurer for the transitional period only if the health care provider agrees (A) to accept reimbursement from the insurer at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the insurer's network for such services; (B) to adhere to the insurer's quality assurance requirements and agrees to provide to the insurer necessary medical information related to such care; and (C) to otherwise adhere to the insurer's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer. In no event shall this

subsection be construed to require an insurer to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the insured's contract.

* NB Effective until January 1, 2027

* (f) If a new insured whose health care provider is not a member of the insurer's in-network benefits portion of the provider network enrolls in the managed care product, the insurer shall permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of up to ninety days from the effective date of enrollment. If the insured is pregnant at the time of enrollment, the transitional period shall include the provision of care for the duration of the pregnancy and postpartum care directly related to the delivery. If an insured elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the insurer for the transitional period only if the health care provider agrees: (A) to accept reimbursement from the insurer at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the insurer's network for such services; (B) to adhere to the insurer's quality assurance requirements and agrees to provide to the insurer necessary medical information related to such care; and (C) to otherwise adhere to the insurer's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer. In no event shall this subsection be construed to require an insurer to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the insured's contract.

* NB Effective January 1, 2027

§ 4805. Access to end of life care. (a) Every contract issued by an insurer that provides coverage for hospital, surgical or medical care that includes coverage for acute care services shall provide coverage for an insured diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by

the patient's attending health care practitioner) for acute care services at an acute care facility licensed pursuant to article twenty-eight of the public health law specializing in the treatment of terminally ill patients if the patient's attending health care practitioner, in consultation with the medical director of the facility determines that the insured's care would appropriately be provided by such a facility.

(b) Notwithstanding the provisions of article forty-nine of this chapter, if the insurer disagrees with the admission of or provision or continuation of care for the insured by the facility, the insurer shall initiate an expedited external appeal in accordance with the provisions of paragraph three of subsection (b) of section four thousand nine hundred fourteen of this chapter, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by the insurer and the insurer shall provide coverage and reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the insured's contract. The decision of the external appeal agent shall be binding on all parties. If the insurer does not initiate an expedited external appeal the insurer shall reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the insured's contract.

(c) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the facility. In the absence of agreed upon rates, an insurer shall pay for acute care at the facility's acute care rate under the Medicare program (Title XVIII of the federal Social Security Act), including the Part A rate for Part A services and the Part B rate for Part B services, and shall pay for alternate level care days at seventy-five percent of the acute care rate, including the Part A rate for Part A services and the Part B rate for Part B services.

(d) Payment by an insurer pursuant to this section shall be payment in full for the services provided to the insured. An acute care facility reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an insured for the services provided by the acute care facility pursuant to this section,

except for the collection of copayments, coinsurance or visit fees, or deductibles for which the insured is responsible under the terms of the applicable contract.

(e) No provision of this section shall be construed to require an insurer to provide coverage for benefits not otherwise covered under the insured's contract.

§ 4806. Health care facility applications. (a) An insurer that offers a managed care product shall, upon request, make available and disclose to facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified facilities in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the facility's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a facility's completed application to participate in the insurer's network, shall notify the facility as to: (1) whether the facility is credentialed; or (2) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(b) For the purposes of this section, "facility" shall mean a health care provider that is licensed or certified pursuant to article five, twenty-eight, thirty-six, forty, forty-four, or forty-seven of the public health law or article sixteen, nineteen, thirty-one, thirty-two, or thirty-six of the mental hygiene law.

ARTICLE 49
UTILIZATION REVIEW AND EXTERNAL APPEAL

Title I. Registration of agents and review process (§§ 4900-4909).
II. Right to external appeal (§§ 4910-4917).

TITLE I

REGISTRATION OF AGENTS AND REVIEW PROCESS

Section 4900. Definitions.
4901. Reporting requirements for utilization review agents.
4902. Utilization review program standards.
4903. Utilization review determinations.
4904. Appeal of adverse determinations by utilization review agents.
4905. Required and prohibited practices.
4906. Waiver.
4907. Rights and remedies.
4908. Applicability to ERISA Plans.
4909. Site of service clinical review.

§ 4900. Definitions. For purposes of this article:

(a) "Adverse determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

(b) "Clinical peer reviewer" means:

(1) for purposes of section four thousand nine hundred three of this article:

(A) a physician who possesses a current and valid non-restricted license to practice medicine; or

(B) a health care professional other than a licensed physician who:

(i) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(ii) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review;

or

* (C) for purposes of a determination involving substance use disorder treatment:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or

* NB Effective until January 1, 2027

* (C) for purposes of a determination involving substance-related and addictive disorder treatment:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or

* NB Effective January 1, 2027

(D) for purposes of a determination involving treatment for a mental health condition:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of

mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(2) for purposes of section four thousand nine hundred four and title two of this article:

(A) a physician who:

(i) possesses a current and valid non-restricted license to practice medicine;

(ii) where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(iii) for purposes of title two of this article, has been practicing in such area of specialty for a period of at least five years;

* (iv) for purposes of a determination involving substance use disorder treatment, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment;

* NB Effective until January 1, 2027

* (iv) for purposes of a determination involving substance-related and addictive disorder treatment, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment;

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(v) for purposes of a determination involving treatment for a mental health condition, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; and

(vi) is knowledgeable about the health care service or treatment under appeal; or

(B) a health care professional other than a licensed physician who:

(i) where applicable, possesses a current and valid non-restricted license, certificate or registration;

(ii) where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(iii) for purposes of title two of this article, has been practicing in such area of specialty for a period of at least five years;

* (iv) for purposes of a determination involving substance use disorder treatment, specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

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* (iv) for purposes of a determination involving substance-related and addictive disorder treatment, specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

* NB Effective January 1, 2027

(v) for purposes of a determination involving treatment for a mental health condition, specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

(vi) is knowledgeable about the health care service or treatment under appeal; and

(vii) where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine.

(3) Nothing in this subsection shall be construed to change any

statutorily-defined scope of practice.

(b-1) "Clinical standards" means those guidelines and standards set forth in the utilization review plan by the utilization review agent whose adverse determination is under appeal or, in the case of medically fragile children those guidelines and standards as required by section three thousand two hundred seventeen-j and four thousand three hundred six-i of this chapter.

(b-2) "Clinical trial" means a peer-reviewed study plan which has been:

(1) reviewed and approved by a qualified institutional review board, and

(2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

As used in this subsection, the term "cooperative groups" means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups; and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups, the NCI Community Clinical Oncology Program (CCOP), the AIDS Clinical Trials Groups (ACTG), and the Community Programs for Clinical Research in AIDS (CPCRA).

* (b-3) "Disabling condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's attending physician, is consistent with the definition of "disabled person" pursuant to subdivision five of section two hundred eight of the social services law.

* NB Effective until January 1, 2027

* (b-3) "Chronic health condition" means a condition that is expected to last for at least one year and requires ongoing treatment to effectively manage the condition or prevent an adverse health event.

* NB Effective January 1, 2027

* (b-4) "Disabling condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's attending physician, is consistent with the definition of "disabled person" pursuant to subdivision five of section two hundred eight of the social services law.

* NB Effective January 1, 2027

(c) "Emergency condition" means a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (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; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(d) "Insured" means a person subject to utilization review.

(d-1) "Experimental and investigational treatment review plan" means:

(1) a description of the process for developing the written clinical review criteria used in rendering an experimental and investigational treatment review determination; and

(2) a description of the qualifications and experience of the clinical peers who developed the criteria, who are responsible for periodic evaluation of the criteria, and who use the written clinical review criteria in the process of reviewing proposed experimental and investigational health services and procedures.

(d-2) "External appeal" means an appeal conducted by an external appeal agent, pursuant to section four thousand nine hundred fourteen of this article.

(d-3) "External appeal agent" means an entity certified by the superintendent pursuant to section four thousand nine hundred eleven of this article.

(d-4) "Final adverse determination" means an adverse determination which has been upheld by a utilization review agent with respect to a

proposed health care service following a standard appeal, or an expedited appeal where applicable, pursuant to section four thousand nine hundred four of this title.

(d-5) "Health care plan" means an insurer subject to article thirty-two or forty-three of this chapter, or any organization licensed under article forty-three of this chapter.

(e) (1) For purposes of this title and for appeals requested pursuant to paragraph one of subsection (b) of section four thousand nine hundred ten of title two of this article, "health care service" means:

(A) health care procedures, treatments or services

(i) provided by a facility licensed pursuant to article twenty-eight, thirty-six, forty-four or forty-seven of the public health law or pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law; or

(ii) provided by a health care professional; and

(B) the provision of pharmaceutical products or services or durable medical equipment.

(2) For purposes of appeals requested pursuant to paragraph two of subsection (b) of section four thousand nine hundred ten of title two of this article, "health care services" shall mean experimental or investigational procedures, treatments or services, including:

(A) services provided within a clinical trial, and

(B) the provision of a pharmaceutical product pursuant to prescription by the enrollee's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the federal Food and Drug Administration;

to the extent that coverage for such services are prohibited by law from being excluded under the plan.

Provided that nothing in this subsection shall be construed to define what are covered services pursuant to a subscriber contract or governmental health benefit program.

(f) "Health care professional" means an appropriately licensed, registered or certified health care professional pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

(g) "Health care provider" means a health care professional or a

facility licensed pursuant to article twenty-eight, thirty-six, forty-four or forty-seven of the public health law or a facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law.

(g-1) "Life-threatening condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's attending physician, has a high probability of causing the enrollee's death.

(g-2) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

(g-3) "Material financial affiliation" means any financial interest of more than five percent of total annual revenue or total annual income of an external appeal agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any external appeal. The term "material financial affiliation" shall not include revenue received from a health care plan by (1) an external appeal agent to conduct an external appeal pursuant to section four thousand nine hundred fourteen of title two of this article, or (2) a clinical peer reviewer for health services rendered to enrollees.

(g-4) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent organization.

(g-5) "Medical and scientific evidence" means the following sources:

(1) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and

MEDLARS database Health Services Technology Assessment Research;

(3) peer-reviewed abstracts accepted for presentation at major medical association meetings;

(4) peer-reviewed literature shall not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer;

(5) medical journals recognized by the secretary of Health and Human Services, under section 1861 (t)(2) of the federal Social Security Act;

(6) the following standard reference compendia:

(A) the American Hospital Formulary Service - Drug Information;

(B) the National Comprehensive Cancer Network's Drugs and Biologics Compendium;

(C) the American Dental Association Accepted Dental Therapeutics;

(D) Thomson Micromedex DrugDex;

(E) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal;

(7) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(g-6) "Out-of-network denial" means a denial under a managed care product as defined in subsection (c) of section four thousand eight hundred one of this chapter of a request for pre-authorization to receive a particular health service from an out-of-network provider on the basis that such out-of-network health service is not materially different than the health service available in-network. The notice of an out-of-network denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network denial pursuant to subsection (a-1) of section four thousand nine hundred four of this article. An out-of-network denial

under this subsection does not constitute an adverse determination as defined in this article. Notwithstanding any other provision of this subsection, an out-of-network denial shall not be construed to include a denial for a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by the insured.

(g-6-a) "Out-of-network referral denial" means a denial under a managed care product as defined in subsection (c) of section four thousand eight hundred one of this chapter of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial pursuant to subsection (a-2) of section four thousand nine hundred four of this article. An out-of-network referral denial under this subsection does not constitute an adverse determination as defined in this article. An out-of-network referral denial shall not be construed to include an out-of-network denial as defined in subsection (g-6) of this section.

(g-7) "Rare disease" means a condition or disease that (1)(A) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (B) affects fewer than two hundred thousand United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the insured's treating physician, shall certify in writing that the condition is a rare disease as defined in this subsection. The certifying physician shall be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the insured's rare disease. The certification shall provide either: (1) that the insured's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (2) that the insured's rare

disease affects fewer than two hundred thousand United States residents per year. The certification shall rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the insured than the requested health service or procedure and the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure. The certifying physician shall disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of denial of a rare disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, an insured or insured's designee shall also submit such approval as part of the external appeal application.

(g-8) "Step therapy protocol override determination" means a determination made by a utilization review agent as defined in subsection (i) of this section to override a step therapy protocol pursuant to subsections (c-1), (c-2) and (c-3) of section forty-nine hundred three of this title granting coverage for the health care professional's selected prescription drug or drugs. Any step therapy override determination as defined by this subsection shall be eligible for appeal by an insured pursuant to this article.

(g-9) "Step therapy protocol" means a policy, protocol or program established by a utilization review agent as defined in subsection (i) of this section that establishes the specific sequence in which prescription drugs for a specified medical condition are approved for a particular insured. Nothing in this chapter shall impair or prevent an insured from having the right to appeal pursuant to this article relating to the imposition of a step therapy protocol.

(h) "Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purposes of this article none of the

following shall be considered utilization review:

(1) Denials based on failure to obtain health care services from a designated or approved health care provider as required under a contract;

(2) Where any determination is rendered pursuant to subdivision three-a of section twenty-eight hundred seven-c of the public health law;

(3) The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure;

(4) Any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination; and

(5) Any determination of any coverage issues other than whether health care services are or were medically necessary.

(i) "Utilization review agent" means any insurer subject to article thirty-two or forty-three of this chapter and any municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter performing utilization review and any independent utilization review agent performing utilization review under contract with such insurer or municipal cooperative health benefit plan.

(j) "Utilization review plan" means: (1) a description of the process for developing the written clinical review criteria; (2) a description of the types of written clinical information which the plan might consider in its clinical review, including a set of specific written clinical review criteria; (3) a description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity, which, in the case of medically fragile children, shall incorporate the standards required by sections three thousand two hundred seventeen-j and four thousand three hundred six-i of this chapter; (4) the procedures for scheduled review and evaluation of the written clinical review criteria; and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of utilization review.

§ 4901. Reporting requirements for utilization review agents. (a) Every utilization review agent shall biennially report to the superintendent of financial services, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.

(b) Such report shall contain a description of the following:

(1) The utilization review plan;

(2) Those circumstances, if any, under which utilization review may be delegated to a utilization review program conducted by a facility licensed pursuant to article twenty-eight of the public health law or pursuant to article thirty-one of the mental hygiene law;

(3) The provisions by which an insured, the insured's designee, or a health care provider may seek reconsideration of or appeal from adverse determinations by the utilization review agent, in accordance with the provisions of this title, including provisions to ensure a timely appeal and that an insured, the insured's designee, and, in the case of an adverse determination involving a retrospective determination, the insured's health care provider is informed of their right to appeal adverse determinations;

(4) Procedures by which a decision on a request for utilization review for services requiring preauthorization shall comply with timeframes established pursuant to this title;

(5) A description of an emergency care policy, which shall include the procedures under which an emergency admission shall be made or emergency treatment shall be given;

(6) A description of the personnel utilized to conduct utilization review including a description of the circumstances under which utilization review may be conducted by:

(i) administrative personnel;

(ii) health care professionals who are not clinical peer reviewers; and

(iii) clinical peer reviewers;

(7) A description of the mechanisms employed to assure that administrative personnel are trained in the principles and procedures of intake screening and data collection and are appropriately monitored by

a licensed health care professional while performing an administrative review;

(8) A description of the mechanisms employed to assure that health care professionals conducting utilization review are:

(i) appropriately licensed, registered or certified; and

(ii) trained in the principles, procedures and standards of such utilization review agent.

(9) A description of the mechanisms employed to assure that only a clinical peer reviewer shall render an adverse determination;

(10) Provisions to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subsection (a) of section four thousand nine hundred three of this title or an expedited appeal filed pursuant to subsection (b) of section four thousand nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(11) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical and treatment records are followed;

(12) A copy of the materials to be disclosed to an insured or prospective insured pursuant to sections three thousand two hundred seventeen-a or four thousand three hundred twenty-four of this chapter, whichever is applicable, and this title;

(13) A description of the mechanisms employed by the utilization review agent to assure that all subcontractors, subvendors, agents or employees affiliated by contract or otherwise with such utilization

review agent will adhere to the standards and requirements of this title; and

(c) The clinical review criteria and standards contained within the utilization review plan shall not be subject to disclosure pursuant to the provisions of article six of the public officers law.

§ 4902. Utilization review program standards. (a) Each utilization review agent shall adhere to utilization review program standards consistent with the provisions of this title which shall, at a minimum, include:

(1) Appointment of a medical director, who is a licensed physician; provided, however, that the utilization review agent may appoint a clinical director when the utilization review performed is for a discrete category of health care service and provided further that the clinical director is a licensed health care professional who typically manages the category of service. Responsibilities of the medical director, or, where appropriate, the clinical director, shall include, but not be limited to, the supervision and oversight of the utilization review process;

(2) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to insureds and health care providers a written description of such procedures including procedures to appeal an adverse determination together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such appeals;

(3) Utilization of written clinical review criteria developed pursuant to a utilization review plan;

(4) Establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization reviews and determinations are conducted within the timeframes established herein; procedures to notify an insured, an insured's designee and/or an insured's health care provider of adverse

determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the insured;

(5) (i) Establishment of a written procedure to assure that the notice of an adverse determination includes:

(A) the reasons for the determination including the clinical rationale, if any;

(B) instructions on how to initiate standard and expedited appeals pursuant to section four thousand nine hundred four of this article and an external appeal pursuant to section four thousand nine hundred fourteen of this article; (C) notice of the availability, upon request of the insured or the insured's designee, of the clinical review criteria relied upon to make such determination;

(D) what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on appeal; and

(E) for an adverse determination related to a step therapy protocol override determination, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the utilization review agent.

(ii) A utilization review agent may provide a notice of an adverse determination related to a step therapy protocol override determination electronically pursuant to subsection (i) of section four thousand nine hundred three of this title, including by electronic mail or through the health care plan's member portal and provider portal. An electronic notice of such an adverse determination may meet the requirements of clause (E) of subparagraph (i) of this paragraph by linking to information posted on the website of the health care plan;

(6) Establishment of a requirement that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone

calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subsection (a) of section four thousand nine hundred three of this title or an expedited appeal filed pursuant to subsection (b) of section four thousand nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(7) Establishment of appropriate policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(8) Establishment of a requirement that emergency services rendered to an insured shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.

* (9) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

* NB Effective until January 1, 2027

* (9) When conducting utilization review for purposes of determining health care coverage for substance-related and addictive disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an

evidence-based and peer reviewed clinical tool designated by the office of addiction services and supports that is consistent with the treatment service levels within the office of addiction services and supports system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

* NB Effective January 1, 2027

10. When establishing a step therapy protocol, a utilization review agent shall utilize recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses when establishing the clinical review criteria.

11. When conducting utilization review for a step therapy protocol override determination, a utilization review agent shall utilize, in addition to any other requirements of this article, recognized evidence-based and peer reviewed clinical review criteria that is appropriate for the insured and the insured's medical condition.

(12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

(13) Establishment of a requirement that emergency department and inpatient hospital services rendered by a general hospital certified pursuant to article twenty-eight of the public health law to an insured to treat COVID-19 during a declared state disaster emergency related to COVID-19 shall not be denied on retrospective review on the basis that such services were not medically necessary.

(14) The superintendent, in consultation with the commissioner of health, may, as necessary, promulgate by regulation special considerations and processes for utilization review related to medically

fragile children. Such regulations may include, at a minimum, considerations and processes related to:

(i) medically necessary covered services to medically fragile children;

(ii) determinations specific to the needs of medically fragile children;

(iii) stabilization and discharge plans; and

(iv) payment for the care of medically fragile children.

(15) When establishing a step therapy protocol, a utilization review agent shall ensure that the protocol cannot:

(i) require a prescription drug that has not been approved by the United States Food and Drug Administration for the medical condition being treated or is not supported by current evidence-based guidelines for the medical condition being treated;

(ii) require an insured to try and fail on more than two drugs used to treat the same medical condition or disease before providing coverage to the insured for the prescribed drug;

(iii) require the use of a step therapy-required drug for longer than thirty days or a duration of treatment supported by current evidence-based treatment guidelines appropriate to the specific disease state being treated;

(iv) be imposed on an insured if a therapeutic equivalent to the prescribed drug is not available, or if the health care plan has documentation that it has covered the drug for the insured within the past three hundred sixty-five days;

(v) require a newly enrolled insured to repeat a step therapy protocol for a prescribed drug where that insured already completed a step therapy protocol for that drug under a prior health care plan, so long as the enrollee or provider submits information demonstrating completion of a step therapy protocol of the prior health care plan within the past three hundred sixty-five days; and

(vi) be imposed on an insured for a prescribed drug that was previously approved for coverage by the insured's current health care plan for a specific medical condition after the insured's current health care plan implements a formulary change or utilization management that impacts the coverage criteria for the prescribed drug until the approved override expires, unless a specifically identified and current

evidence-based safety concern exists and a different therapeutic alternative drug exists.

(16) When establishing a step therapy protocol, a utilization review agent shall ensure that the protocol accepts any written or electronic attestation submitted by the insured's health care professional, as defined in section four thousand nine hundred of this title, who prescribed the drug and stating that a required drug has failed, as evidence that the required drug has failed.

(b) Each utilization review agent shall assure adherence to the requirements stated in subsection (a) of this section by all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent.

§ 4903. Utilization review determinations. (a) Utilization review shall be conducted by:

(1) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;

(2) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and

(3) A clinical peer reviewer where the review involves an adverse determination.

(b) (1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the

insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

* (2) With regard to individual or group contracts authorized pursuant to article thirty-two, forty-three or forty-seven of this chapter or article forty-four of the public health law, for utilization and review determinations involving proposed mental health and/or substance use disorder services where the insured or the insured's designee has, in a format prescribed by the superintendent, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the insured or the insured's designee by telephone within seventy-two hours of receipt of the request. Written notice of the determination to the insured or insured's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective until January 1, 2027

* (2) With regard to individual or group contracts authorized pursuant to article thirty-two, forty-three or forty-seven of this chapter or article forty-four of the public health law, for utilization and review determinations involving proposed mental health and/or substance-related and addictive disorder services where the insured or the insured's designee has, in a format prescribed by the superintendent, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the insured or the insured's designee by telephone

within seventy-two hours of receipt of the request. Written notice of the determination to the insured or insured's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective January 1, 2027

* (c) (1) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance use disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance use disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(2) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(3) Provided that a request for inpatient treatment for substance use disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance use disorder treatment while a

determination by the utilization review agent is pending.

* NB Effective until January 1, 2027

* (c) (1) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance-related and addictive disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance-related and addictive disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(2) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(3) Provided that a request for inpatient treatment for substance-related and addictive disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance-related and addictive disorder treatment while a determination by the utilization review agent is pending.

* NB Effective January 1, 2027

(c-1) A utilization review agent shall grant a step therapy protocol override determination within seventy-two hours of the receipt of information that includes supporting rationale and documentation from a health care professional which demonstrates that:

(1) The required prescription drug or drugs is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the insured;

(2) The required prescription drug or drugs is expected to be ineffective based on the known clinical history and conditions of the insured and the insured's prescription drug regimen;

(3) The insured has tried the required prescription drug or drugs while under their current or a previous health insurance or health benefit plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action and such prescription drug or drugs was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(4) The insured is stable on a prescription drug or drugs selected by their health care professional for the medical condition under consideration, provided that this shall not prevent a utilization review agent from requiring an insured to try an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug or drugs; or

(5) The required prescription drug or drugs is not in the best interest of the insured because it will likely cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care, will likely worsen a comorbid condition of the insured, or will likely decrease the covered individual's ability to achieve or maintain reasonable functional ability in performing daily activities.

(c-2) For an insured with a medical condition that places the health of the insured in serious jeopardy without the prescription drug or drugs prescribed by the insured's health care professional, the step therapy protocol override determination shall be granted within twenty-four hours of the receipt of information that includes supporting rationale and documentation from a health care professional demonstrating one or more of the standards provided for in subsection (c-1) of this section.

(c-3) Upon a determination that the step therapy protocol should be overridden, the health care plan shall authorize immediate coverage for the prescription drug prescribed by the insured's treating health care professional. Any approval of a step therapy protocol override determination request shall be honored until the lesser of either treatment duration based on current evidence-based treatment guidelines or twelve months following the date of the approval of the request or renewal of the insured's coverage.

(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.

(e) (1) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(i) the reasons for the determination including the clinical rationale, if any;

(ii) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article;

(iii) notice of the availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal; and

(iv) for an adverse determination related to a step therapy protocol override request, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the utilization review agent.

(2) A utilization review agent may provide notice of an adverse determination related to a step therapy protocol override determination electronically pursuant to subsection (i) of this section, including by electronic mail or through the health care plan's member portal and provider portal. An electronic notice of such an adverse determination may meet the requirements of subparagraph (iv) of paragraph one of this subsection by linking to information posted on the website of the health

care plan.

(f) In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the request and shall be conducted by the insured's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, the utilization review agent shall provide notice as required pursuant to subsection (e) of this section. Nothing in this section shall preclude the insured from initiating an appeal from an adverse determination.

(g) Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to section four thousand nine hundred four of this title, provided, however, that failure to meet such time periods for a step therapy protocol as defined in subsection (g-9) of section forty-nine hundred of this title or a step therapy protocol override determination pursuant to subsections (c-1), (c-2) and (c-3) of this section shall be deemed to be an override of the step therapy protocol. A utilization review agent's failure to comply with any of the step therapy protocol requirements required in paragraphs fifteen and sixteen of subsection (a) of section four thousand nine hundred two of this title shall be considered a basis for granting an override of the step therapy protocol, absent fraud.

(h) The superintendent, in conjunction with the commissioner of health, shall develop standards for prior authorization requests to be utilized by all health care plans for the purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits under this article. The department and the department of health, in development of the standards, shall take into consideration existing electronic prior authorization standards including National Council for Prescription Drug Programs (NCPDP)

electronic prior authorization standard transactions.

(i) A utilization review agent shall have procedures for obtaining an insured's, or insured's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the superintendent. Written and telephone notification to an insured or the insured's designee under this section may be provided by electronic means where the insured or the insured's designee has informed the utilization review agent in advance of a preference to receive such notifications by electronic means. A utilization review agent shall permit the insured and the insured's designee to change the preference at any time. To the extent practicable, such written and telephone notification to the insured's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the superintendent upon request.

§ 4904. Appeal of adverse determinations by utilization review agents. (a) An insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, may appeal an adverse determination rendered by a utilization review agent.

(a-1) An insured or the insured's designee may appeal an out-of-network denial by a health care plan by submitting: (1) a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health services sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and (2) two documents from the available medical and scientific evidence, that the out-of-network health service is likely to be more clinically beneficial to the insured than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

(a-2) An insured or the insured's designee may appeal an out-of-network referral denial by a health care plan by submitting a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, provided that: (1) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and (2) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service.

* (b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this title; (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination; or (3) potential court-ordered mental health and/or substance use disorder services pursuant to paragraph two of subsection (b) of section four thousand nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party

may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. Provided that the insured or the insured's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective until January 1, 2027

* (b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this title; (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination; or (3) potential court-ordered mental health and/or substance-related and addictive disorder services pursuant to paragraph two of subsection (b) of section four thousand nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance-related and addictive disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, expedited

appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. Provided that the insured or the insured's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance-related and addictive disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance-related and addictive disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective January 1, 2027

(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse decision, shall comply with subsection (a) of section three thousand two hundred twenty-four-a of this chapter as applicable. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination.

The notice of the appeal determination shall include:

(1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include

the clinical rationale for such determination; and

(2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals. A utilization review agent shall have procedures for obtaining an insured's, or insured's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the superintendent. Written and telephone notification to an insured or the insured's designee under this section may be provided by electronic means where the insured or the insured's designee has informed the insurer in advance of a preference to receive such notifications by electronic means. A utilization review agent shall permit the insured and the insured's designee to change the preference at any time. To the extent practicable, written and telephone notification to the insured's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the superintendent upon request.

(d) Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

(e) Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

§ 4905. Required and prohibited practices. (a) Each utilization review agent shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(1) kept confidential in accordance with applicable state and federal laws; and

(2) shared only with the insured, the insured's designee, the insured's health care provider and those who are authorized by law to

receive such information.

(b) Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients.

(c) Any health care professional who makes determinations regarding the medical necessity of health care services during the course of utilization review shall be appropriately licensed, registered or certified.

(d) A utilization review agent shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

(1) either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

(2) any other method that encourages the rendering of an adverse determination.

(e) If a health care service has been specifically preauthorized or approved for an insured by a utilization review agent, a utilization review agent shall not pursuant to retrospective review revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the insured, during the same course of treatment.

* (f) Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary.

* NB Effective until January 1, 2027

* (f) Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary provided, however, that utilization review shall not be conducted more than once per year for an outpatient course of treatment for a chronic health condition starting from the date of a pre-authorization approval for the course of treatment unless the insured's attending provider recommends a change to the course of treatment, then utilization review may be conducted for the new course of treatment. Any new treatment, testing or procedures related to the specific medical problem, condition, or illness being managed but not already included in the approved course of treatment may be subject to a separate pre-authorization.

* NB Effective January 1, 2027

(g) When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively.

(h) In no event shall information be obtained from the health care providers for the use of the utilization review agent by persons other than health care professionals, medical record technologists or administrative personnel who have received appropriate training.

(i) The utilization review agent shall not undertake utilization review at the site of the provision of health care services unless the utilization review agent:

(1) Identifies himself or herself by name and the name of his or her organization, including displaying photographic identification which includes the name of the utilization review agent and clearly identifies the individual as representative of the utilization review agent;

(2) Whenever possible, schedules review at least one business day in advance with the appropriate health care provider;

(3) If requested by a health care provider, assures that the on-site review staff register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from the health care provider; and

(4) Obtains consent from the insured or the insured's designee before interviewing the patient's family, or observing any health care service being provided to the insured.

(5) This subsection shall not apply to health care professionals engaged in providing care or case management or making on-site discharge decisions.

(j) A utilization review agent shall not base an adverse determination

on a refusal to consent to observing any health care service.

(k) A utilization review agent shall not base an adverse determination on lack of reasonable access to a health care provider's medical or treatment records unless the utilization review agent has provided reasonable notice to the insured, the insured's designee or the insured's health care provider, in which case the insured must be notified, and has complied with all provisions of subsection (i) of this section.

(l) Neither the utilization review agent nor the entity for which the agent provides utilization review shall take any action with respect to a patient or a health care provider that is intended to penalize such insured, the insured's designee, or the insured's health care provider for, or to discourage such insured, the insured's designee, or the insured's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination.

(m) In no event shall an insured, an insured's designee, an insured's health care provider, any other health care provider, or any other person or entity be required to inform or contact the utilization review agent prior to the provision of emergency care, including emergency treatment or emergency admission.

(n) No contract or agreement between a utilization review agent and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the utilization review agent as opposed to the health care provider.

(o) A health care professional providing health care services to an insured shall be prohibited from serving as the clinical peer reviewer for such insured in connection with the health care services being provided to the insured.

§ 4906. Waiver. (a) Any agreement which purports to waive, limit, disclaim, or in any way diminish the rights set forth in this article, except as provided pursuant to section four thousand nine hundred ten of this article shall be void as contrary to public policy.

(b) Notwithstanding subsection (a) of this section, in lieu of the external appeal process as set forth in this article, a health care plan

and a facility licensed pursuant to article twenty-eight of the public health law may agree to an alternative dispute resolution mechanism to resolve disputes otherwise subject to this article.

§ 4907. Rights and remedies. The rights and remedies conferred in this article upon insureds and health care providers shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.

§ 4908. Applicability to ERISA Plans. Notwithstanding the foregoing, the provisions of this article shall not apply to any utilization review conducted by, or on behalf of, a self-insured employee welfare benefit plan, as defined in the employee retirement income security act of 1974, as amended.

§ 4909. Site of service clinical review. (a) For purposes of this section:

(1) "Free-standing ambulatory surgical center" shall mean a diagnostic and treatment center authorized pursuant to article twenty-eight of the public health law and operated independently from a hospital.

(2) "Health care plan" shall mean an insurer, a corporation organized pursuant to article forty-three of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, and a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract or that arranges for care and services for members under a contract with the department of health with a network of health care providers and utilizes site of service clinical review to determine coverage for services delivered by network participating providers.

(3) "Hospital-based outpatient clinic" shall mean a clinic authorized pursuant to article twenty-eight of the public health law and listed on a hospital's operating certificate.

(4) "Site of service clinical review" shall mean clinical criteria applied by a health care plan for the purpose of determining whether non-urgent outpatient medical procedures and surgeries will be covered for a given insured or enrollee when rendered by a network participating provider at a hospital-based outpatient clinic rather than a free-standing ambulatory surgical center.

(b) Site of service clinical review shall be deemed utilization review in accordance with and subject to the requirements and protections of this article and article forty-nine of the public health law, including the right to internal and external appeal of denials related to site of service clinical review.

(c) Site of service clinical review shall consider the insured's health and safety, choice of health care provider, and timely access to care and shall not be based solely on cost.

(d) A health care plan that utilizes site of service clinical review that is intended to direct insureds and enrollees to free-standing ambulatory surgical centers shall be able to demonstrate to the department or, as applicable, to the department of health, that it has an adequate network of free-standing ambulatory surgical center providers to meet the health needs of insureds and enrollees and to provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. Such network shall be in compliance with network adequacy standards established by the superintendent and section three thousand two hundred forty-one of this chapter.

(e) Except as provided in subsection (g) of this section, starting January first, two thousand twenty-four, a health care plan that utilizes a site of service clinical review shall deliver a notice disclosing and clearly explaining the site of service clinical review to:

(1) policyholders, contract holders, insureds, and enrollees and prospective policyholders, contract holders, insureds, and enrollees at the time of plan and policy or contract selection and at least ninety days prior to the implementation of new site of service clinical review or modification of existing site of service clinical review. Such notice shall include the specific services under the site of service review policy, a statement that site of service clinical review may limit the

settings in which services covered under the policy or contract may be provided and render a network participating provider unable to perform a service; shall disclose to insureds or enrollees any quality or cost differential, including differences in out-of-pocket costs, between the hospital-based outpatient clinic and the free-standing ambulatory surgical center when services at a hospital-based outpatient clinic are requested; and shall set forth any rights the insured or enrollee may have to obtain the service at a hospital-based outpatient clinic through a utilization review appeal. Notifications shall also be made at any other time upon the insured's or enrollee's request;

(2) network participating providers at least ninety days prior to implementation. A health care plan shall also inform providers of the process for requesting coverage of a service in a hospital-based outpatient clinic setting, including the right to request a real time clinical peer to peer discussion as part of the authorization process; and

(3) the superintendent and, as applicable, to the commissioner of health, at least forty-five days prior to notifying policyholders, contract holders, insureds and enrollees and prospective policyholders, contract holders, insureds and enrollees and network participating providers in accordance with this subsection. Such notice to the superintendent and, as applicable, to the commissioner of health, shall include (A) draft communications to the foregoing persons for purposes of complying with this subsection and (B) an explanation of how the site of service clinical review selected by the health care plan complies with this article and article forty-nine of the public health law.

(f) A health care plan's provider directory shall explain that even though a provider is participating in the network, a site of service clinical review may affect where services will need to be obtained and whether the provider will be available to provide such service, as applicable.

(g) A health care plan that has implemented site of service clinical review prior to January first, two thousand twenty-four that is not in compliance with this section shall revise such site of service clinical review to comply with this section and deliver the notices required under subsection (e) of this section at the beginning of the open enrollment period for individual health insurance policies and

contracts, and for group health insurance policies and contracts, prior to January first, two thousand twenty-four.

(h) Starting January first, two thousand twenty-four, at a minimum, a health care plan shall approve a request for authorization for a service covered under the policy or contract and requested to be performed by a network participating provider at a hospital-based outpatient clinic in the following situations:

(1) the procedure cannot be safely performed in a free-standing ambulatory surgical center due to the insured's or enrollee's health condition;

(2) there is no free-standing ambulatory surgical center capacity in the insured's or enrollee's geographic area; or

(3) the provision of health care services at a free-standing ambulatory surgical center would result in undue delay.

(i) Starting January first, two thousand twenty-four, site of service clinical review criteria developed by health care plans shall also take into consideration whether:

(1) the insured's or enrollee's treating network participating provider recommends, based on a written clinical justification submitted to the health care plan, that the service be provided at a hospital-based outpatient clinic; or

(2) the insured or enrollee has requested a particular network participating provider who performs the requested service in a hospital-based outpatient clinic because the insured or enrollee is undergoing a continuing course of treatment with the participating provider or because the insured has previously obtained the requested service from the participating provider, and the provider is not credentialed at any free-standing ambulatory surgical center in the service area and is not able to be credentialed within ninety days following the submission of the authorization request to the health care plan.

TITLE II

RIGHT TO EXTERNAL APPEAL

Section 4910. Right to external appeal established.
4911. Powers of the superintendent.

4912. Standards for certification.
4913. Conflict of interest.
4914. Procedures for external appeals of adverse determinations.
4915. Prohibited practices.
4916. Oversight and surveillance of the external appeal process.
4917. Hold harmless.

§ 4910. Right to external appeal established. (a) There is hereby established an insured's right to an external appeal of a final adverse determination by a health plan.

(b) An insured, the insured's designee and, in connection with concurrent and retrospective adverse determinations, an insured's health care provider, shall have the right to request an external appeal when:

(1) (A) the insured has had coverage of the health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or other ground consistent with 42 U.S.C. § 300gg-19 as determined by the superintendent, and

(B) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the insured have jointly agreed to waive any internal appeal, or the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19; or

(2) (A) the insured has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under title one of this article, or both the plan and the insured have jointly agreed to waive any internal appeal, or the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19, and

(B) the insured's attending physician has certified that the insured has a condition or disease (a) for which standard health services or

procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial or rare disease treatment, and

(C) the insured's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as the insured, the insured's designee or the insured's attending physician may present, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure; or (b) a clinical trial for which the insured is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

(D) the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational; or

(3)(A) the insured has had coverage of the health service (other than a clinical trial to which paragraph two of this subsection shall apply), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health service is out-of-network and an alternate recommended treatment is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial or both the health plan and the insured have jointly agreed to waive any

internal appeal; and

(B) the insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network health service, and recommends a health service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

(4)(A) The insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

(B) The insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of an insured, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

(c) (1) The health care plan may charge the insured a fee of up to twenty-five dollars per external appeal with an annual limit on filing fees for an insured not to exceed seventy-five dollars within a single plan year; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the insured. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if the enrollee is a recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of the public health law. Notwithstanding the foregoing, the health plan shall not require the

insured to pay any such fee if such fee shall pose a hardship to the insured as determined by the plan.

(2) The health care plan may charge the insured's health care provider a fee of up to fifty dollars per external appeal, other than for an external appeal requested pursuant to paragraph two or three of subsection (d) of section four thousand nine hundred fourteen of this article; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the insured's health care provider.

(d) An enrollee covered under the Medicare or Medicaid program may appeal the denial of a health care service pursuant to the provisions of this title, provided, however, that any determination rendered concerning such denial pursuant to existing federal and state law relating to the Medicare or Medicaid program or pursuant to federal law enacted subsequent to the effective date of this title and providing for an external appeal process for such denial shall be binding on the enrollee and the insurer and shall supersede any determinations rendered pursuant to this title.

§ 4911. Powers of the superintendent. (a) The superintendent shall have the power to grant and revoke certifications of external appeal agents to conduct external appeals requested pursuant to paragraph one or two of subsection (b) of section four thousand nine hundred ten of this title or pursuant to both such paragraphs.

(b) If, after reviewing the application authorized by section four thousand nine hundred twelve of this title, the superintendent is satisfied that the applicant meets the requirements of this section, the superintendent shall issue a certificate to the applicant. A certificate issued under this section shall be valid for a period of not more than two years.

(c) In order to be re-certified, an external appeal agent must demonstrate to the superintendent on forms prescribed by the superintendent that it continues to meet all applicable standards required by this title. Re-certification under this section shall be valid for a period of not more than two years.

§ 4912. Standards for certification. (a) The superintendent shall develop an application for certification. At a minimum, applicants shall provide:

(1) a description of the qualifications of the clinical peer reviewers retained to conduct external appeals of final adverse determinations including such reviewers' current and past employment history and practice affiliations;

(2) a description of the procedures employed to ensure that clinical peer reviewers conducting external appeals are:

(i) appropriately licensed, registered or certified;

(ii) trained in the principles, procedures and standards of the external appeal agent; and

(iii) knowledgeable about the health care service which is the subject of the final adverse determination under appeal;

(3) a description of the methods of recruiting and selecting impartial clinical peer reviewers and matching such reviewers to specific cases;

(4) the number of clinical peer reviewers retained by the external appeal agent, and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review;

(5) a description of the policies and procedures employed to protect the confidentiality of individual medical and treatment records in accordance with applicable state and federal laws;

(6) a description of the quality assurance program established by the external appeal agent pursuant to paragraph three of subsection (b) of this section;

(7) the names of all corporations and organizations owned or controlled by the external appeal agent, or which owns or controls such agent, and the nature and extent of any such ownership or control;

(8) the names and biographies of all directors, officers, and executives of the external appeal agent;

(9) an experimental and investigational treatment review plan to conduct appeals pursuant to subparagraph (B) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this title; and

(10) a description of the fees to be charged by agents for external

appeals.

(b) The superintendent shall, at a minimum, require an external appeal agent to:

(1) appoint a medical director, who is a physician in possession of a current and valid non-restricted license to practice medicine. Such director shall be responsible for the supervision and oversight of the external appeal process;

(2) develop written policies and procedures governing all aspects of the appeal process, including, at a minimum:

(i) procedures to ensure that appeals are conducted within the time frames specified in section four thousand nine hundred fourteen of this title, and any required notices are provided in a timely manner;

(ii) procedures to ensure the selection of qualified and impartial clinical peer reviewers. Such reviewers shall be qualified to render and impartial determinations relating to the health care service which is the subject of the final adverse determination under appeal;

(iii) procedures to ensure the confidentiality of medical and treatment records and review materials; and

(iv) procedures to ensure adherence to the requirements of this title by any contractor, subcontractor, subvendor, agent or employee affiliated by contract or otherwise with such external appeal agent;

(3) establish a quality assurance program. Such program shall include written descriptions, to be provided to all individuals involved in such program, of the organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in external appeals performed by the external appeal agent and to ensure the maintenance of program standards pursuant to this section;

(4) establish a toll-free telephone service to receive information on a 24-hour-a-day 7-day-a-week basis relating to external appeals pursuant to this title. Such system shall be capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours;

(5) develop procedures to ensure that:

(i) appropriate personnel are reasonably accessible not less than forty hours per week during normal business hours to discuss patient care and to allow response to telephone requests, and

(ii) response to accepted or recorded messages shall be made not less than one business day after the date on which the call was received; and

(6) be accredited by a nationally recognized private accrediting organization.

(c) No entity shall be qualified to submit such request for application if it owns or controls, is owned or controlled by, or exercises common control with, any of the following:

(1) any national, state or local illness, health benefit or public advocacy group;

(2) any national, state or local society or association of hospitals, physicians, or other providers of health care services; or

(3) any national, state or local association of health care plans.

(d) A health care plan shall transmit, and an external appeal agent shall be authorized to receive and review, an insured's medical and treatment records in order to conduct an external appeal pursuant to this title.

(e) An external appeal agent shall provide ready access to the superintendent to all data, records, and information collected and maintained concerning such agent's external appeal activities.

(f) An external appeal agent shall agree to provide the superintendent such data, information, and reports as the superintendent determines necessary to evaluate the external appeal process established pursuant to this title.

(g) The superintendent shall provide, upon the request of any interested person, a copy of all non-proprietary information filed with the superintendent by the external appeal agent. The superintendent may charge a reasonable fee to the interested person for reproducing the requested information.

§ 4913. Conflict of interest. (a) No external appeal agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any external appeal pursuant to this title, shall have any material professional affiliation, material familial affiliation, material financial affiliation, or other affiliation prescribed pursuant to regulation, with any of the following:

(1) the health care plan;

(2) any officer, director, or management employee of the health care plan;

(3) any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable medical equipment, proposing to provide or supply the health service;

(4) the facility at which the health service would be provided;

(5) the developer or manufacturer of the principal health service which is the subject of the appeal; or

(6) the insured whose health care service is the subject of the appeal, or the insured's designee.

(b) Notwithstanding subsection (a) of this section, the superintendent shall promulgate regulations to minimize any conflict of interest where such conflict may be unavoidable.

§ 4914. Procedures for external appeals of adverse determinations. (a) The superintendent shall establish procedures by regulation to randomly assign an external appeal agent to conduct an external appeal, provided that the superintendent may establish a maximum fee which may be charged for any such external appeal, or the superintendent may exclude from such random assignment any external appeal agent which charges a fee which he deems to be unreasonable.

(b) (1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19. Where applicable, the insured's health care provider shall have sixty days to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal.

Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

(2) The external appeal agent shall make a determination with regard to the appeal within thirty days of the receipt of the request therefor, submitted in accordance with the superintendent's instructions. The external appeal agent shall have the opportunity to request additional information from the insured, the insured's health care provider and the insured's health care plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the insured, the insured's health care provider where appropriate, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, if the insured's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the insured, or if the insured is entitled to an expedited external appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19, the external appeal shall be completed within no more than seventy-two hours of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the insured, the insured's health care provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

(4) (A) For external appeals requested pursuant to paragraph one of subsection (b) of section four thousand nine hundred ten of this title, the external appeal agent shall review the utilization review agent's

final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient. When the external appeal agent makes its determination, it shall consider the clinical standards of the plan, the information provided concerning the patient, the attending physician's recommendation, applicable and generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations. Provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a notice of appeal determination which shall include the reasons for the determination; provided, however, that where the final adverse determination is upheld on appeal, the notice shall include the clinical rationale, if any, for such determination,

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the insured, and

(v) be admissible in any court proceeding.

(B) For external appeals requested pursuant to paragraph two of subsection (b) of section four thousand nine hundred ten of this title, the external appeal agent shall review the proposed health service or procedure for which coverage has been denied and, in accordance with the provisions of this title and the external agent's investigational treatment review plan, make a determination as to whether the patient costs of such health service or procedure shall be covered by the health care plan; provided that such determination shall:

(i) be conducted by a panel of three or a greater odd number of clinical peer reviewers,

(ii) be accompanied by a written statement:

(a) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, based upon review of the applicable medical and scientific evidence and, in connection with rare diseases, the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as

the insured, the insured's designee or the insured's attending physician may present (or upon confirmation that the recommended treatment is a clinical trial), the insured's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the insured's condition or disease or, for rare diseases, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure (or, in the case of a clinical trial, is likely to benefit the insured in the treatment of the insured's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

(b) upholding the health plan's denial of coverage;

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the insured, and

(v) be admissable in any court proceeding.

As used in this subparagraph (B) with respect to a clinical trial, patient costs shall include all costs of health services required to provide treatment to the insured according to the design of the trial. Such costs shall not include the costs of any investigational drugs or devices themselves, the cost of any nonhealth services that might be required for the insured to receive the treatment, the costs of managing the research, or costs which would not be covered under the policy for noninvestigational treatments.

(C) For external appeals requested pursuant to paragraph three of subsection b of section four thousand nine hundred ten of this title relating to an out-of-network denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network health service shall be covered by the health plan.

(i) The external appeal agent shall assign one clinical peer reviewer

to make a determination as to whether the out-of-network health service is materially different from the alternate recommended in-network health service.

(ii) If a determination is made that the out-of-network health service is not materially different from the alternate recommended in-network health service, the out-of-network health service shall not be covered by the health plan.

(iii) If a determination is made that the out-of-network health service is materially different from the alternate recommended in-network health service, the external appeal agent shall assign a panel with an additional two or a greater odd number of clinical peer reviewers, which shall make a determination as to whether the out-of-network health service shall be covered by the health plan; provided that such determination shall:

(I) be accompanied by a written statement:

(1) that the out-of-network health service shall be covered by the health care plan either: when a majority of the panel of reviewers determines, upon review of the treatment requested by the insured, the alternate recommended health service proposed by the plan, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the applicable medical and scientific evidence, the insured's medical record, and any other pertinent information that the out-of-network health service is likely to be more clinically beneficial than the alternate recommended in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the in-network health service; or

(2) uphold the health plan's denial of coverage;

(II) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(III) be binding on the plan and the insured; and

(IV) be admissible in any court proceeding.

(D) For external appeals requested pursuant to paragraph four of subsection (b) of section four thousand nine hundred ten of this title relating to an out-of-network referral denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a

determination as to whether the out-of-network referral shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(I) that the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the insured's medical record, and any other pertinent information, that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and that the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome; or

(II) upholding the health plan's denial of coverage;

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(iv) be binding on the plan and the insured; and

(v) be admissible in any court proceeding.

(c) No external appeal agent or clinical peer reviewer conducting an external appeal shall be liable in damages to any person for any opinions rendered by such external appeal agent or clinical peer reviewer upon completion of an external appeal conducted pursuant to this section, unless such opinion was rendered in bad faith or involved gross negligence.

(d) (1) Except as provided in paragraphs two and three of this subsection, payment for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days, from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest

thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

(2) If an insured's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in whole, payment for the external appeal shall be made by the health care provider in the manner and subject to the timeframes and requirements set forth in paragraph one of this subsection.

(3) If an insured's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in part, payment for the external appeal shall be evenly divided between the health care plan and the insured's health care provider who requested the external appeal and shall be made by the health care plan and the insured's health care provider in the manner and subject to the timeframes and requirements set forth in paragraph one of this subsection; provided, however, that the superintendent may, upon a determination that health care plans or health care providers are experiencing a substantial hardship as a result of payment for the external appeal when the external appeal agent upholds the health care plan's determination in part, in consultation with the commissioner of health, promulgate regulations to limit such hardship.

(4) If an insured's health care provider was acting as the insured's designee, payment for the external appeal shall be made by the health care plan. The external appeal and any designation shall be submitted on a standard form developed by the superintendent in consultation with the commissioner of health pursuant to subsection (e) of this section. The superintendent shall have the authority upon receipt of an external appeal to confirm the designation or request other information as necessary, in which case the superintendent shall make at least two written requests to the insured to confirm the designation. The insured shall have two weeks to respond to each such request. If the insured fails to respond to the superintendent within the specified timeframe,

the superintendent shall make two written requests to the health care provider to file an external appeal on his or her own behalf. The health care provider shall have two weeks to respond to each such request. If the health care provider does not respond to the superintendent's requests within the specified timeframe, the superintendent shall reject the appeal. If the health care provider responds to the superintendent's requests, payment for the external appeal shall be made in accordance with paragraphs two and three of this subsection.

(e) The superintendent, in consultation with the commissioner of health, shall promulgate by regulation a standard description of the external appeal process established under this section, which shall provide a standard form and instructions for the initiation of an external appeal by an insured.

§ 4915. Prohibited practices. An external appeal agent shall not, with respect to external appeal activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

(a) either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

(b) any other method that encourages the upholding of an adverse determination.

§ 4916. Oversight and surveillance of the external appeal process. (a) The superintendent shall have the power to:

(1) review the activities of the health care plans and external appeal agents pursuant to this title, including the extent to which such plans and agents adhere to the standards and time frames required pursuant to this title;

(2) investigate complaints by insureds regarding requests for and processing of external appeals; and

(3) conduct random audits of health care plans and external appeal agents to determine compliance with the provisions of this title.

(b) Each health care plan and external appeal agent shall annually, in such form as the superintendent shall require, report the number of

external appeals requested by insureds and the outcomes of any such external appeals.

(c) The superintendent shall annually report, by plan and by agent, such information to the governor and the legislature, provided that no such information shall be included which would otherwise be deemed confidential information within the meaning of this chapter.

§ 4917. Hold harmless. A health care provider requesting an external appeal of a concurrent adverse determination, including when the health care provider requests an external appeal as the insured's designee, shall not pursue reimbursement from the insured for services determined not medically necessary by the external appeal agent, except to collect a copayment, coinsurance or deductible.

ARTICLE 51

COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS

Section 5101. Title.
5102. Definitions.
5103. Entitlement to first party benefits; additional financial security required.
5104. Causes of action for personal injury.
5105. Settlement between insurers.
5106. Fair claims settlement.
5107. Coverage for non-resident motorists.
5108. Limit on charges by providers of health services.
5109. Unauthorized providers of health services.

§ 5101. Title. This article shall be known and may be cited as the "Comprehensive Motor Vehicle Insurance Reparations Act".

§ 5102. Definitions. In this chapter:

(a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of

section five thousand one hundred eight of this article:

(1) All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; (ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation (provided that treatment is rendered pursuant to a referral); (iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and (iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury. For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article.

(2) Loss of earnings from work which the person would have performed had he not been injured, and reasonable and necessary expenses incurred by such person in obtaining services in lieu of those that he would have performed for income, up to two thousand dollars per month for not more than three years from the date of the accident causing the injury. An employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of the employee's inability to work because of personal injury arising out of the use or operation of a motor vehicle, is not entitled to receive first party benefits for "loss of earnings from work" to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in the employee's level of future benefits arising from a subsequent illness or injury.

(3) All other reasonable and necessary expenses incurred, up to twenty-five dollars per day for not more than one year from the date of the accident causing the injury.

(4) "Basic economic loss" shall not include any loss incurred on account of death; subject, however, to the provisions of paragraph four

of subsection (a) of section five thousand one hundred three of this article.

(5) "Basic economic loss" shall also include an additional option to purchase, for an additional premium, an additional twenty-five thousand dollars of coverage which the insured or his legal representative may specify will be applied to loss of earnings from work and/or psychiatric, physical or occupational therapy and rehabilitation after the initial fifty thousand dollars of basic economic loss has been exhausted. This optional additional coverage shall be made available and notice with explanation of such coverage shall be provided by an insurer at the first policy renewal after the effective date of this paragraph, or at the time of application.

(b) "First party benefits" means payments to reimburse a person for basic economic loss on account of personal injury arising out of the use or operation of a motor vehicle, less:

(1) Twenty percent of lost earnings computed pursuant to paragraph two of subsection (a) of this section.

(2) Amounts recovered or recoverable on account of such injury under state or federal laws providing social security disability benefits, or workers' compensation benefits, or disability benefits under article nine of the workers' compensation law, or medicare benefits, other than lifetime reserve days and provided further that the medicare benefits utilized herein do not result in a reduction of such person's medicare benefits for a subsequent illness or injury.

(3) Amounts deductible under the applicable insurance policy.

(c) "Non-economic loss" means pain and suffering and similar non-monetary detriment.

(d) "Serious injury" means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; or significant limitation of use of a body function or system.

(e) "Owner" means an owner as defined in section one hundred twenty-eight of the vehicle and traffic law.

(f) "Motor vehicle" means a motor vehicle as defined in section three hundred eleven of the vehicle and traffic law and also includes fire and police vehicles. It shall not include any motor vehicle not required to

carry financial security pursuant to article six, eight or forty-eight-A of the vehicle and traffic law or a motorcycle, as defined in subsection (m) hereof.

(g) "Insurer" means the insurance company or self-insurer, as the case may be, which provides the financial security required by article six, eight, or forty-four-B of the vehicle and traffic law.

(h) "Member of his household" means a spouse, child or relative of the named insured who regularly resides in his household.

(i) "Uninsured motor vehicle" means a motor vehicle, the owner of which is (i) a financially irresponsible motorist as defined in subsection (j) of section five thousand two hundred two of this chapter or (ii) unknown and whose identity is unascertainable.

(j) "Covered person" means any pedestrian injured through the use or operation of, or any owner, operator or occupant of, a motor vehicle which has in effect the financial security required by article six or eight of the vehicle and traffic law or which is referred to in subdivision two of section three hundred twenty-one of such law; or any other person entitled to first party benefits.

(k) "Bus" means both a bus and a school bus as defined in sections one hundred four and one hundred forty-two of the vehicle and traffic law.

(l) "Compensation provider" means the state insurance fund, or the person, association, corporation or insurance carrier or statutory fund liable under state or federal laws for the payment of workers' compensation benefits or disability benefits under article nine of the workers' compensation law.

(m) "Motorcycle" means any motorcycle, as defined in section one hundred twenty-three of the vehicle and traffic law, and which is required to carry financial security pursuant to article six, eight or forty-eight-A of the vehicle and traffic law.

§ 5103. Entitlement to first party benefits; additional financial security required. (a) Every owner's policy of liability insurance issued on a motor vehicle in satisfaction of the requirements of article six or eight of the vehicle and traffic law shall also provide for; every owner who maintains another form of financial security on a motor vehicle in satisfaction of the requirements of such articles shall be

liable for; and every owner of a motor vehicle required to be subject to the provisions of this article by subdivision two of section three hundred twenty-one of the vehicle and traffic law shall be liable for; the payment of first party benefits to:

(1) Persons, other than occupants of another motor vehicle or a motorcycle, for loss arising out of the use or operation in this state of such motor vehicle. In the case of occupants of a bus other than operators, owners, and employees of the owner or operator of the bus, the coverage for first party benefits shall be afforded under the policy or policies, if any, providing first party benefits to the injured person and members of his household for loss arising out of the use or operation of any motor vehicle of such household. In the event there is no such policy, first party benefits shall be provided by the insurer of such bus.

(2) The named insured and members of his household, other than occupants of a motorcycle, for loss arising out of the use or operation of (i) an uninsured motor vehicle or motorcycle, within the United States, its territories or possessions, or Canada; and (ii) an insured motor vehicle or motorcycle outside of this state and within the United States, its territories or possessions, or Canada.

(3) Any New York resident who is neither the owner of a motor vehicle with respect to which coverage for first party benefits is required by this article nor, as a member of a household, is entitled to first party benefits under paragraph two of this subsection, for loss arising out of the use or operation of the insured or self-insured motor vehicle outside of this state and within the United States, its territories or possessions, or Canada.

(4) The estate of any covered person, other than an occupant of another motor vehicle or a motorcycle, a death benefit in the amount of two thousand dollars for the death of such person arising out of the use or operation of such motor vehicle which is in addition to any first party benefits for basic economic loss.

(b) An insurer may exclude from coverage required by subsection (a) hereof a person who:

(1) Intentionally causes his own injury.

(2) Is injured as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is

impaired by the use of a drug within the meaning of section eleven hundred ninety-two of the vehicle and traffic law; provided, however, that an insurer shall not exclude such person from coverage with respect to necessary emergency health services rendered in a general hospital, as defined in subdivision ten of section two thousand eight hundred one of the public health law, including ambulance services attendant thereto and related medical screening. Notwithstanding any other law, where the covered person is found to have violated section eleven hundred ninety-two of the vehicle and traffic law, the insurer has a cause of action for the amount of first party benefits paid or payable on behalf of such covered person against such covered person.

(3) Is injured while he is: (i) committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer, or (ii) operating a motor vehicle in a race or speed test, or (iii) operating or occupying a motor vehicle known to him to be stolen, or (iv) operating or occupying any motor vehicle owned by such injured person with respect to which the coverage required by subsection (a) hereof is not in effect, or (v) a pedestrian, through being struck by any motor vehicle owned by such injured pedestrian with respect to which the coverage required by subsection (a) hereof is not in effect, or (vi) repairing, servicing or otherwise maintaining a motor vehicle if such conduct is within the course of a business of repairing, servicing or otherwise maintaining a motor vehicle and the injury occurs on the business premises.

(4) Is injured while a motor vehicle is being used or operated by a TNC driver pursuant to article forty-four-B of the vehicle and traffic law, provided, however, that only the insurer issuing the owner's policy of liability insurance providing coverage for the motor vehicle being operated by a TNC driver may exclude such coverage and an insurer may not include this exclusion in a policy used to satisfy the requirements under article forty-four-B of the vehicle and traffic law.

5. Is injured while a motor vehicle is being used or operated by a shared vehicle driver pursuant to article forty of the general business law, provided, however, that only the insurer issuing the owner's policy of liability insurance providing coverage for the motor vehicle being used or operated by a shared vehicle driver may exclude such coverage

and an insurer may not include this exclusion in a policy used to satisfy the requirements of article forty of the general business law.

(c) Insurance offered by any company to satisfy the requirements of subsection (a) hereof shall be offered (i) without a deductible and (ii) with a family deductible of up to two hundred dollars (which deductible shall apply only to the loss of the named insured and members of his household). The superintendent may approve a higher deductible in the case of insurance policies providing additional benefits or pursuant to a plan designed and implemented to coordinate first party benefits with other benefits.

(d) Insurance policy forms for insurance to satisfy the requirements of subsection (a) hereof shall be subject to approval pursuant to article twenty-three of this chapter. Minimum benefit standards for such policies and for self-insurers, and rights of subrogation, examination and other such matters, shall be established by regulation pursuant to section three hundred one of this chapter.

(e) Every owner's policy of liability insurance issued in satisfaction of article six or eight of the vehicle and traffic law shall also provide, when a motor vehicle covered by such policy is used or operated in any other state or in any Canadian province, insurance coverage for such motor vehicle at least in the minimum amount required by the laws of that state or province.

(f) Every owner's policy of liability insurance issued on a motorcycle or an all terrain vehicle in satisfaction of the requirements of article six or eight of the vehicle and traffic law or section twenty-four hundred seven of such law shall also provide for; every owner who maintains another form of financial security on a motorcycle or an all terrain vehicle in satisfaction of the requirements of such articles or section shall be liable for; and every owner of a motorcycle or an all terrain vehicle required to be subject to the provisions of this article by subdivision two of section three hundred twenty-one of such law shall be liable for; the payment of first party benefits to persons, other than the occupants of such motorcycle or all terrain vehicle, another motorcycle or all terrain vehicle, or any motor vehicle, for loss arising out of the use or operation of the motorcycle or all terrain vehicle within this state. Every insurer and self-insurer may exclude from the coverage required by this subsection a person who intentionally

causes his own injury or is injured while committing an act which would constitute a felony or while seeking to avoid lawful apprehension or arrest by a law enforcement officer.

(g) A company authorized to provide the insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter or a corporation organized pursuant to article forty-three of this chapter may, individually or jointly, with the approval of the superintendent upon a showing that the company or corporation is qualified to provide for all of the items of basic economic loss specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, provide coverage for such items of basic economic loss to the extent that an insurer would be required to provide under this article. Where a policyholder elects to be covered under such an arrangement the insurer providing coverage for the automobile shall be furnished with the names of all persons covered by the company or corporation under the arrangement and such persons shall not be entitled to benefits for any of the items of basic economic loss specified in such paragraph. The premium for the automobile insurance policy shall be appropriately reduced to reflect the elimination of coverage for such items of basic economic loss. Coverage by the automobile insurer of such eliminated items shall be effected or restored upon request by the insured and payment of the premium for such coverage. All companies and corporations providing coverage for items of basic economic loss pursuant to the authorization of this subsection shall have only those rights and obligations which are applicable to an insurer subject to this article.

(h) Any policy of insurance obtained to satisfy the financial security requirements of article six or eight of the vehicle and traffic law which does not contain provisions complying with the requirements of this article, shall be construed as if such provisions were embodied therein.

§ 5104. Causes of action for personal injury. (a) Notwithstanding any other law, in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the use or operation of a motor vehicle in this state, there shall be

no right of recovery for non-economic loss, except in the case of a serious injury, or for basic economic loss. The owner, operator or occupant of a motorcycle which has in effect the financial security required by article six or eight of the vehicle and traffic law, or which is referred to in subdivision two of section three hundred twenty-one of such law, shall not be subject to an action by or on behalf of a covered person for recovery for non-economic loss, except in the case of a serious injury, or for basic economic loss. No liability for non-economic loss shall be fixed unless and until the trier of fact has determined the existence of a serious injury. In any action to recover non-economic loss pursuant to this article, the trier of fact shall not determine the question of whether an injury is a serious injury until the trier of fact has determined the party or parties at fault.

(b) In any action by or on behalf of a covered person, against a non-covered person, where damages for personal injuries arising out of the use or operation of a motor vehicle or a motorcycle may be recovered, an insurer which paid or is liable for first party benefits on account of such injuries has a lien against any recovery to the extent of benefits paid or payable by it to the covered person. No such action may be compromised by the covered person except with the written consent of the insurer, or with the approval of the court, or where the amount of such settlement exceeds fifty thousand dollars. The failure of such person to commence such action within two years after accrual gives the insurer a cause of action for the amount of first party benefits paid or payable against any person who may be liable to the covered person for his personal injuries. The insurer's cause of action shall be in addition to the cause of action of the covered person except that in any action subsequently commenced by the covered person for such injuries, the amount of his basic economic loss shall not be recoverable.

(c) Where there is no right of recovery for basic economic loss, such loss may nevertheless be pleaded and proved to the extent that it is relevant to the proof of non-economic loss.

(d) Notwithstanding the foregoing, and other than in an action for damages for injuries resulting in death, recovery for non-economic loss shall be limited to one hundred thousand dollars in the case of a serious injury in any action by or on behalf of an injured person who is

at fault, is not barred from recovery by section fourteen hundred eleven of the civil practice law and rules, and was (1) operating an uninsured motor vehicle and responsible under article six of the vehicle and traffic law for insuring such motor vehicle, except if a lapse in motor vehicle insurance coverage occurs for a period of time less than thirty days; (2) operating a motor vehicle while impaired at the time of the accident and convicted of such; or (3) operating a motor vehicle in the commission of a felony, or immediate flight therefrom, at the time of the accident and has been convicted of such felony.

§ 5105. Settlement between insurers. (a) Any insurer liable for the payment of first party benefits to or on behalf of a covered person and any compensation provider paying benefits in lieu of first party benefits which another insurer would otherwise be obligated to pay pursuant to subsection (a) of section five thousand one hundred three of this article or section five thousand two hundred twenty-one of this chapter has the right to recover the amount paid from the insurer of any other covered person to the extent that such other covered person would have been liable, but for the provisions of this article, to pay damages in an action at law. In any case, the right to recover exists only if at least one of the motor vehicles involved is a motor vehicle weighing more than six thousand five hundred pounds unloaded or is a motor vehicle used principally for the transportation of persons or property for hire. However, in the case of occupants of a bus other than operators, owners, and employees of the owner or operator of the bus, an insurer which, pursuant to paragraph one of subsection (a) of section five thousand one hundred three of this article, provides coverage for first party benefits for such occupants under a policy providing first party benefits to the injured person and members of his household for loss arising out of the use or operation of any vehicle of such household, shall have no right to recover the amount of such benefits from the insurer of such bus.

(b) The sole remedy of any insurer or compensation provider to recover on a claim arising pursuant to subsection (a) hereof, shall be the submission of the controversy to mandatory arbitration pursuant to procedures promulgated or approved by the superintendent. Such

procedures shall also be utilized to resolve all disputes arising between insurers concerning their responsibility for the payment of first party benefits.

(c) The liability of an insurer imposed by this section shall not affect or diminish its obligations under any policy of bodily injury liability insurance.

§ 5106. Fair claims settlement. (a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

(b) Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent. Such simplified procedures shall include an expedited eligibility hearing option, when required, to designate the insurer for first party benefits pursuant to subsection (d) of this section. The expedited eligibility hearing option shall be a forum for eligibility disputes only, and shall not include the submission of any particular bill, payment or claim for any specific benefit for adjudication, nor shall it consider any other defense to payment.

(c) An award by an arbitrator shall be binding except where vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the superintendent. The grounds for vacating or modifying an arbitrator's award by a master arbitrator shall

not be limited to those grounds for review set forth in article seventy-five of the civil practice law and rules. The award of a master arbitrator shall be binding except for the grounds for review set forth in article seventy-five of the civil practice law and rules, and provided further that where the amount of such master arbitrator's award is five thousand dollars or greater, exclusive of interest and attorney's fees, the insurer or the claimant may institute a court action to adjudicate the dispute de novo.

(d) (1) Except as provided in paragraph two of this subsection, where there is reasonable belief more than one insurer would be the source of first party benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, then the first insurer to whom notice of claim is given shall be responsible for payment. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section five thousand one hundred five of this article and regulations as promulgated by the superintendent, and any insurer paying first-party benefits shall be reimbursed by other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the provisions entitled "other coverage" contained in regulation and the provisions entitled "other sources of first-party benefits" contained in regulation. If there is no such insurer and the motor vehicle accident occurs in this state, then an applicant who is a qualified person as defined in article fifty-two of this chapter shall institute the claim against the motor vehicle accident indemnification corporation.

(2) A group policy issued pursuant to section three thousand four hundred fifty-five or three thousand four hundred fifty-eight of this chapter shall provide first party benefits when a dispute exists as to whether a driver was using or operating a motor vehicle in connection with a transportation network company or peer-to-peer car sharing program when loss, damage, injury, or death occurs. A transportation network company or peer-to-peer car sharing program administrator shall notify the insurer that issued the owner's policy of liability insurance of the dispute within ten business days of becoming aware that the dispute exists. When there is a dispute, the group insurer liable for

the payment of first party benefits under a group policy shall have the right to recover the amount paid from the driver's insurer or in the case of a peer-to-peer car sharing program, the shared vehicle owner's insurer to the extent that the driver would have been liable to pay damages in an action at law.

(e) With respect to an action for serious personal injury permissible under section five thousand one hundred four of this article, an award or decision of an arbitrator or master arbitrator or that is court rendered pursuant to subsection (c) of this section seeking no-fault reimbursement by or for medical providers, shall not be given collateral estoppel effect in any action or proceeding arising out of the same occurrence and shall not be admissible in any action or proceeding in actions seeking damages for bodily injuries, pain suffering, medical care and loss of wages as evidence of any facts.

§ 5107. Coverage for non-resident motorists. (a) Every insurer authorized to transact or transacting business in this state, or controlling or controlled by or under common control by or with such an insurer, which sells a policy providing motor vehicle liability insurance coverage or any similar coverage in any state or Canadian province, shall include in each such policy coverage to satisfy the financial security requirements of article six or eight of the vehicle and traffic law and to provide for the payment of first party benefits pursuant to subsection (a) of section five thousand one hundred three of this article when a motor vehicle covered by such policy is used or operated in this state.

(b) Every policy described in subsection (a) hereof shall be construed as having the coverage required by subsection (a) of section five thousand one hundred three of this article.

§ 5108. Limit on charges by providers of health services. (a) The charges for services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges

permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.

(b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall promulgate rules and regulations implementing and coordinating the provisions of this article and the workers' compensation law with respect to charges for the professional health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board.

(c) No provider of health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

§ 5109. Unauthorized providers of health services. (a) The superintendent, in consultation with the commissioner of health and the commissioner of education, shall by regulation, promulgate standards and procedures for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in paragraph one of subsection (a) of section five thousand one hundred two of this article upon findings reached after investigation pursuant to this section. Such regulations shall ensure the same or greater due process provisions, including notice and opportunity to be heard, as those afforded physicians investigated under article two of the workers' compensation law and shall include provision for notice to all providers of health services of the provisions of this section and regulations promulgated thereunder at least ninety days in advance of the effective date of such regulations.

(b) The commissioner of health and the commissioner of education shall provide a list of the names of all providers of health services who the commissioner of health and the commissioner of education shall deem, after reasonable investigation, not authorized to demand or request any payment for medical services in connection with any claim under this article because such provider of health services:

(1) has been guilty of professional or other misconduct or incompetency in connection with medical services rendered under this article; or

(2) has exceeded the limits of his or her professional competence in rendering medical care under this article or has knowingly made a false statement or representation as to a material fact in any medical report made in connection with any claim under this article; or

(3) solicited, or has employed another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under this article; or

(4) has refused to appear before, or to answer upon request of, the commissioner of health, the superintendent, or any duly authorized officer of the state, any legal question, or to produce any relevant information concerning his or her conduct in connection with rendering medical services under this article; or

(5) has engaged in patterns of billing for services which were not provided.

(c) Providers of health services shall refrain from subsequently treating for remuneration, as a private patient, any person seeking medical treatment under this article if such provider pursuant to this section has been prohibited from demanding or requesting any payment for medical services under this article. An injured claimant so treated or examined may raise this as a defense in any action by such provider for payment for treatment rendered at any time after such provider has been prohibited from demanding or requesting payment for medical services in connection with any claim under this article.

(d) The commissioner of health and the commissioner of education shall maintain and regularly update a database containing a list of providers of health services prohibited by this section from demanding or requesting any payment for health services connected to a claim under this article and shall make such information available to the public by

means of a website and by a toll free number.

(e) Nothing in this section shall be construed as limiting in any respect the powers and duties of the commissioner of health, commissioner of education or the superintendent to investigate instances of misconduct by a health care provider and, after a hearing and upon written notice to the provider, to temporarily prohibit a provider of health services under such investigation from demanding or requesting any payment for medical services under this article for up to ninety days from the date of such notice.

ARTICLE 52

MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION

Section 5201. Title and purpose.
5202. Definitions.
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§ 5201. Title and purpose. (a) This article may be cited as the "motor vehicle accident indemnification corporation act".

(b) The legislature finds and declares that the motor vehicle financial security act in the vehicle and traffic law, which requires the owner of a motor vehicle to furnish proof of financial security as a condition to registration, fails to accomplish its full purpose of securing to innocent victims of motor vehicle accidents recompense for the injury and financial loss inflicted upon them, in that the act makes no provision for the payment of loss on account of injury to or death of persons who, through no fault of their own, were involved in motor vehicle accidents caused by:

(1) uninsured motor vehicles registered in a state other than New York,

(2) unidentified motor vehicles which leave the scene of the accident,

(3) motor vehicles registered in this state as to which at the time of the accident there was not in effect a policy of liability insurance,

(4) stolen motor vehicles,

(5) motor vehicles operated without the permission of the owner,

(6) insured motor vehicles where the insurer disclaims liability or denies coverage, and

(7) unregistered motor vehicles.

In addition, this article is intended to provide no-fault benefits for qualified persons for basic economic loss arising out of the use and operation in this state of an uninsured motor vehicle, as provided herein and in the comprehensive motor vehicle insurance reparations act. The legislature determines that it is a matter of grave concern that those persons are not recompensed for their injury and financial loss inflicted upon them and that the public interest can best be served by closing such gaps in the motor vehicle financial security act and the comprehensive motor vehicle insurance reparations act through the continued operation of the motor vehicle accident indemnification corporation.

§ 5202. Definitions. In this article:

(a) "Motor vehicle" means a motor vehicle as defined in section one hundred twenty-five of the vehicle and traffic law and also includes trailers, semi-trailers, motorcycles, tractors and snowmobiles as defined in subdivision three of section 21.05 of the parks, recreation and historic preservation law and shall exclude fire and police vehicles, self-propelled combines, self-propelled corn and hay harvesting machines and tractors used exclusively for agricultural purposes.

(b) "Qualified person" means (i) a resident of this state, other than an insured or the owner of an uninsured motor vehicle and his spouse when a passenger in such vehicle, or his legal representative, or (ii) a resident of another state, territory or federal district of the United States or province of the Dominion of Canada, or foreign country, in which recourse is afforded, to residents of this state, of substantially similar character to that provided for by this article, or his legal representative. It does not include any operator of or passenger on a snowmobile. In this subsection, "operator" means every person who operates or is in actual physical control of a snowmobile, whether or not it is under way.

(c) "Insured motor vehicle" means a motor vehicle as to which there is maintained proof of financial security as defined in subdivision three of section three hundred eleven of the vehicle and traffic law or section 25.13 of the parks, recreation and historic preservation law.

(d) "Uninsured motor vehicle" means a motor vehicle other than a motor vehicle described in subsection (c) hereof.

(e) "Insurer" means any company authorized by the superintendent to do any form of motor vehicle liability insurance business in this state.

(f) "Corporation" means the "motor vehicle accident indemnification corporation".

(g) "Board" means the board of directors of the corporation.

(h) "Member" means any insurer authorized to write motor vehicle liability insurance in this state and any self-insurer subject to section three hundred sixteen or three hundred seventy of the vehicle and traffic law.

(i) "Insured" means a person defined as an insured under the coverage required by subsection (f) of section three thousand four hundred twenty of this chapter.

(j) "Financially irresponsible motorist" means the owner, operator, or other person legally responsible for the operation of an uninsured motor vehicle involved in an accident resulting in personal injury or death who did not have in effect at the time of such accident either:

(1) a valid and collectible policy of bodily injury liability and property damage liability insurance or bond with applicable limits at least equal to those specified in section three hundred eleven of the vehicle and traffic law; or

(2) a certificate of self insurance issued by the department of motor vehicles pursuant to section three hundred sixteen of the vehicle and traffic law; or

(3) who has not otherwise complied with the provisions of section three hundred twelve of the vehicle and traffic law; or

(4) who does not have in effect at the time of such accident a valid and collectible policy of bodily injury liability and property damage liability insurance with applicable limits at least equal to those specified in section 25.13 of the parks, recreation and historic preservation law.

(k) "Commissioner" means the commissioner of motor vehicles.

(l) "Court" means the supreme court, the county court or the civil court of the city of New York, in the county where an action on the cause of action of the qualified person could properly be brought for trial.

§ 5203. Motor vehicle accident indemnification corporation. (a) The non-profit corporation known as the "motor vehicle accident indemnification corporation" shall be continued.

(b) Every insurer authorized to write motor vehicle liability insurance in this state, as a condition of its authorization, shall be and remain a member of the corporation.

(c) The corporation shall be obligated to provide the protection required by this article to a qualified person on account of a motor vehicle accident caused by owners or operators of motor vehicles occurring within the state.

§ 5204. Board of directors. (a) The board of directors of the corporation shall be composed of nine persons. Seven of such directors shall be representatives of motor vehicle liability insurers, shall serve without compensation and be elected from among the members of the corporation by the members of the corporation, each of which members shall have one vote. In addition, the superintendent shall appoint two directors as representing broad segments of the public; one such director shall be a duly licensed insurance agent or broker and one shall have no affiliation with insurers or insurance producers.

(b) Each director shall serve for a term of two years. At the expiration of the initial term their successors in office shall serve for terms as fixed in the by-laws of the corporation.

§ 5205. Liability of directors and members. (a) No director shall be individually liable for anything done or any liability incurred or assumed by virtue of this article and any such liability shall be collectible only from the corporation.

(b) No member shall be subject to any liability except for unpaid assessments.

§ 5206. Powers of corporation. The corporation shall have the power:

(a) To use a corporate seal, to contract, to sue and be sued, to adopt and amend by-laws and to exercise all powers necessary and convenient to accomplish the purposes of this article.

(b) To prescribe, subject to the approval of the superintendent, the policy or endorsement form to be issued by the members embodying the coverage required by subsection (f) of section three thousand four hundred twenty of this chapter.

(c) To provide for the investigation of any claim asserted by a qualified person against a financially irresponsible motorist.

(d) To settle and pay any claim or judgment asserted by a qualified person against a financially irresponsible motorist.

(e) To appear and defend, through attorneys representing the corporation, on behalf of the financially irresponsible motorist or on behalf of the corporation in any action brought against him or it as

provided in subsection (b) of section five thousand two hundred nine of this article.

(f) To levy and collect assessments against its members for any operating deficits of the corporation and for any funds required for its operation and to enforce payment by legal proceedings.

(g) To borrow for its corporate purposes, with or without security, and to pledge any of its assets as security for such loan. Notes or other evidences of indebtedness of the corporation are legal investments for domestic property/casualty insurance companies and may be carried as admitted assets.

(h) To pay expenses reasonably incurred by the corporation in the exercise of any of its powers.

§ 5207. Assessments against members. (a) If at any time in the opinion of the board, the corporation shall require funds for the operation of its business, the board shall levy an assessment against the members of the corporation.

(b) Each member shall be liable to the corporation for that portion of the assessment which the net direct written premiums written by the member, namely the gross direct written premiums less return premiums on such direct business, for policies insuring against legal liability arising out of the ownership, operation or maintenance of motor vehicles which are principally garaged in this state, shall bear to the total or aggregate of such net direct premiums written by all members in this state in the last complete calendar year as shown by the records of the superintendent.

(c) In this section "member" also includes a former member which has withdrawn from the state or whose license has been revoked or which has been merged into another corporation or has been placed in liquidation, and such member or its successor shall be liable for all assessments under this section based upon premiums written by it in New York prior to the liquidation, withdrawal, revocation of license or merger.

(d) The assessment of self-insurers under sections three hundred sixteen and three hundred seventy of the vehicle and traffic law shall be based upon the amount determined by dividing the amount of the annual assessment on insurers by the number of insured vehicles for the year

preceding the determination.

§ 5208. Notice of claim. (a) The protection provided by the corporation on account of motor vehicle accidents caused by financially irresponsible motorists shall be available to:

(1) Any qualified person having a cause of action because of death or bodily injury, arising out of a motor vehicle accident occurring within this state, who files with the corporation within one hundred eighty days of the accrual of the cause of action, as a condition precedent to the right to apply for payment from the corporation, an affidavit stating that:

(A) the person has a cause of action for damages arising out of the accident and setting forth the facts in support,

(B) the cause of action is against the owner or operator of a designated uninsured motor vehicle, and

(C) the person is making a claim for such damages.

(2) (A) Any qualified person having a cause of action because of death or bodily injury, arising out of a motor vehicle accident occurring within this state and reported within twenty-four hours after the occurrence to a police, peace or judicial officer in the vicinity or to the commissioner, and who files with the corporation within ninety days of the accrual of the cause of action, as a condition precedent to the right to apply for payment from the corporation, an affidavit stating that:

(i) the person has the cause of action for damages arising out of the accident and setting forth the supporting facts,

(ii) the cause of action is against a person whose identity is unascertainable, and

(iii) the person is making a claim for those damages.

(B) The fact that the accident was not reported within twenty-four hours after the occurrence as required by subparagraph (A) hereof shall not prejudice the rights of the person if it is shown that it was not reasonably possible to make such a report or that it was made as soon as was reasonably possible.

(3) (A) Any qualified person having a cause of action because of death or bodily injury, arising out of a motor vehicle accident occurring

within this state, who files with the corporation an affidavit as a condition precedent to the right to apply for payment from the corporation, stating that:

(i) the person has a cause of action for damages arising out of the accident for damages and setting forth the supporting facts,

(ii) the insurers of the person alleged to be liable for the damages have disclaimed liability or denied coverage because of some act or omission of the person alleged to be liable including the denial of coverage based upon the lack of a policy of insurance in effect at the time the cause of action arose; provided, however, that in the case of a denial of coverage based upon the lack of a policy of insurance in effect at the time the cause of action arose, timely reasonable efforts had been made to ascertain insurance coverage, and

(iii) the person is making a claim for those damages.

(B) The affidavit shall be filed within one hundred eighty days of the affiant's receipt of notice of the disclaimer or denial of coverage.

(b) If a qualified person fails to file the affidavit as provided in paragraphs one and two of subsection (a) hereof within the specified period, or by reason of being an infant or mentally or physically incapacitated or deceased, is prevented from filing the affidavit as provided in paragraph three of such subsection within the specified period, or fails to file within one hundred eighty days, due to receipt of erroneous information from the department of motor vehicles or erroneous information from a police report with respect to identification of a vehicle, then upon a filing within thirty-one days of receipt of written notice of correction of the error by the department of motor vehicles or discovery of the mistake contained in the police report:

(1) The corporation may accept the filing of the affidavit if accompanied by proof satisfactory to it, of the facts which caused the delay and that it was not reasonably possible to file the affidavit within the specified period and that the affidavit was filed as soon as was reasonably possible.

(2) A court may upon like proof grant leave to file the affidavit within a reasonable time after the expiration of the specified period. In making its decision the court shall also and in particular consider, whether the corporation acquired actual knowledge of the essential facts

constituting the claim within the time specified in paragraph one of subsection (a) hereof or a reasonable time thereafter. The court shall also consider all other relevant facts and circumstances, including whether:

(A) The claimant failed to file a timely affidavit by reason of the claimant's justifiable reliance upon settlement representations made by a person believed to be the insurance representative of the financially irresponsible motorist.

(B) The claimant in filing made an excusable error concerning the identity or existence of the corporation against which the claim should or could be filed.

(C) The delay in filing substantially prejudiced the corporation in maintaining a defense on the merits.

(c) Application to the court for leave to file must be made within one year from the beginning of the period for filing the affidavit, specified in paragraph one, two, or three of subsection (a) hereof upon affidavit showing the evidentiary facts which are relied on in support of the proof required in subsection (b) of this section, accompanied by a copy of the proposed affidavit. Notice of the return time together with a copy of the application must be served at least eight days before the time named for the hearing upon the corporation by delivery to the person designated by law as a person to whom a summons in an action in the supreme court issued against such party may be delivered.

(d) Every qualified person shall promptly furnish the corporation with copies of all papers in any action for the enforcement of every cause of action referred to in paragraph one, two, or three of subsection (a) hereof.

(e) The commissioner shall furnish to the corporation, upon request, information as to whether any operator or owner of a motor vehicle involved in any accident had in effect at the time of the accident any motor vehicle liability insurance or other evidence that the motor vehicle was an insured motor vehicle.

§ 5209. Investigation and defense of claims. (a) The corporation shall provide for the investigation of accidents and actions governed by this article it deems necessary.

(b) The corporation may through counsel appear and defend in any action on its own behalf and on behalf of a defendant and take any other steps it deems appropriate including any appropriate method of review. All such acts shall be deemed to be the acts of the corporation and the defendant.

(c) Nothing in this article shall deprive a defendant of the right also to employ counsel and defend the action.

(d) In any case in which the corporation has assumed the defense of any action under this article, the defendant shall cooperate with the corporation in the defense of the action. In the event of the defendant's failure to do so, the corporation may apply to the court for an order directing cooperation.

§ 5210. Application for payment of judgment. (a) When any qualified person who has complied with all the applicable requirements of this article recovers a final judgment in a court against a financially irresponsible motorist, for injury to, or death of, any person arising out of the ownership, maintenance or use of the uninsured motor vehicle in this state, which remains unpaid, and all appeals have been concluded or the time for commencing them has expired, the judgment creditor may file a verified petition in the court in which the judgment was entered and, upon ten days' written notice to the corporation apply to the court for an order directing payment by the corporation of the amount unpaid on the judgment. However, there shall be no right of recovery by a covered person from the corporation for non-economic loss unless such person has incurred a serious injury, as such terms are defined in section five thousand one hundred two of this chapter. Such judgment exclusive of interest and costs shall not exceed:

(1) twenty-five thousand dollars on account of injury to one person in any one accident, and

(2) fifty thousand dollars on account of death to one person in any one accident, and

(3) fifty thousand dollars on account of injury to more than one person in any one accident subject to the limit of twenty-five thousand dollars for any one person, and

(4) one hundred thousand dollars on account of death to more than one

person in any one accident subject to the limit of fifty thousand dollars for any one person.

(b) The above applicable limit of liability shall be reduced by the amount of:

(1) any collectible liability insurance and available assets or contribution of the financially irresponsible motorist; and

(2) any payment received by the qualified person from or on behalf of any person jointly or severally liable with the financially irresponsible motorist.

(c) Any such judgment shall be regarded as excess to any other collectible liability insurance afforded to any financially irresponsible motorist.

§ 5211. Hearing on application for payment of judgment. (a) The court shall proceed upon the petition in a summary manner and the petitioner must show:

(1) the petitioner is a qualified person;

(2) the petitioner was not at the time of the accident operating an uninsured motor vehicle or operating a motor vehicle in violation of an order of suspension or revocation;

(3) the petitioner has complied with the requirements of section five thousand two hundred eight of this article;

(4) whether the judgment debtor at the time of the accident was insured under a policy of motor vehicle liability insurance or indemnity bond under which the insurer or surety is liable to pay all or part of the judgment;

(5) the petitioner has obtained a judgment as provided in section five thousand two hundred ten of this article, the amount of the judgment and the amount unpaid at the date of the application;

(6) the application is not made by or on behalf of any insurer or surety liable for the payment of all or part of the judgment by reason of any motor vehicle liability insurance policy or any indemnity bond and that no part of the amount to be paid by the corporation is sought in lieu of making a claim, receiving a payment which is payable by, or to indemnify, such an insurer or surety; and

(7) whether he has obtained judgment against any other person liable

for damages for bodily injury or death arising out of the accident and the amounts paid.

(b) The corporation may appear and be heard in opposition to the petition.

§ 5212. Order for payment of judgment. The court shall order the corporation to pay the sum, if any, it finds payable on the claim pursuant to the provisions and limitations of this article if it is satisfied of the truth of all matters required to be shown by the petitioner by section five thousand two hundred eleven of this article, and that the petitioner has fully pursued and exhausted all remedies available for recovering upon the judgments against all persons mentioned in paragraph seven of subsection (a) of section five thousand two hundred eleven of this article.

§ 5213. Settlement of claims or actions. (a) The corporation may, except in the case of claims or actions by or on behalf of infants or judicially declared incompetents, settle without court approval any claim or action against a financially irresponsible motorist if the board, after due deliberation, is satisfied that the settlement is fair and has approved payment, which shall in no event exceed the applicable amount specified in section five thousand two hundred ten of this article and that:

(1) the claimant has complied with the requirements prescribed in paragraphs one, two and three of subsection (a) of section five thousand two hundred eleven of this article;

(2) the settlement is not made on the behalf of an insurer or surety under circumstances described in paragraph six of subsection (a) of section five thousand two hundred eleven of this article;

(3) the financially irresponsible motorist involved in the accident was not insured under a policy of motor vehicle liability insurance or an indemnity bond under which the insurer or surety is liable for the damages sustained; and

(4) a judgment against the financially irresponsible motorist would not be collectible within a reasonable time.

(b) As a condition to the payment of the amount of the settlement the qualified person, notwithstanding the provisions of title one of article thirteen of the general obligations law, shall assign his claim to the corporation which shall then be subrogated to all of the rights of the qualified person against the financially irresponsible motorist.

§ 5214. Default and consent judgments. (a) No claim shall be allowed and ordered to be paid by the corporation if the court finds upon the hearing for the allowance of the claim that it is founded upon a judgment which was entered by default or consent of the defendant.

(b) When the corporation receives notice of intention to enter judgment and intention to file a claim against the corporation and the time allowed for filing an answer has expired, the corporation shall be granted a reasonable time after the receipt of notice by it to answer and to defend the action.

(c) If upon a hearing for the allowance of any claim against the corporation the court finds that the judgment was entered by default or with the consent or agreement of the defendant it shall order that the judgment insofar as it affects the corporation be set aside and the corporation permitted to proceed in the action as provided above.

§ 5215. Collusive judgments. No claim against the corporation shall be allowed if the court finds, upon the hearing for the allowance of the claim, that the judgment upon which the claim is founded was obtained by fraud, or by collusion of the plaintiff and of any defendant in the action, relating to any matter affecting the cause of action upon which the judgment is founded or the amount of damages assessed therein.

§ 5216. Assignments of judgments to corporation. (a) The corporation shall not pay any sum, in compliance with an order made for that purpose, if the claim is founded upon a judgment, except a judgment obtained against the corporation under this article, until the petitioner assigns the judgment to the corporation.

(b) After assignment the corporation shall be entitled to enforce the

judgment for the full amount with interest and costs. Money collected on the judgment in excess of all amounts paid by the corporation shall be paid to the judgment creditor.

§ 5217. "Hit and run" causes of action. The protection provided by this article shall not apply to any cause of action by a qualified person arising out of a motor vehicle accident occurring in this state against a person whose identity is unascertainable, unless the bodily injury to the qualified person arose out of physical contact of the motor vehicle causing the injury with the qualified person or with a motor vehicle which the qualified person was occupying (meaning in or upon or entering into or alighting from) at the time of the accident.

§ 5218. Procedure for "hit and run" cases. (a) Any qualified person having a cause of action for death or personal injury arising out of the ownership, maintenance or use of a motor vehicle in this state, when the identity of the motor vehicle and of the operator and owner cannot be ascertained or it is established that the motor vehicle was at the time of the accident, in the possession of a person without the owner's consent and that the identity of such person cannot be ascertained may, upon notice to the corporation, apply to a court for an order permitting an action therefor against the corporation in that court.

(b) The court may proceed upon the application in a summary manner and may make an order permitting the action when after a hearing it is satisfied that:

(1) the applicant has complied with the requirements of section five thousand two hundred eight of this article;

(2) the applicant is a qualified person;

(3) the injured or deceased person was not at the time of the accident operating an uninsured motor vehicle or operating a motor vehicle in violation of an order of suspension or revocation;

(4) the applicant has a cause of action against the operator or owner of the motor vehicle;

(5) all reasonable efforts have been made to ascertain the identity of the motor vehicle and of the owner and operator and either the identity

of the motor vehicle and the owner and operator cannot be established, or the identity of the operator, who was operating the motor vehicle without the owner's consent, cannot be established; and

(6) the application is not made by or on behalf of an insurer or surety under circumstances described in paragraph six of subsection (a) of section five thousand two hundred eleven of this article.

(c) In any action in which the plaintiff is a qualified person, for the death of, or bodily injury to, any person arising out of the ownership, maintenance or use of a motor vehicle in this state and judgment is rendered for the defendant on the sole ground that the death or personal injury was occasioned by a motor vehicle: (i) the identity of which, and of the owner and operator of which, has not been established, or (ii) which was in the possession of some person other than the owner or his agent without the consent of the owner and the identity of the operator has not been established, that ground shall be stated in the judgment. The plaintiff, upon complying with paragraph one of subsection (a) of section five thousand two hundred eight of this article, may within three months from the date of the entry of the judgment make application to bring an action upon the cause against the corporation in the manner provided in this section.

(d) In any action commenced in respect of the death or injury of any person arising out of the ownership, maintenance or use of a motor vehicle in this state the plaintiff shall be entitled to make the corporation a party defendant if the court has entered the order provided for in subsection (a) of this section.

(e) The corporation may generally deny the allegations of the complaint and shall not be required to set forth the facts upon which it relies. It may assert any defense which would have been available to the operator or owner if the action had been brought against them and process in the action had been duly served within this state upon them.

(f) (1) The corporation may settle without court approval any claim or action if the board, after due deliberation: (i) determines that the claim or action is asserted or brought pursuant to this section; (ii) is satisfied that the settlement is fair; and (iii) approves payment which in no event shall exceed the applicable amount specified in section five thousand two hundred ten of this article.

(2) Settlement of claims and actions without court order shall not

apply to settlement of claims or actions by infants or judicially declared incompetents.

(g) (1) Any judgment obtained pursuant to this section shall be reduced by any amount recovered by the plaintiff as specified in paragraph seven of subsection (a) of section five thousand two hundred eleven of this article. Upon conclusion of all proceedings, including appeals and reviews, the court shall order the corporation to pay the plaintiff the amount of the judgment or the applicable amount specified in subsection (a) of section five thousand two hundred ten of this article, whichever is less.

(2) Upon payment by the corporation it shall be subrogated to the cause of action of the judgment creditor against the operator and owner of the motor vehicle by which the accident was occasioned. It may bring an action against either or both of such persons for the amount of the damage sustained by the judgment creditor when the identity of either becomes known. It shall be entitled to recover the amount of the damage out of any funds which would be payable in respect to the death or injury under any policy of insurance which was in force at the time of the accident. Money collected in excess of all amounts paid by the corporation shall be paid to the judgment creditor.

§ 5219. Disclaimer or denial of coverage cases. If a qualified person who has complied with paragraph three of subsection (a) of section five thousand two hundred eight of this article obtains judgment against an owner of a motor vehicle after a trial on the merits and there is a final judgment in favor of the insurer of the owner based on a disclaimer or denial of coverage by the insurer, the qualified person may preserve his right to apply for payment from the corporation by complying with the procedure prescribed in section five thousand two hundred ten of this article.

§ 5220. Notice of judgment to commissioner. The corporation shall give notice to the commissioner of the entry of any judgment upon which a claim is made against the corporation under this article and of the payment of any such judgment, or the payment or settlement of any claim

by the corporation.

§ 5221. "No-fault" benefits to qualified persons. (a) The terms "basic economic loss", "first party benefits", "non-economic loss", "serious injury", "motor vehicle", "insurer", "uninsured motor vehicle" and "covered person", as used in this section, shall have the same meaning given them in section five thousand one hundred two of this chapter.

(b) (1) Notwithstanding the provisions of this article, the corporation shall also provide for the payment of first party benefits to a qualified person for basic economic loss arising out of the use or operation in this state of an uninsured motor vehicle.

(2) A qualified person who has complied with all the applicable requirements of this article shall be deemed to be a covered person and shall have only such rights as a covered person may have under article fifty-one of this chapter.

(3) The corporation shall have only those rights and obligations which are applicable to an insurer subject to article fifty-one of this chapter.

(4) No payment for non-economic loss shall be made pursuant to this article to a covered person unless such person has incurred a serious injury, as such terms are defined in section five thousand one hundred two of this chapter.

(5) The corporation shall not duplicate any element of basic economic loss provided for under this section or any section of article fifty-one of this chapter. No payments of first party benefits for basic economic loss made pursuant to this section shall diminish the obligations of the corporation under this article for the payment of non-economic loss and economic loss in excess of basic economic loss.

(6) If a controversy arises between the corporation and an insurer concerning the obligation to pay first party benefits, payment of first party benefits by the corporation shall not be stayed pending resolution of the controversy. Any such controversy shall be solely resolved by submission to mandatory arbitration pursuant to procedures promulgated or approved by the superintendent. Such procedures shall, to the extent practicable, be those applicable to insurers pursuant to section five thousand one hundred five of this chapter.

(c) The corporation shall continue to comply with the plan of operation approved by the superintendent, which provides for the economical, prompt and fair payment of first party benefits to qualified persons in substantially the same manner as is required of insurers and self-insurers by article fifty-one of this chapter and regulations of the superintendent. The plan may provide for the corporation to utilize the service of authorized insurers in the payment of claims for first party benefits. Amendments to the plan of operation may be made on the initiative of the directors, subject to the approval of the superintendent, or shall be made at the direction of the superintendent.

§ 5222. Examination of corporation. The superintendent shall make an examination into the affairs of the corporation as provided in subsection (a) of section three hundred nine of this chapter.

§ 5224. Penalty for false statements. Any person and any agent or employee of a person, who knowingly files with the corporation any document required under this article, which is false or contains any material misstatement of fact shall be guilty of a misdemeanor and upon conviction therof shall be subject to a fine of not less than five hundred dollars, nor more than twenty-five hundred dollars, or imprisonment for not more than thirty days.

§ 5225. Exemption from taxation. The corporation shall be exempt from all taxes and fees now or hereafter imposed by the state, or by any county, municipality or local authority or subdivision, except that any real property owned by the corporation shall be subject to county, municipal or local taxation to the same extent according to its value as other similar real property is taxed and that the corporation shall be subject to the fees imposed pursuant to section two hundred two of the vehicle and traffic law.

ARTICLE 53

MOTOR VEHICLE INSURANCE ASSIGNED RISK PLANS

Section 5301. Participation in assigned risk plans.
5302. Administration.
5303. Coverage.
5304. Appeals; process of claims.

§ 5301. Participation in assigned risk plans. (a) All insurers licensed to write motor vehicle insurance in this state shall subscribe to and participate in the reasonable plan or plans, approved, or which may be approved, by the superintendent after consultation with such insurers, for equitable apportionment among such insurers of applicants for such insurance who are in good faith entitled to but are unable to procure it through ordinary methods.

(b) Amendments to the plan may be made by the committee designated to administer the plan, subject to the approval of the superintendent, or shall be made at the direction of the superintendent.

§ 5302. Administration. (a) In addition to the members of the committee elected by the subscribers to administer the plan, the superintendent shall appoint annually two additional members who shall be duly licensed insurance agents or brokers representative of broad segments of the public obtaining insurance through the plan.

(b) Such committee shall establish for the benefit of applicants standards of service of participating insurers including timely issuance of policies, certificates and endorsements, financial security forms, and the collection of required deposits.

§ 5303. Coverage. (a) Any such plan shall provide for availability to applicants of motor vehicle insurance coverages for:

(1) legal liability, up to fifty thousand dollars because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to one hundred thousand dollars because of bodily injury to or death of two or more persons in any one accident, and up to ten thousand dollars because of injury to or destruction of

property of others in any one accident; and

(2) loss or damage to an automobile insured under a policy, up to ten thousand dollars actual cash value, subject to a deductible of not less than one hundred dollars; provided, however, that the physical damage insurance for a private passenger automobile shall be subject to all of the provisions of sections two thousand three hundred thirty-seven, three thousand four hundred eleven and three thousand four hundred thirty-two of this chapter; and

(3) medical payments with respect to private passenger motor vehicles not for hire, irrespective of the legal liability of the insured, because of bodily injury to or death of any person insured thereunder, up to one thousand dollars; and

(4) supplementary uninsured motorists insurance, as defined in subsection (f) of section three thousand four hundred twenty of this chapter.

(b) Any such plan shall provide for availability to applicants of twice the dollar level of first party benefits prescribed in section five thousand one hundred three of this chapter; and commensurate first party benefits for personal injury arising out of the use or operation of a motor vehicle in any other state or Canadian province.

(c) Such plan shall provide for the method of classifying risks, establishing territories and making rates applicable thereto. Such rates, except with respect to rates for the minimum limits of insurance required by article six or seven of the vehicle and traffic law, shall be based upon loss and expense experience of the risks insured pursuant to the plan.

§ 5304. Appeals; process of claims. (a) Any applicant for insurance through a plan governed by this article, any person insured under such plan and any insurer affected may appeal to the superintendent from any ruling or decision of the manager or committee.

(b) All participating insurers shall maintain an office in this state or establish a communications system by direct toll free telephone line, or otherwise, to conveniently process claims of the insureds.

ARTICLE 54

NEW YORK PROPERTY INSURANCE UNDERWRITING ASSOCIATION

Section 5401. Definitions.
5402. Joint underwriting association.
5403. Procedures.
5404. Rates, rating plans, rules and statistics.
5405. Participation.
5406. Appeals.
5407. Availability of reports; immunity.
5408. Annual statement.
5409. Examinations.
5410. Reimbursement fund.
5412. Additional powers of the association.
5414. Coastal market assistance program (C-MAP).

§ 5401. Definitions. In this article:

(a) "Fire insurance" means coverage against loss of or damage to any property resulting from fire, as defined in paragraph four of subsection (a) of section one thousand one hundred thirteen of this chapter and implemented by section three thousand four hundred four of this chapter.

(b) "Extended coverage" means insurance against direct loss to property by windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles and smoke, as limited by paragraph five of subsection (a) of section one thousand one hundred thirteen of this chapter.

(c) "Broad form coverage" includes extended coverage, as well as insurance against direct loss to property by volcanic eruption, burglary damage, weight of ice, snow or sleet, glass breakage, accidental discharge or overflow of water or steam, falling objects, freezing, artificially generated electrical current, collapse, and tearing apart, cracking, burning or bulging.

(d) "Additional perils coverage" means any of the following written in connection with fire, extended coverage and broad form coverage policies issued pursuant to this article:

(1) "Vandalism and malicious mischief insurance", means coverage against loss or damage to property resulting from vandalism or malicious

mischief, as defined in subparagraph (D) of paragraph five of subsection (a) of section one thousand one hundred thirteen of this chapter, subject to a reasonable graded deductible, of not less than two hundred fifty dollars.

(2) "Sprinkler leakage insurance", means coverage against loss or damage to property resulting from the breakage or leakage of sprinklers, as defined in paragraph six of subsection (a) of section one thousand one hundred thirteen of this chapter.

(3) "Rent insurance", means coverage against actual loss of rental income resulting from property being rendered necessarily untenantable due to its damage or destruction by a peril insured against.

(4) "Business interruption insurance", means coverage against actual loss resulting from necessary interruption of business due to damage or destruction of property by a peril insured against.

(e) "Association" means the joint underwriting association continued by this article.

(f) "Plan of operation" or "plan" means the plan of operation complying with section five thousand four hundred two of this article.

(g) "Insurable property" means real property at fixed locations anywhere in this state, or the tangible personal property located thereon, which is determined by the association, after inspection and pursuant to criteria specified in the plan, to be insurable. Neighborhood or area location shall not be considered in determining insurable condition. Property is not insurable if it has characteristics of ownership, condition, occupancy or maintenance which violate public policy.

(h) "Net direct premiums" means gross direct premiums written on property in this state for fire and extended coverage insurance, including the fire and extended coverage components of homeowners and commercial multiple peril package policies as computed by the superintendent, less return premiums or the unused or unabsorbed portions of premium deposits.

(i) For the purposes of this section "homeowners insurance" means such homeowners insurance policies defined in subsection (a) of section two thousand three hundred fifty-one of this chapter, as are determined by the superintendent to be equivalent to any homeowners policies developed by a nationally recognized principal rate service organization, except

that where the market value of the insured property is less than its replacement cost, then the coverage shall be provided in policies determined by the superintendent to be equivalent to that contained in market value (HO-8) policies.

§ 5402. Joint underwriting association. (a) The joint underwriting association known as the New York property insurance underwriting association is continued, consisting of all insurers authorized to write and engaged in writing within this state, on a direct basis, fire and extended coverage insurance, including insurers covering such perils in homeowners and commercial multiple peril package policies but excluding assessment cooperative fire insurance companies transacting business pursuant to article sixty-six of this chapter. Every such insurer shall be and remain a member of the association as a condition of its authority to continue to transact fire, extended coverage and homeowners insurance in this state.

(b) The association shall be governed by a board of thirteen directors, ten of whom shall be elected annually by cumulative voting by the members of the association, whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. The remaining three directors shall be appointed annually by the superintendent and be duly licensed insurance agents or brokers representative of broad segments of the public obtaining insurance through the association.

(c) The association shall, pursuant to the provisions of this article and the plan of operation and with respect to fire insurance, extended coverage, broad form coverage issued pursuant to subsection (g) of this section, coverage for additional perils, and homeowners insurance should the same be made available through the association in accordance with a determination of necessity made by the superintendent pursuant to section five thousand four hundred twelve of this article on insurable property, have the power on behalf of its members:

(i) to cause policies of insurance to be issued to applicants;

(ii) to assume reinsurance from its members; and

(iii) to cede reinsurance.

(d) The association shall adhere to a plan of operation, consistent

with the provisions of this article, approved by the superintendent after consultation with affected individuals and organizations. The plan shall provide for economical, fair and non-discriminatory administration and prompt and efficient provision of fire, extended coverage, broad form coverage pursuant to subsection (g) of this section and homeowners insurance, when a determination of necessity is made by the superintendent pursuant to section five thousand four hundred twelve of this article to promote orderly community development. It shall contain other matters including, but not limited to, provision for necessary facilities; management of the association; assessment of members to defray losses and expenses; commission arrangements; reasonable and objective underwriting standards; acceptance and cession of reinsurance and procedures for determining amounts of insurance to be provided by the association. The amounts shall not be in excess of one million five hundred thousand dollars for the insurable real property or the tangible personal property thereon.

(e) The directors of the association may, on their own initiative or at the request of the superintendent, amend the plan subject to approval by the superintendent.

(f) The association shall offer homeowners insurance, as defined in subsection (h) of section five thousand four hundred one of this article upon a determination of necessity having been made by the superintendent pursuant to section five thousand four hundred twelve of this article.

(g) In addition to fire insurance, extended coverage, coverage for additional perils and homeowners insurance should the same be made available through the association in accordance with a determination of necessity pursuant to section five thousand four hundred twelve of this article, the association may offer broad form coverage to applicants seeking to insure real property at fixed locations of this state, or the tangible personal property located thereon. The association may offer broad form coverage until June thirtieth, two thousand twenty-eight. On or before October first, two thousand twenty-seven the superintendent shall require the association to report to the superintendent as to the number of policies written pursuant to this subsection and paragraph three of subsection (f) of section five thousand four hundred five of this article, and any other information the superintendent may require. On or before January first, two thousand twenty-eight, the

superintendent shall report to the governor and the legislature regarding the number of policies issued pursuant to this section and such paragraph and shall include recommendations as to the continuation of such insurance offerings.

(i) Not less than once every thirty days, the association shall report to the superintendent, the speaker of the assembly, and the temporary president of the senate on the number, location and type of policies written through a coastal market assistance program.

§ 5403. Procedures. (a) Any person having an insurable interest in insurable property, who has made a diligent effort in the normal insurance market to procure fire insurance, extended coverage and coverage for additional perils and broad form coverage pursuant to subsection (g) of section five thousand four hundred two of this article and homeowners insurance upon a determination of necessity having been made by the superintendent pursuant to section five thousand four hundred twelve of this article from an authorized insurer, is entitled to apply to the association for such coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by him.

(b) If the association determines that (i) the property is insurable in accordance with the plan and (ii) there is no unpaid, uncontested premium due from the applicant for prior insurance on the property (as shown by the insured having failed to make written objection to charges within thirty days after billing), the association, upon receipt of the premium or portion prescribed in the plan, shall cause a policy of fire insurance or homeowners insurance upon a determination of necessity having been made by the superintendent pursuant to section five thousand four hundred twelve of this article to be issued for a term of one year. The fire insurance policy shall also include, upon application therefor, extended coverage, broad form coverage pursuant to subsection (g) of section five thousand four hundred two of this article and coverage for additional perils as may be requested.

(c) Any member may cede fire insurance, extended coverage, broad form coverage pursuant to subsection (g) of section five thousand four hundred two of this article and coverage for additional perils and homeowners insurance upon a determination of necessity having been made

by the superintendent pursuant to section five thousand four hundred twelve of this article written on insurable property to the association as provided in the plan.

(d) The association shall notify those policyholders whose insured properties are located in areas served by a market assistance program established by the superintendent for the purpose of facilitating placement of homeowners' insurance of the possibility of eligibility for coverage through such program. Such notification shall include information on how to apply and such other information as required by the superintendent.

§ 5404. Rates, rating plans, rules and statistics. (a) The rates, rating plans, rating rules and statistics applicable to the insurance written by the association shall be subject to the relevant provisions of article twenty-three of this chapter except as otherwise provided in this section.

(b) Rates, rating plans and rating rules applicable to fire insurance, extended coverage, additional perils, broad form coverage pursuant to subsection (g) of section five thousand four hundred two of this article and homeowners insurance upon a determination of necessity having been made by the superintendent pursuant to section five thousand four hundred twelve of this article written by the association shall be no greater than the following percentages of those recommended for the voluntary market by the principal rate service organization in this state:

(1) one hundred twenty percent with respect to:

(A) owner-occupied residential dwellings consisting of not more than four dwelling units;

(B) household furnishings and personal property contained in any household unit;

(C) contents of any retail-type business located in store-type premises and operating in a single location, provided such business is owned by its operators, who are all related by blood or affinity;

(D) real property of eleemosynary institutions used exclusively for such eleemosynary purposes including furnishings and personal property contained therein;

(2) one hundred thirty percent with respect to:

(A) non-owner occupied residential dwellings consisting of not more than four dwelling units;

(B) residential structures consisting of more than four but not exceeding eight units with or without business occupancies;

(C) homeowners insurance upon a determination of necessity having been made by the superintendent pursuant to section five thousand four hundred twelve of this article;

(3) one hundred forty percent with respect to residential dwellings consisting of more than eight dwelling units, with or without business occupancies;

(4) one hundred thirty percent with respect to any risks not otherwise provided for in paragraphs one, two and three of this subsection.

(c) The rates, rating plans and rating rules recommended by the principal rate service organization, together with such other information the superintendent may require, shall be submitted by the association at least sixty days prior to the date on which they are to become effective for risks written by it.

(d) Filed rating rules or plans may provide standards for the application of surcharges for risks containing unsafe or hazardous conditions, and shall provide for prompt removal of the surcharges upon the elimination of those conditions.

§ 5405. Participation. (a) Every member of the association shall participate in its writings, expenses, profits and losses in the proportion that the net direct premiums of the member (but excluding that portion of premiums attributable to the operation of the association) written during the preceding calendar year bear to the aggregate net direct premiums written in this state by all members of the association. Each member's participation in the association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year as disclosed in the annual statements and other reports filed by the member with the superintendent.

(b) No member shall be obligated in any year to reimburse the association on account of its proportionate share in the deficit from operations of the association in that year in excess of one percent of

its surplus to policyholders. The aggregate amount not so reimbursed shall be reallocated among the remaining members in accordance with the method of determining participation prescribed in this section, after excluding from the computation the total net direct premiums of all members not sharing in such excess deficit. In the event that the deficit from operations allocated to all members in any calendar year shall exceed one percent of their respective surplus to policyholders, the amount of such deficit shall be allocated to each member in accordance with the method of determining participation prescribed in this section.

(c) Annually, on a date set by the superintendent, the association shall estimate its deficit from operations, and after application of the funds provided for in subsection (d) of this section, calculate a factor, not to exceed one percent, by relating such deficit to net direct premiums written for the latest calendar year, subject to the approval of the superintendent. Such factor may be reflected in the determination of rates filed by the principal rating organization in this state and by members of the association for fire, extended coverage, broad form coverage pursuant to subsection (g) of section five thousand four hundred two of this article, additional perils, homeowners and commercial multiple peril package policies which include the perils of fire and extended coverage. Notwithstanding the provisions of section five thousand four hundred four of this article to the contrary, any part of such deficit which exceeds one percent as so calculated, shall be defrayed by an increase in rates for the respective occupancy classes, based upon the association's related loss and expense experience together with other information the superintendent requires, in accordance with filings approved by the superintendent. Each member's share of the estimated deficit shall be collected by the association in accordance with the plan of operation.

(d) In accordance with regulations of the superintendent, the deficit from the operations of the association shall be credited with income earned from the New York property/casualty insurance security fund. The credit shall be an amount determined by the superintendent, which in no year shall exceed income earned or the sum of fifteen million dollars whichever is less. The credit shall be estimated annually by the superintendent on a date set by the superintendent, and such estimated

amount shall be credited to the association and transferred from the income as earned during the year by the New York property/casualty insurance security fund. Any difference between the estimated amount of income and the actual amount of income for the year shall be taken into account in computing the estimate for the next period. Notwithstanding the foregoing provisions of this section or any other law to the contrary, if the assets of the association exceed its liabilities on the thirtieth day of November in any year commencing on or after April first, nineteen hundred eighty-two in accordance with regulations of the superintendent, the association shall pay to the New York property/casualty insurance security fund an amount equal to any amounts paid from such fund to the association in accordance with the provisions of article seventy-six of this chapter and this section which have not been repaid prior to such thirtieth day of November, together with any investment income attributable thereto, as determined by the superintendent, up to the amount of such excess. Any such payment shall be made no later than February first of the following year.

(e) Members shall not be relieved of their obligation to reimburse the association for their share of the deficit resulting from the operations of the association prior to August first, nineteen hundred seventy-nine.

(f) (1) Any member that voluntarily writes, as of expiration date, a policy or coverage currently written through the association, shall receive credit against its participation in association writings. Such credit shall be to the extent of twice the net direct premium, on an annual basis, of such policy or coverage voluntarily written and shall apply for one year.

(2) Subject to approval by the superintendent, the association shall develop and implement an incentive plan for members which voluntarily write policies that include windstorm coverage in coastal areas. Such plan shall also include incentives for members to voluntarily write wraparound policies, as defined by the association, in coastal areas, when such wraparound policies include coverage for windstorm on a replacement cost basis in excess of the windstorm coverage contained in an association policy issued to the same policyholder. The purpose of these incentives shall be to encourage the writing of voluntary insurance policies in coastal areas by reducing the participation in the writings of the association of those member companies which voluntarily

write policies that include windstorm coverage in such areas. For the purposes of this section, coastal areas include: areas within one mile of a saltwater ocean, sound, inlet or bay on Long Island's south shore or along the shore of Brooklyn, Queens, Staten Island and Long Island's forks; areas within two thousand five hundred feet of a saltwater ocean, sound, inlet or bay on Long Island's north shore, the Bronx or Westchester.

(3) The association shall offer a policy form which may be used only in conjunction with voluntary market wraparound policies that provide windstorm coverage in excess of amounts insured by the association. The policy form, which may include broad form coverage, shall provide replacement cost coverage for dwellings and personal property for repair or replacement without deduction for depreciation on terms and conditions generally consistent with policies customarily in use in the voluntary market as modified to make the association policy compatible with voluntary market wraparound policies. Coverage offered by the association under such policy shall not exceed six hundred thousand dollars for dwelling coverage and two hundred fifty thousand dollars for personal property, and shall be available to cover one to four family owner-occupied dwellings, apartment units or condominium units. The association may require applicants to provide evidence of the purchase of flood insurance as a condition of eligibility for coverage under this policy. The association shall file the form for approval with the superintendent.

§ 5406. Appeals. Any applicant to the association and any person insured pursuant to this article, or their representatives, or any affected insurer, may appeal to the superintendent within thirty days after any ruling, action or decision by or on behalf of the association, with respect to those items the plan of operation defines as appealable matters.

§ 5407. Availability of reports; immunity. (a) Reports of inspection performed by or on behalf of the association shall be available to members of the association, applicants and the superintendent.

(b) No liability or cause of action shall exist against the association or its agents or employees, an insurer or the superintendent or his authorized representatives for any statements made in good faith by them in any reports or communications concerning risks insured or to be insured by the association or at any related administrative hearings.

§ 5408. Annual statement. (a) The association shall annually file a statement in the office of the superintendent on or before the first day of March. Such statement shall be in a form approved by and contain information required by the superintendent with respect to its transactions, condition, operations and affairs during the preceding year.

(b) The superintendent may at any time require the association to furnish additional information which he considers to be material in evaluating the scope, operation and experience of the association.

§ 5409. Examinations. The superintendent may, in accordance with article three of this chapter, make an examination into the affairs of the association whenever the superintendent deems it expedient. The expenses of every such examination shall be borne and paid by the association in the manner prescribed by subsection (f) of section two hundred six of the financial services law.

§ 5410. Reimbursement fund. (a) The superintendent shall assess each member of the association an amount sufficient to provide reimbursement payments, pursuant to the provisions of section 1223(a)(1) of the federal Urban Property Protection and Reinsurance Act of 1968, to the agency of the federal government administering the act in an aggregate amount not to exceed five per centum of the aggregate property insurance premiums earned in the state during the preceding calendar year on those lines of insurance reinsured under such act during the calendar year.

(b) The total amount of any assessment on each such member shall be in the proportion that the premiums earned during the preceding calendar year by each such member in this state bear to the aggregate premiums

earned in this state during the preceding calendar year on those lines of insurance reinsured under the federal act during the current year by all members of the association. Assessments shall be collectible from all members on and after the forty-fifth day following receipt of a claim from the federal agency.

(c) The superintendent shall receive all assessments payable on account of the claim of the federal agency and make all disbursements in carrying out this section from the riot reinsurance revolving fund which is continued. Notwithstanding any other law, rule or regulation requiring that money received for or on behalf of the state shall be paid into the state treasury, the superintendent shall deposit the assessments in a separate bank account or accounts in a trust company or bank having trust powers within the state. All deposits shall be secured by obligations of the United States or this state and all banks and trust companies are authorized to give the same. The monies of the fund may, at the discretion of the superintendent, be invested in obligations of or guaranteed by this state or the United States. Any income or earnings derived from such investments shall be deposited in the fund.

(d) The monies in the fund shall be paid on the order of the superintendent solely for reimbursement payments as provided in subsection (a) hereof after any investigation the superintendent deems appropriate to verify the correctness of the claim. Any balance remaining shall be retained by the superintendent in the fund and used only for the purpose of meeting future claims of the federal agency.

(e) The superintendent may at any time require any member to furnish information he deems necessary to determine if the member has complied with the provisions of this section.

(f) The comptroller shall have the power and authority to audit the accruals, the receipts, the payments and the expenditure of all monies of the fund.

*** § 5412. Additional powers of the association.** (a) As used in this article:

(1) "Commercial risk insurance", "public entity insurance" and "professional liability insurance" have the meanings ascribed to them by section one hundred seven of this chapter, except that motor vehicle

insurance and medical malpractice liability insurance are excluded from such meanings for purposes of this article;

(2) "Market" means a line, subline or classification (other than a classification delineated by geographic location) of property/casualty insurance not subject to subsection (b) of section two thousand three hundred five, section two thousand three hundred twenty-eight or section three thousand four hundred twenty-five of this chapter. Provided, however, a "market" shall also include homeowners insurance as defined in subsection (h) of section five thousand four hundred one of this article. A "market" shall also include mandatory minimum surety bonds required pursuant to section two hundred fifty-eight-b of the agriculture and markets law.

(b) The association shall begin, or resume after any suspension, its insurance underwriting operations for any market only after the superintendent has determined after a hearing on a record that it is necessary, due to unavailability of meaningful coverage in a particular voluntary market, to activate the association to write coverage for such market. In making a determination of necessity pursuant to this subsection, the superintendent may consider such factors as: the extent and nature of competition; size and significance of the coverage; availability of adequate limits of coverage; efficacy of any market assistance program administered by the superintendent including but not limited to actual placement of coverage through a voluntary market assistance program at the time such determination is to be made; reinsurance availability; extent of consumer complaints to the department of financial services; extent of denials and restrictions of coverage; volume of cancellations and nonrenewals; or changing conditions in the economic, judicial and social environment. If, after activating the association in regard to a particular market, the superintendent determines that ready availability of meaningful coverage in such voluntary market has been restored, the association shall thereupon suspend its underwriting in regard to such market. The superintendent shall, no later than October first, nineteen hundred eighty-six, activate the association to write particular markets in regard to public entities, unless the superintendent determines that activation is unnecessary because public entities are able to secure meaningful coverage in voluntary markets, including through any market

assistance program administered by the superintendent.

(c) The directors of the association, after consultation with the superintendent, shall forthwith prepare a plan of operation, subject to approval by the superintendent who shall act expeditiously thereon, and the directors shall take all other necessary steps on and after the effective date of this section to prepare for prompt implementation of the association's powers in the event that any market is activated by the superintendent pursuant to subsection (b) of this section. The directors of the association may, on their own initiative or at the request of the superintendent, amend the plan subject to approval by the superintendent. The superintendent may direct that the plan of operation, or amendments to such plan, shall include specified limits of coverage for particular markets activated.

(d) Upon activation by the superintendent of any market pursuant to subsection (b) of this section, all insurers (excluding assessment cooperative fire insurers) authorized to write and engaged in writing on a direct basis within this state commercial risk, public entity or professional liability insurance, including commercial multiple peril policies, shall participate as members in the association. Every such insurer shall be and remain a member of the association as a condition of its authority to continue to transact such insurance in this state. In addition to the credit provided pursuant to subsection (f) of section five thousand four hundred five of this article, the superintendent may by regulation provide for additional credits to such insurers that voluntarily provide a market for those risks that the superintendent determines to be extremely difficult to place in the voluntary market.

(e) The association shall with respect to any market activated by the superintendent pursuant to subsection (b) of this section issue policies in accordance with the association's plan of operation, and shall maintain separate accounts and records for premiums, losses, expenses and investment income attributable to such insurance. Assessments of insurers for expenses and any losses of the association in connection with such insurance shall be based on an insurer's net direct premiums attributable to the types of insurance specified in subsection (a) of this section. Rates shall be based upon loss and expense experience of the risks insured by the association pursuant to this section and shall be on an actuarially sound basis, calculated to be self-supporting at

the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves, surplus and expenses, including commissions. The provisions of subsection (d) of section five thousand four hundred five of this article shall not apply to insurance written pursuant to this section.

(f) The superintendent may also activate the association for purposes of providing excess or umbrella coverages in connection with a market. Hazards that the superintendent determines are uninsurable shall be excluded from coverages which the association is required to furnish.

(g) The provisions of this section shall cease to be of any force or effect on or after June thirtieth, two thousand twenty-nine, except that policies issued or other obligations incurred by the association shall not be impaired by the expiration of this section and the association shall continue for the purpose of servicing such policies and performing such obligations.

* NB Expires June 30, 2029

§ 5414. Coastal market assistance program (C-MAP). (a) The association shall create a coastal market assistance program to provide a voluntary mechanism whereby insurers and insurance agents and brokers facilitate efficient access to participating private market insurance companies for those personal residential property risks located in coastal areas.

(b) To provide the association with advice and assistance with the operations of the coastal market assistance program, a C-MAP agents advisory council shall be established, consisting of nine members appointed as follows: three members shall be appointed by the governor, two members shall be appointed by the temporary president of the senate, two members shall be appointed by the speaker of the assembly, one member shall be appointed by the minority leader of the senate, and one member shall be appointed by the minority leader of the assembly, provided however that each member shall be an insurance producer, as defined in article twenty-one of this chapter, who sells homeowners' insurance in an area served by the coastal market assistance program. The superintendent, or his or her designee, also may participate as an ex-officio member. Each member of such advisory council shall serve at the pleasure of the official who appointed such member.

(c) The association shall administer the coastal market assistance program. The association may, subject to approval of the superintendent, adopt reasonable eligibility standards for participation in the coastal market assistance program. At a minimum, properties eligible for the program shall be located within one mile of the shore. For purposes of this section, shore shall mean salt-water ocean, sound, bay, inlet, Lake Erie, Lake Ontario, the Saint Lawrence River, the Hudson River, or the Niagara River with distance measured from mean high water. The association may adopt additional or more expansive eligibility standards for participation in the coastal market assistance program.

(d) The C-MAP agents advisory council shall provide recommendations to the association for consideration by the board of directors. The board of directors shall promptly advise the superintendent, in writing, of any recommendations received from the C-MAP agents advisory council.

(e) The association shall study and may adopt a voluntary single adjuster program, under which a residence insured under both an association and a private market policy would have claims under both policies adjusted by the private market carrier. The association may adopt other incentives to encourage voluntary participation in the coastal market assistance program, subject to the approval of the superintendent.

ARTICLE 55

MEDICAL MALPRACTICE INSURANCE ASSOCIATION

Section 5501. Definitions.
5502. Medical malpractice insurance association.
5503. Plan of operation.
5504. Policies.
5505. Rates.
5506. Procedures.
5507. Participation.
5508. Directors.
5509. Stabilization reserve fund.
5510. Appeals.
5511. Annual statement.
5512. Examinations.

5513. Immunity.
5515. Federal program.
5516-d. Further transfer of association funds.
5516-f. Further transfer of moneys of the association.
5517. Transfer of association funds; reinsurance evaluation.
5517-a. Return of association premium.

§ 5501. Definitions. In this article:

(a) "Association" means the medical malpractice insurance association.

(b) "Medical malpractice insurance" means insurance against legal liability of the insured, and against loss, damage, or expense incident to a claim of such liability arising out of the death or injury of any person due to medical, dental, podiatric, certified nurse-midwifery or hospital malpractice by any licensed physician, dentist, podiatrist, certified nurse-midwife, certified registered nurse anesthetist or hospital.

(c) "Hospital" means:

(1) Any facility defined as a hospital under section twenty-eight hundred one of the public health law and issued an operating certificate as a hospital or nursing home, and those distinct parts of a facility which are subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene which provide hospital or nursing home service.

(2) Any ambulance service which is registered or certified under article thirty of the public health law and which is designed and equipped to provide definitive acute medical care pursuant to rules and regulations of the commissioner of health in accordance with such article concerning the requirements for an advanced life support system. Such a service must include, but not be limited to, the provision of advanced life support services.

(3) Any community mental health center operated by a county, city, town or village, holding an operating certificate issued by an office of the department of mental hygiene.

(4) Any certified public or voluntary non-profit home care service agency which possesses a valid certificate of approval issued under article twenty-eight or thirty-six of the public health law.

(d) "Net direct premiums" means gross direct premiums written on personal injury liability insurance, including the liability component of multiple peril package policies as computed by the superintendent, less return premiums for the unused or unabsorbed portions of premium deposits.

(e) "Personal injury liability insurance" means all forms of insurance written under paragraph thirteen of subsection (a) of section one thousand one hundred thirteen of this chapter, including the liability component of multiple peril package policies.

§ 5502. Medical malpractice insurance association. (a) The medical malpractice insurance association is continued consisting of all insurers authorized to write and engaged in writing, within this state, on a direct basis, personal injury liability insurance but excluding assessment cooperative fire insurance companies transacting business pursuant to article sixty-six of this chapter. Every such insurer shall be and remain a member of the association as a condition of its authority to continue to transact personal injury liability insurance in this state.

(b) The association shall be a non-profit unincorporated association constituting a legal entity separate and distinct from its members. All funds and reserves of the association shall be separately held and invested. It shall maintain complete accounts of all monies received and all losses and expenses incurred in connection with its operations, including investment income on policyholder-supplied funds. For the purpose of any contributions required by insurers to the property/casualty insurance security fund pursuant to article seventy-six of this chapter, and for the purpose of the protection afforded policyholders by such fund, the association is an authorized insurer. The association shall include in the premiums charged for medical malpractice insurance an amount sufficient to offset any such contributions.

(c) (1) The purpose of the association is to provide, for the period July first, nineteen hundred seventy-five through June thirtieth, two thousand one, a market for medical malpractice insurance pursuant to this article and subject to regulation pursuant to section two thousand

three hundred seventeen of this chapter. If, after June thirtieth, two thousand one, the surcharges on premiums imposed pursuant to section forty, as amended, of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, by the superintendent to satisfy any actuarially projected deficiency that is attributable to the premium levels for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, two thousand one, are still in effect or may still be reasonably imposed, the association shall continue in existence until June thirtieth next following such time as such surcharges are no longer imposed or may no longer be reasonably imposed.

** (2) (A) The association shall, no later than December thirtieth, nineteen hundred ninety-nine, submit to the superintendent for approval a plan for the final dissolution of the association, including a transfer or extinguishment of all liabilities of the association and a plan for the servicing of existing policies of the association. The dissolution of the association and cessation of its activities shall be fully accomplished and the association shall be deemed dissolved at such time and under such conditions as the superintendent deems proper; provided, however, that all policies of insurance written by the association shall expire or be transferred prior to such dissolution.

(B) In the preparation of a plan for the final dissolution of the association, the board of directors of the association shall: (i) solicit proposed plans for the dissolution of the association from at least three outside entities; (ii) arrange for an independent actuarial review of the association, its operations, assets and liabilities; and (iii) recommend, by a majority vote of its board of directors, that proposal which maximizes the value of the association to the state. The association shall thereafter file all proposed plans, along with the plan recommended by the board, to the superintendent for approval.

(C) (i) The superintendent shall, by April thirtieth, two thousand, review all proposed plans, along with the recommended plan, filed by the board of directors of the association with the superintendent and may approve a plan of dissolution. The superintendent may determine to add provisions which may vary from those submitted by the association or delete others as proposed by the association or adopt an alternate plan.

Any plan of dissolution of the association which provides for the sale or transfer of its operations, assets and/or liabilities to a private entity shall do so net of any appropriated and encumbered amounts required by subsection (c) of section five thousand five hundred sixteen, subsection (c) of section five thousand five hundred sixteen-a, subsection (c) of section five thousand five hundred sixteen-b, subsection (c) of section five thousand five hundred sixteen-c and subsection (c) of section five thousand five hundred sixteen-e of this article and, in the event such plan is approved and implemented, such sections five thousand five hundred sixteen, five thousand five hundred sixteen-a, five thousand five hundred sixteen-b, five thousand five hundred sixteen-c, and five thousand five hundred sixteen-e are hereby deemed repealed. A public hearing shall be held to examine the proposed plan of dissolution, the plans reviewed, and the superintendent's recommended plan of approval. Such public hearing shall be held not later than thirty days prior to the superintendent's approval of that plan which maximizes the value of the association to the state while not impairing or impeding the operation of the voluntary medical malpractice insurance market or limiting the access to medical malpractice coverage for health care practitioners or facilities insured by the association. Upon approval, the superintendent shall certify the estimated amount of funds to be transferred pursuant to subsection (b) of section five thousand five hundred sixteen-f of this article and shall transmit such certification to the director of the division of the budget.

To assist in making such determination, the superintendent may appoint one or more qualified disinterested persons or institutions as consultants to advise on any matters related to the dissolution. The appointment of a consultant shall be in writing and shall set forth the duties and responsibilities of the consultant. The association shall provide access to the superintendent, and any consultants appointed by the superintendent, to its books and records and any information in its possession necessary to make valuations and determinations required by this section. For the purposes of this section, all expenses and costs associated with such appointment shall be deemed and considered expenses pursuant to section three hundred thirteen of this chapter.

(ii) (I) Any action challenging the validity of or arising out of acts

taken or proposed to be taken under this paragraph two of this subsection must be commenced within two months after a copy of the plan of final dissolution of the association, with the superintendent's approval endorsed thereon, has been filed in the office of the superintendent.

(II) In any action arising out of acts taken or proposed to be taken under this paragraph two of this subsection, the superintendent shall be entitled to, at any stage of the proceedings before final judgment, petition the court to give security for the costs and charges which may be incurred by the superintendent in connection with such action and by any other parties defendant in connection therewith or for which the superintendent or the association may become liable under this chapter, under any contract or otherwise by law, to which security the superintendent shall have recourse in such amount as the court having jurisdiction of such action shall determine upon termination of such action. The amount of security may thereafter from time to time be increased or decreased in the discretion of the court having jurisdiction of such action upon showing that the security provided has or may become inadequate or excessive.

(III) Any person aggrieved by any act taken or order, regulation, or rule issued pursuant to this paragraph two of this subsection may petition for judicial review of such acts taken or orders, regulations or rules, pursuant to the limitations period prescribed in clause (I) of item (ii) of this subparagraph. The petition shall be brought in the appellate division of the supreme court in the third judicial department. The jurisdiction of the appellate division of the supreme court in the third judicial department shall be exclusive and its judgment and order shall be final subject to review by the court of appeals in the same manner and form and with the same effect as provided for appeals in a special proceeding. All such proceedings shall be heard and determined by the appellate division and by the court of appeals as expeditiously as possible and with lawful precedence over other matters. Acts taken or orders, regulations or rules issued pursuant to this section shall not be stayed or enjoined except upon application to the appellate division of the supreme court in the third judicial department after notice to the superintendent and to the attorney general and upon a showing that the petitioner has a substantial likelihood of success

and will suffer irreparable harm if the stay or injunction is not granted.

(IV) Provided, however, that if a determination by a judicial proceeding prevents the final consummation of the determination by the superintendent that the association be dissolved, and if the amounts required to be transferred and deposited from the association to the miscellaneous special revenue fund pursuant to the requirements of section five thousand five hundred sixteen-f of this article are not in fact so transferred and deposited in the miscellaneous special revenue fund, then the provisions of subsections (a) through (f) of section nine thousand one hundred eleven-c of this chapter shall become operative and the tax imposed by subsections (a) through (e) of such section shall be imposed. Provided, further, however, that if there is thereafter a final judicial determination that the final consummation of the dissolution of the association may be effectuated, and the full transfer and deposit shall be made to the miscellaneous special revenue fund, then in such event the amount of the tax imposed and paid pursuant to the provisions of subsections (a) through (e) of section nine thousand one hundred eleven-c of this chapter shall be returned to the companies that paid such assessment on a pro rata basis, in a manner consistent with the procedures set forth in subsections (f) and (g) of section nine thousand one hundred eleven-c of this chapter.

* (D) Prior to July first, two thousand, the superintendent shall, after a public hearing to be held not less than thirty days before such promulgation, promulgate regulations prescribing a plan for the equitable distribution to authorized medical malpractice insurers writing such coverage in the state the insureds of the association and health care practitioners and facilities which are otherwise unable to secure coverage in the voluntary market following the dissolution of the association. Such plan shall provide that upon initial distribution to the voluntary market the insureds of the association receive policies in the voluntary market with provisions and at a rate which are at least as favorable to the insured as those which they would have received if they were issued a renewal policy by the association, provided, however, that subsequent to the initial distribution, the plan shall not be required to make available a second layer of excess medical malpractice insurance to insureds. Such plan shall also ensure that all health care

practitioners or facilities have access to medical malpractice insurance from an authorized insurer pursuant to the provisions of this chapter. Such plan may also provide for, and the superintendent may designate, in lieu of the plan for the equitable distribution of policies from the association and the availability of coverages to health care practitioners and facilities, a single entity or entities to provide such coverages consistent with such a plan if the superintendent determines that such entity or entities can provide the coverages necessary to meet the purposes and objectives of an equitable plan of distribution were it to have been effectuated. Notice of the hearing required by this subparagraph shall be no less than thirty days before the date of the hearing and shall include a summary of the plan proposed by the superintendent.

* NB Effective until July 1, 2028

* (D) Prior to July first, two thousand, the superintendent shall, after a public hearing to be held not less than thirty days before such promulgation, promulgate regulations prescribing a plan for the equitable distribution to authorized medical malpractice insurers writing such coverage in the state the insureds of the association and health care practitioners and facilities which are otherwise unable to secure coverage in the voluntary market following the dissolution of the association. Such plan shall provide that upon initial distribution to the voluntary market the insureds of the association receive policies in the voluntary market with provisions and at a rate which are at least as favorable to the insured as those which they would have received if they were issued a renewal policy by the association. Such plan shall also ensure that all health care practitioners or facilities have access to medical malpractice insurance from an authorized insurer pursuant to the provisions of this chapter. Such plan may also provide for, and the superintendent may designate, in lieu of the plan for the equitable distribution of policies from the association and the availability of coverages to health care practitioners and facilities, a single entity or entities to provide such coverages consistent with such a plan if the superintendent determines that such entity or entities can provide the coverages necessary to meet the purposes and objectives of an equitable plan of distribution were it to have been effectuated. Notice of the hearing required by this clause shall be no less than thirty days before

the date of the hearing and shall include a summary of the plan proposed by the superintendent.

* NB Effective July 1, 2028

** NB The plan referred to herein is Title 11 NYCRR, Chapter XX, Part 430

(d) Upon dissolution, the association shall not resume underwriting operations for physicians, dentists, podiatrists, certified nurse-midwives, certified registered nurse anesthetists or for hospitals respectively, until the superintendent, after consultation with the commissioner of health, has determined that medical malpractice insurance is not readily available for physicians, dentists, podiatrists, certified nurse-midwives, certified registered nurse anesthetists or for hospitals, as the case may be, in the voluntary market and has approved or promulgated a new plan of operation. If the superintendent determines during such period that insurance is readily available for physicians, dentists, podiatrists, certified nurse-midwives, certified registered nurse anesthetists or for hospitals, as the case may be, in the voluntary market, the superintendent shall not authorize its underwriting operations for the respective categories.

(e) The association shall, pursuant to the provisions of this article and the plan of operation with respect to medical malpractice insurance, have the power:

(1) To issue, or to cause to be issued, policies of insurance to physician, dentist and podiatrist applicants subject to primary limits specified in the plan of operation not in excess of one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year, and excess coverage as provided in this paragraph. Each applicant shall be entitled to purchase a policy providing primary limits not to exceed one million dollars for each claimant and three million dollars for all claimants in any one year. In addition, any applicant insured by the association in an amount equal to or greater than one million dollars for each claimant and three million dollars for all claimants in any one year, or any other applicant covered under a policy or policies providing such primary levels of insurance against liability for medical, dental or podiatric malpractice that is issued by an authorized insurer, shall be

entitled to purchase a policy from the association providing excess coverage of at least one million dollars per claimant and three million dollars for all claimants in any one year. The association shall, subject to the approval of the superintendent, make available, and if requested by the applicant, provide additional excess coverage in an amount requested by such applicant. With respect to the coverage required to be made available on and after July first, nineteen hundred eighty-five by this paragraph, the superintendent shall establish and promulgate rates to be charged for such excess coverage and additional excess coverage and shall require that the association accept payment for such coverage from the hospital excess liability pool pursuant to a payment schedule that is consistent with the receipt of funds by such pool from the hospital reimbursement system. Rates for excess coverage and additional excess coverage shall not be subject to the stabilization reserve fund charge established by section five thousand five hundred nine of this article.

(2) To issue, or cause to be issued, policies of insurance, including incidental liability coverages, to hospital applicants subject to limits specified in the plan of operation with limits not in excess of one million dollars for each claimant and ten million dollars for all claimants in any one year; provided that policies for coverage in excess of one million dollars for each claimant and three million dollars for all claimants in any one year shall be issued only upon the obtaining of reinsurance for such excess coverage for the term of the policy and the excess coverage shall remain in effect only so long as reinsurance is in effect. The association shall obtain such reinsurance, if available, for coverage in excess of one million dollars for each claimant and three million dollars for all claimants in any one year. If the association fails to obtain such reinsurance, the superintendent may order it to do so for the term of the policy from sources found by him to be available. The rates charged by the association for coverage in excess of three million dollars shall not be subject to prior approval by the superintendent, and shall equal the charges to the association for such reinsurance.

(3) To underwrite such insurance and to adjust and pay losses or to appoint service companies to perform those functions.

(4) To assume reinsurance from its members.

(5) To cede reinsurance.

(6) To make the lump sum payments provided for in subdivision (b) of section five thousand thirty-six of the civil practice law and rules and receive the periodic payments due under the annuity contract provided for therein.

§ 5503. Plan of operation. (a) The association shall operate in accordance with a plan of operation approved by the superintendent which provides for economic, fair and non-discriminatory administration and for the prompt and efficient provision of medical malpractice insurance.

(b) The plan shall contain other provisions including but not limited to preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, service charges, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the association.

(c) Amendments to the plan of operation may be made by the board of directors of the association, subject to the approval of the superintendent, or shall be made at the direction of the superintendent.

(d) The association shall be subject to the provisions of this chapter applicable to property/casualty insurers in the conduct of its business, in order to provide for the fair treatment of policyholders and claimants.

(e) The association shall make the lump sum payments provided for in subdivision (b) of section five thousand thirty-six of the civil practice law and rules and receive the periodic payments due under the annuity contract provided for therein.

§ 5504. Policies. (a) No policy form shall be used by the association unless it has been filed with the superintendent and either he has approved it, or thirty days have elapsed and he has not disapproved it as misleading or violative of public policy.

(b) (1) Except as provided in paragraph two of this subsection, no

cancellation notice or nonrenewal notice shall be effective unless the association at least forty-five days prior to the effective date of such cancellation or the end of the policy period, as the case may be, mails or delivers such notice to the insured at the address shown on the policy and to such insured's licensed representative.

(2) Where the cancellation is for nonpayment of premium or loss of license to practice or, if the insured is a hospital, it no longer possesses a valid operating certificate under section twenty-eight hundred one-a of the public health law, such cancellation notice must be mailed or delivered at least fifteen days prior to the effective date of the cancellation.

(3) Upon written request by an insured or such insured's licensed representative, the association shall mail or deliver loss information as provided in subsection (g) of section three thousand four hundred twenty-six of this chapter to such insured or such insured's licensed representative within ten business days of such request.

(4) All cancellation notices or nonrenewal notices shall state the grounds upon which the policy is cancelled or nonrenewed and that, upon written request of an insured or such insured's licensed representative, the association will furnish the facts on which the cancellation or nonrenewal is based. Grounds for nonrenewal shall be limited to the same grounds as for cancellation. All cancellation notices or nonrenewal notices shall also provide or be accompanied by a statement advising the insured of the availability of the loss information specified in subsection (g) of section three thousand four hundred twenty-six of this chapter.

(c) A policy of insurance issued by the association may be terminated other than for non-payment of premiums if the insured:

(1) Is not complying substantially with any term or condition of such contract.

(2) Has knowingly made, or caused to be made, any false statement or misrepresentation of a material fact for use in applying for insurance.

(3) Has failed to pay to the association all stabilization reserve fund charges.

(d) Any termination shall apply to care or services provided after the effective date of termination, except that insurance coverage may continue for up to thirty days after termination with respect to care or

services to patients which are a continuation of a treatment begun prior to the effective date of termination.

(e) Policies issued by the association shall provide at the insured's option for deductibles and for co-insurance. An applicant electing an option for a deductible or for co-insurance shall have the right to purchase an option under which the association shall not settle any claim under the policy without the consent of the insured. Any policy issued by the association without a deductible or co-insurance shall provide that the association shall have the sole authority to settle any claim up to policy limits without the consent of the insured.

(f) (1) The association shall issue or renew policies of medical malpractice insurance for physicians on a claims-made or occurrence basis, as prescribed by the superintendent by regulation.

(2) A claims-made policy shall contain the following provisions:

(A) if the insured has purchased a claims-made policy from an admitted insurer or the association for a period of five or more consecutive years and the insured, after attaining the age of sixty-five or older, retires permanently and totally from the practice of medicine or if the insured has purchased a claims-made policy for a period of ten or more consecutive years and the insured, after attaining the age of fifty-five or older, retires permanently and totally from the practice of medicine, the association shall, without charging an additional premium therefor at the time of, or subsequent to, such retirement, also cover all occurrences between the inception date of the first such consecutive policy from such association and such retirement date which, subsequent to the termination date, are reported in accordance with statutory and policy requirements;

(B) if the insured dies or becomes permanently disabled and unable to practice medicine while covered by such policy the association shall, without charging an additional premium therefor at the time of, or subsequent to, such event, also cover all occurrences between the inception date of the first such consecutive policy from such association and the death or disability of the insured, and

(C) the association shall make available and shall advise the insured of the availability and cost of coverage for occurrences between the inception date of the first such consecutive policy from such association and the termination of such policy which, subsequent to the

termination date, are reported in accordance with statutory and policy requirements, pursuant to such terms and conditions as may be specified by the superintendent by regulation. The insured shall have the option of purchasing such coverage either in a single payment or in three annual installments with an additional finance charge.

(3) Such regulation shall also provide that if the coverage of an insured who continues to practice in this state is transferred from an admitted insurer or the association to another admitted insurer or the association without any gap in coverage, the former entity shall pay over to the successor an actuarially appropriate dollar amount to provide for the requirements of paragraph two of this subsection, and the insured shall be entitled to the benefits of this provision as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

(4) Such regulation shall also provide that if the coverage of an insured is transferred from the association, if the association is in liquidation, to an admitted insurer not in liquidation without any gap in coverage, then the successor entity shall accept the amounts payable from the property-casualty insurance security fund as provided in subparagraph (G) of paragraph one of subsection (a) of section seven thousand six hundred three of this chapter, to provide for the requirements of paragraphs two and three of this subsection, and the insured shall be entitled to the benefits of such paragraphs as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

(5) The association may issue a claims-made policy with more liberal policy provisions than are required in this subsection, subject to the approval of the superintendent. Such liberal policy provisions may include but shall not be limited to a provision which, for all of the policyholders of the association, grants credits toward the cost of coverage provided in paragraph two of this subsection in proportion to the number of years the insured has purchased a claims-made policy.

§ 5505. Rates. (a) The rates, rating plans, rating rules, rating classifications, territories and statistics applicable to the insurance written by the association shall be subject to article twenty-three of

this chapter, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require.

(b) All rates shall be on an actuarially sound basis, be calculated to be self-supporting, be based upon reasonable standards, and may give consideration to such factors as the experience of the insured, geographical area and specialties of practice. The superintendent shall take all appropriate steps to make available to the association the loss and expense experience of insurers previously writing medical malpractice insurance in this state. The premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor.

(c) The association's rates, rating plans, rating rules and rating classifications may provide for premium discounts for physicians, dentists, certified nurse-midwives, certified registered nurse anesthetists or podiatrists commencing practice or conducting a limited practice as set forth in the plan of operation.

(d) In filing rates, the association may include in its experience the annuity payments received, the then present value of annuity payments to which it is entitled, and lump sum payments made by the association in accordance with subdivision (b) of section five thousand thirty-six of the civil practice law and rules.

§ 5506. Procedures. (a) Any licensed physician, dentist, podiatrist, certified nurse-midwife, certified registered nurse anesthetist or hospital is entitled to apply to the association for coverage pursuant to this article. Application may be made directly to the association by the applicant, in which event no service fee shall be charged. If the applicant authorizes a broker or agent to make the application, the only charge for such service shall be a service fee as limited by the plan of operation and in compliance with the procedure established in subsections (c) and (d) of section two thousand one hundred nineteen of this chapter.

(b) A policy shall be issued when the association determines that the

applicant is duly licensed and receives the premium or the portion prescribed in the plan of operation.

§ 5507. Participation. (a) Every member of the association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of the member (excluding that portion of premiums attributable to the operation of the association) written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Each member's participation in the association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the superintendent.

(b) In the event that sufficient funds are not available for the payment of losses and expenses incurred under policies issued by the association, the board of directors may require all members to contribute, on a temporary basis pending recoupment as provided in subsection (c) of this section, to the financial requirements of the association in the manner provided for in subsection (a) of this section.

(c) Any contribution made by members pursuant to subsection (b) of this section shall be reimbursed to them by payment from the stabilization reserve fund pursuant to the plan of operation.

§ 5508. Directors. (a) The association shall be governed by a board of twenty-one directors. The superintendent or his duly authorized representative shall serve as a non-voting director. Two directors shall be appointed by the governor. Two directors shall be appointed by the temporary president of the senate and two directors shall be appointed by the speaker of the assembly. Eight directors shall be elected by cumulative voting by the members of the association, whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. Four directors shall be appointed by the superintendent as representatives of physicians and hospitals. The superintendent shall also appoint two

directors as representatives of the public, who shall not be representatives of physicians or hospitals, or representatives of insurers or insurance producers. The eight member companies serving on the board shall be elected annually at a meeting of the members.

(b) The directors shall serve without compensation but shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties under this article.

§ 5509. Stabilization reserve fund. (a) The association shall maintain a stabilization reserve fund. The fund shall be used for payment to the association of any deficit, or for reimbursement to the association's members for payment of any deficit arising out of the operations of the association or for such other purposes as are provided for in this section. Except in the case of a premium payment made pursuant to subsection (c) of this section, a deficit shall exist whenever the sum of the premiums collected by the association and the investment income on policyholder supplied funds is exhausted in payment of the association's administrative expenses, reserves for loss, reserve for loss adjustment expenses, loss and loss adjustment expenses, and taxes.

(b) Each qualified health care provider policyholder shall annually pay to the association a stabilization reserve fund charge in an amount equal to twenty percent of the annual premium charge until the net value of the fund exceeds fifty million dollars. Thereafter, such charges shall be made only when the net value of the fund is less than twenty-five million dollars and shall continue annually until the net value of the fund exceeds fifty million dollars. There shall be no stabilization reserve fund charge payable or receivable in connection with determining the actuarially appropriate amounts for the provision of coverage to comply with the transfer requirements of subsections (c) and (d) of section three thousand four hundred thirty-six and paragraphs three and four of subsection (f) of section five thousand five hundred four of this chapter. There shall be no stabilization reserve fund charge payable if the net value of the fund is less than fifty million dollars due to a transfer pursuant to subsections (c) and (d) of this section.

(c) In addition to those purposes provided for in subsection (a) of this section, the stabilization reserve fund shall also be used for the payment of premiums for excess or equivalent excess coverage provided pursuant to the program established by chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, as amended, for the period of coverage between July first, two thousand and June thirtieth, two thousand one.

(d) The association and such officers and directors thereof responsible for the custody and investment of the stabilization reserve fund shall transfer from such fund and deposit to the hospital excess liability pool created pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six such amounts as directed by the superintendent for the purchase of excess or equivalent excess coverage for eligible participating physicians and dentists for the policy year July first, two thousand to June thirtieth, two thousand one, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, as amended, no later than July fifteenth, two thousand.

Notwithstanding any other provision of law, no director, officer, or employee of the association, nor the association, nor any public officer or employee, nor any actuary, attorney, or advisor to the association or to the superintendent shall incur or suffer any liability whatsoever to any person by reason of actions taken pursuant to this section. Any action which could have been brought against any of the persons or parties or entities noted herein, but for the provisions of this section, shall be brought against the state.

(e) Upon termination of the association and the discharge of all of its liabilities any excess funds remaining in the stabilization reserve fund shall be distributed to the policyholders of the association in an equitable manner as set forth in the plan of operation.

§ 5510. Appeals. Any applicant to the association, any person insured under this article, or their representatives, or any affected insurer,

may appeal to the superintendent within thirty days after any ruling, action or decision by or on behalf of the association, with respect to those items the plan of operation defines as appealable matters.

§ 5511. Annual statement. (a) The association shall annually file a statement in the office of the superintendent on or before the first day of March. The statement shall be in a form approved by and contain information prescribed by the superintendent with respect to its transactions, condition, operations and affairs during the preceding year.

(b) The superintendent may, at any time, require the association to furnish additional information with respect to its transactions, condition or any matter connected therewith which he considers to be material and which will assist him in evaluating the scope, operation and experience of the association.

(c) The association shall include as an asset the then present value of annuity payments to which it is entitled in accordance with subdivision (b) of section five thousand thirty-six of the civil practice law and rules.

§ 5512. Examinations. (a) The superintendent shall make an examination into the affairs of the association at least annually. The examination shall be conducted and the report filed in the manner prescribed in article three of this chapter.

(b) The expenses of the examination shall be paid by the association in the manner prescribed by section three hundred thirteen of this chapter.

§ 5513. Immunity. No liability or cause of action shall exist against the association, its agents or employees, the superintendent or his authorized representatives or any licensed agent or broker for any statements made in good faith by them during any proceedings or concerning any matters within the scope of this article.

§ 5515. Federal program. In addition to any other powers conferred upon him by this or any other law, the superintendent is authorized to do all things necessary to enable this state, the association and members and policyholders of the association to participate fully in any federal program of reinsurance adopted for purposes similar to the purposes of this article.

§ 5516-d. Further transfer of association funds. Notwithstanding any other provision of law, the association and all officers and directors with responsibility for custody or investment of the association's assets are authorized and directed to further transfer and deposit six million dollars to the credit of the medical assistance program general fund - local assistance account before January first, nineteen hundred ninety-six.

§ 5516-f. Further transfer of moneys of the association. (a) Notwithstanding any other provision of law, the association and all officers and directors with responsibility for custody or investment of the association's assets are authorized and directed to further transfer and deposit two hundred fifty million dollars to the miscellaneous special revenue fund on or before September thirtieth, nineteen hundred ninety-nine.

(b) Notwithstanding any other provision of law, the association and all officers and directors with responsibility for custody or investment of the association's assets are authorized and directed to further transfer and deposit all revenues generated pursuant to the association's dissolution pursuant to paragraph two of subsection (c) of section five thousand five hundred two of this article to the miscellaneous special revenue fund on or before December thirtieth, two thousand.

(c) Notwithstanding any other provision of law, no director, officer or employee of the association, nor the association, nor any public officer or employee, nor any actuary, attorney, or advisor to the association or to the superintendent shall incur or suffer any liability

whatsoever to any person by reason of actions taken pursuant to authorizations or directions of the provisions of subsections (a) or (b) of this section pursuant to which any of the moneys of the association are transferred to the miscellaneous special revenue fund. Any action which could have been brought against any of the persons or parties or entities noted herein, but for the provisions of this section, shall be brought against the state.

§ 5517. Transfer of association funds; reinsurance evaluation. (a) In the event that the association has not caused the transfer of certain assets on or before May first, nineteen hundred ninety-two, pursuant to the provisions of section fifty-five hundred sixteen of this article, the board shall undertake an evaluation of the procurement of reinsurance, upon so much of its book of business as is attributable to policies of excess coverage or equivalent excess coverage purchased on behalf of physicians and dentists, as is authorized by paragraph five of subsection (e) of section fifty-five hundred two of this article, specifically assessing the ability of any such reinsurance program to yield such funds as are necessary to effectuate the transfer of assets, in the form and amount provided for in section fifty-five hundred sixteen of this article.

(b) Any such plan of reinsurance developed pursuant to the evaluation undertaken pursuant to subsection (a) of this section shall be subject to the final, non-reviewable determination of the superintendent as to its sufficiency in meeting the objectives provided for in section fifty-five hundred sixteen of this article, that the plan of reinsurance provides for the ceding of risks to one or more reinsurers approved by the superintendent, that the plan of reinsurance in no way adversely affects the solvency of the association, and that the plan of reinsurance to be effectuated through the association's engaging one or more such reinsurers in a contract for the ceding of risk not later than July first, nineteen hundred ninety-two.

(c) The amounts provided for in section fifty-five hundred sixteen of this article, constituting the assets to be transferred, shall be transferred not later than August first, nineteen hundred ninety-two and only after actuarial certification that such assets constitute "surplus

surplus", or that portion of surplus not otherwise necessary for the payment of claims. Upon such certification of such assets as "surplus surplus", and not otherwise necessary for the payment of claims, such assets shall be transferred not later than the date provided for herein. Such transfer shall be deemed to be a transfer authorized by subsection (a) of section five thousand five hundred sixteen of this article.

(d) In the event that the association has failed to comply with the provisions of this section by the time periods provided for herein, the association shall be prohibited from pursuing any such reinsurance plan as a method of averting the imposition of the provisions of section ninety-one hundred ten of this chapter.

§ 5517-a. Return of association premium. (a) Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, if the superintendent determines, for policies of excess coverage or equivalent excess coverage issued by the association and purchased on behalf of eligible participating physicians and dentists, that the rates established pursuant to subdivision one of section forty of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, as amended, have produced premium amounts greater than required to satisfy the standard that premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency and of reasonable reserves and surplus therefor, then the superintendent shall direct the association and all officers and directors of the association with responsibility for custody or investment of the association's assets to return a portion of such premium to the purchaser in an amount not less than the estimated cost of all premiums necessary for the purchase of excess or equivalent excess coverage for eligible participating physicians and dentists for the policy year July first, nineteen hundred ninety-seven to June thirtieth, nineteen hundred ninety-eight, for the policy year July first, nineteen hundred ninety-eight to June thirtieth, nineteen hundred ninety-nine, for the policy year July first, nineteen hundred ninety-nine to June thirtieth, two thousand, and if the superintendent deems it necessary, for the policy year July first, two thousand to June thirtieth, two thousand one, and the cost of administering the hospital excess liability pool for such applicable

policy year. Following such determination, the superintendent shall deliver to the association a schedule providing payment in twelve monthly installments for the return of such premium due for the policy year July first, nineteen hundred ninety-seven to June thirtieth, nineteen hundred ninety-eight, no later than September first, nineteen hundred ninety-seven, for the return of such premium due for the policy year July first, nineteen hundred ninety-eight to June thirtieth, nineteen hundred ninety-nine, no later than September first, nineteen hundred ninety-eight, and for the return of such premium due for the policy year July first, nineteen hundred ninety-nine to June thirtieth, two thousand, no later than September first, nineteen hundred ninety-nine and for the policy year July first, two thousand to June thirtieth, two thousand one, no later than September first, two thousand. Payment to the purchaser for the policy year shall be made prior to the end of the applicable policy year. Upon the association's receipt of notice of such determination and delivery of such schedule, the association and all officers and directors of the association with responsibility for custody or investment of the association's assets are hereby authorized and directed to return the portion of such premium amounts to the purchaser according to such schedule. For policies of excess or equivalent excess coverage provided pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, as amended, the hospital excess liability pool created pursuant to subdivision five of section eighteen of such chapter shall be deemed to be the purchaser. The premium levels for excess coverage established by the superintendent shall, for the purpose of determining any projected deficiency as the basis for imposing a surcharge pursuant to subdivision one of section forty of such chapter as amended, be modified to reflect any such return of premium directed by the superintendent.

(b) Notwithstanding any other provision of law, no director, officer or employee of the association, nor the association, nor any public officer or employee, nor any actuary, attorney, or advisor to the association or to the superintendent shall incur or suffer any liability whatsoever to any person by reason of actions taken pursuant to this section. Any action which could have been brought against such director, officer or employee, or against such public officer or employee, or

against such actuary, attorney or advisor, or against the association, but for the provisions of this section, shall be brought against the state.

ARTICLE 56

HEALTH CARE ARBITRATIONS

Section 5601. Definitions.
5602. Professional liability policies; arbitration coverage.
5603. Arbitration administration fund and expenses.
5604. Arbitration forms, brochures, and materials.
5605. Review of health maintenance organization arbitration experience.

§ 5601. Definitions. In this article: "arbitration administrator" and "hospital" have the same meaning as such terms in article seventy-five-A of the civil practice law and rules.

§ 5602. Professional liability policies; arbitration coverage. Any professional liability policy issued or delivered in the state that provides coverage for physicians, dentists, health maintenance organizations, hospitals or health care providers shall be deemed to include coverage for and defense of claims subject to arbitration pursuant to section thirty hundred forty-five or article seventy-five-A of the civil practice law and rules or section forty-four hundred six-a of the public health law.

§ 5603. Arbitration administration fund and expenses. (a) There is established within the department an arbitration administration fund which shall be considered to be an expense of the department and shall be funded by order of the superintendent, pursuant to section two hundred six of the financial services law in such amount as shall be sufficient to defray the actual administrative expenses of the department and the arbitration administrator for the projected number of

arbitration proceedings for a twelve-month period, after taking into consideration any excessive or insufficient amounts from the previous assessments, any appropriation of public funds for this purpose and any funds collected from claimants participating in the arbitration. If the amount assessed for any twelve-month period is insufficient to defray expenses during that period, a further assessment may be ordered by the superintendent. The arbitration administrator shall establish reasonable fees for claimants who participate in the arbitration, subject to the approval of the superintendent.

(b) The administrative expenses shall include but not be limited to the costs of arbitrators, the arbitration administrator and the department.

§ 5604. Arbitration forms, brochures, and materials. The arbitration administrator shall submit to the superintendent, for review and approval, required forms of agreement and explanatory brochures and materials to be used for the arbitrations authorized by section forty-four hundred six-a of the public health law and article seventy-five-A of the civil practice law and rules.

§ 5605. Review of health maintenance organization arbitration experience. No health maintenance organization shall offer enrollees the option of electing arbitration of claims pursuant to section forty-four hundred six-a of the public health law without notifying the superintendent of an intention to offer the arbitration option and obtaining the superintendent's approval. The superintendent shall approve such requests, subject to the limitations of this section and in a manner that allows for sufficient geographical and program diversity to permit an effective evaluation of the arbitration experience. The superintendent of financial services shall require health maintenance organizations to submit, on a quarterly basis, information concerning the numbers of enrollees who elect the arbitration option, along with such other information as the superintendent may require. Notwithstanding the provisions of section forty-four hundred six-a of the public health law, no health maintenance organization shall permit

new enrollees to elect the arbitration of claims after December first, nineteen hundred ninety-one or after such organizations have been notified by the superintendent that five hundred thousand persons have elected to arbitrate claims, whichever event first occurs. Within one hundred twenty days of such date or event, the superintendent shall submit a report to the governor and the legislature describing the experience of health maintenance organization enrollee arbitration and including any recommendations for the future of such program.

ARTICLE 59
RISK RETENTION GROUPS AND PURCHASING GROUPS

Section 5901. Title and purpose.
5902. Definitions.
5903. Domestic risk retention groups.
5904. Risk retention groups not chartered in this state.
5905. Risk retention groups; notice, prohibited solicitation, coverage and ownership.
5906. Security funds and compulsory associations.
5907. Purchasing groups; exemption from certain laws.
5908. Notice and registration requirements of purchasing groups.
5909. Restrictions on insurance obtained by purchasing groups.
5910. Administrative and procedural authority regarding risk retention groups and purchasing groups.
5911. Insurance agents, insurance brokers and excess line brokers.
5912. Binding effect of orders issued in United States district court.
5913. Financial responsibility.

§ 5901. Title and purpose. This article may be cited as the "risk retention groups and purchasing groups act." The purpose of this article is to regulate the formation and/or operation in this state of risk retention groups and purchasing groups formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (Public Law 99 - 563), to the extent permitted by such law.

§ 5902. Definitions. The terms used in this article shall have the meanings set forth in this chapter, except to the extent added or modified by the following:

(a) "Commissioner" means the commissioner, director or superintendent of financial services in any other state.

(b) "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

(1) any person who performs that work; or

(2) any person who hires an independent contractor to perform that work;

but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(c) "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means:

(1) for a corporation, the state in which the purchasing group is incorporated; and

(2) for an unincorporated entity, the state of its principal place of business.

(d) "Financially impaired" means a risk retention group:

(1) whose admitted assets are less than the sum of its aggregate liabilities and the amount of surplus to policyholders required to be maintained by a domestic risk retention group authorized to do the same kind or kinds of insurance; or

(2) whose admitted assets are less than the sum of its aggregate liabilities and outstanding capital stock; or

(3) which is insolvent.

(e) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired, is unlikely to be able:

(1) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(2) to pay other obligations in the normal course of business.

(f) "Insolvent" means a risk retention group whose admitted assets are

less than the aggregate amount of its liabilities.

(g) "Insurance" means primary insurance, excess insurance, reinsurance, excess line insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(h) "Liability" means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:

(1) (A) any business (whether profit or nonprofit), trade, product, services (including professional services), premises, or operations; or

(B) any activity of any state or local government, or any agency or political subdivision thereof; and

(2) does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. § 51 et seq.).

(i) "Located" or "location", for purposes of determining the state in which a purchasing group is located, shall be defined in regulations promulgated by the superintendent which shall not be inconsistent with the Federal Liability Risk Retention Act of 1986 and amendments thereto.

(j) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in subsection (h) of this section.

(k) "Plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group making application to become chartered and licensed as a domestic property/casualty insurer in this state, including at least the following:

(1) information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises or operations;

(2) for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems

for each kind of insurance the group intends to offer;

(3) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(4) pro forma financial statements and projections;

(5) appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent the development of a hazardous financial condition;

(6) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

(7) identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each state; and

(8) such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of the state.

(l) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

(m) "Purchasing group" means any group formed pursuant to the federal liability risk retention act of 1986 which:

(1) has as one of its purposes the purchase of liability insurance on a group basis;

(2) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph three of this subsection;

(3) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(4) is domiciled in any state.

(n) "Risk retention group" means any corporation or other limited liability association formed pursuant to the federal liability risk retention act of 1986:

(1) whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(2) which is organized for the primary purpose of conducting the activity described under paragraph one of this subsection;

(3) which:

(A) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(B) before January first, nineteen hundred eighty-five, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability;

(4) which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(5) which:

(A) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(B) has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and which organization has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the risk retention group;

(6) whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises or operations;

(7) whose activities do not include the provision of insurance other

than:

(A) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(B) reinsurance with respect to the liability of any other risk retention group (or any member of such other risk retention group) which is engaged in businesses or activities which meet the requirement described in paragraph six of this subsection for membership in the risk retention group which provides such reinsurance; and

(8) the name of which includes the phrase "risk retention group".

(o) "State" means any state of the United States or the District of Columbia.

(p) "Superintendent" means the superintendent of financial services of this state.

§ 5903. Domestic risk retention groups. (a) A domestic risk retention group shall, pursuant to the provisions of this chapter, be chartered and licensed as a domestic property/casualty insurer to write only liability insurance pursuant to this article and, except as provided elsewhere in this article, shall comply with all of the laws, regulations and orders applicable to property/casualty insurers organized and licensed in this state.

(b) Before it may offer insurance in any state, each domestic risk retention group shall submit to the superintendent for approval a plan of operation or feasibility study, and shall also submit a completed National Association of Insurance Commissioners risk retention report form to the superintendent. Such group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study within ten days of any such change. Such group shall not offer any additional kinds of liability insurance in any state until a revision of the plan or study has been approved by the superintendent.

(c) The submission of a plan of operation or feasibility study shall not be required with respect to any kind or classification of liability insurance which was:

(1) defined in the federal Product Liability Risk Retention Act of 1981 (Public Law 97-45) before October twenty-seventh, nineteen hundred

eighty-six; and

(2) offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date.

(d) Immediately upon receipt of any application for licensing as a domestic risk retention group, the superintendent shall provide summary information concerning the filing to the National Association of Insurance Commissioners.

(e) The name under which a domestic risk retention group may be chartered and licensed shall be a brief description of its membership followed by the phrase "Risk Retention Group", and, unless its membership consists solely of insurers, shall not include the use of the terms "insurance", "insurance company", "mutual", "reciprocal", or any similar terms.

§ 5904. Risk retention groups not chartered in this state. A risk retention group not chartered and licensed as a property/casualty insurer in this state, seeking to do business or doing business as a risk retention group in this state, shall comply with the laws of this state, as follows:

(a) Notice of operations and designation of superintendent as agent. Before offering insurance in this state, such risk retention group shall submit to the superintendent:

(1) a statement identifying the state or states in which the risk retention group is chartered and licensed as an insurance company to write liability insurance, the dates of chartering and licensing, and its principal place of business;

(2) a copy of its plan of operation or feasibility study and all revisions of such plan or study submitted to its chartering and licensing state; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any kind or classification of liability insurance which was:

(A) defined in the federal Product Liability Risk Retention Act of 1981 before October twenty-seventh, nineteen hundred eighty-six; and

(B) offered before such date by any risk retention group which had

been chartered and was operating for not less than three years before such date; and

(3) a statement of registration, for which a filing fee shall be imposed in accordance with a regulation to be promulgated by the superintendent, which statement of registration shall include a power of attorney designating the superintendent as its agent for the purpose of receiving service of process in any proceeding against it on a contract delivered or issued for delivery, or on a cause of action arising, in this state.

(A) The power of attorney shall be accompanied by written designation of the name and address of the officer, agent, or other person to whom such process shall be forwarded by the superintendent or his deputy on behalf of such risk retention group. In the event such designation is changed, a new certificate of designation shall be filed with the superintendent within ten days of such change.

(B) Service of process upon a risk retention group pursuant to this paragraph shall be made by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose with two copies thereof and the payment of a fee of twenty dollars. The superintendent shall forward a copy of such process by registered or certified mail to the risk retention group at the address given in its written certificate of designation, and shall keep a record of all such process served. Service of process so made shall be deemed made within the territorial jurisdiction of any court in this state.

(b) Financial condition. Any such risk retention group doing business in this state, shall submit to the superintendent:

(1) a copy of the annual financial statement submitted to the state in which the risk retention group is chartered and licensed, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners):

(2) a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(3) upon request by the superintendent, a copy of any audit performed with respect to the risk retention group; and

(4) such information as may be required to verify its continuing qualification as a risk retention group.

(c) Taxation. (1) Any such risk retention group shall be liable for the payment of franchise taxes and taxes on premiums and shall report to the superintendent the gross direct premiums, less returns thereon, written on risks resident or located within this state. Any such risk retention group shall be deemed to be a licensed foreign insurer for the purposes of taxation, and any applicable fines and penalties related thereto.

(2) Whenever licensed insurance agents or insurance brokers place business with a risk retention group, such licensee shall report to the superintendent the premiums of direct business for risks resident or located within this state which they have placed with such risk retention group, and such licensee shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the superintendent, as provided in section three hundred ten of this chapter. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

(A) the limit of liability;

(B) the time period covered;

(C) the effective date;

(D) the name of the risk retention group which issued the policy;

(E) the gross premium charged; and

(F) the amount of return premiums, if any.

(d) Compliance with unfair claims settlement practices law. Any such risk retention group and its agents and representatives shall comply with the unfair claims settlement practices provisions as set forth in section two thousand six hundred one of this chapter, and any regulations promulgated thereunder.

(e) Deceptive, false, or fraudulent acts or practices. Any such risk retention group shall comply with the deceptive, false or fraudulent act or practices provisions set forth in article twenty-four of this chapter, and any regulations promulgated thereunder.

(f) Examination regarding financial condition. Any such risk retention

group shall submit to an examination by the superintendent to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty days after a request by the superintendent. Any such examination shall be coordinated with other jurisdictions to the extent feasible in order to avoid unjustified repetition, and shall be conducted in an expeditious manner.

(g) Injunctions. Any such risk retention group shall comply with an injunction issued by a court of competent jurisdiction upon a petition by the superintendent that the risk retention group is in hazardous financial condition or financially impaired.

(h) Dissolution or article seventy-four proceedings. Any such risk retention group shall comply with any lawful order issued in a voluntary dissolution proceeding or in an article seventy-four proceeding commenced by the superintendent if there has been a finding, after an examination conducted pursuant to subsection (f) of this section, that such risk retention group is financially impaired.

(i) Operation prior to enactment of this article. In addition to complying with the requirements of this section, any such risk retention group operating in this state prior to the enactment of this article shall, within thirty days after the effective date of this article, comply with the provisions of subsection (a) of this section.

(j) Penalties. Any such risk retention group which violates any provision of this article shall be deemed to be a licensed foreign insurer for the purposes of assessing fines and penalties and the superintendent shall also have the authority to revoke such group's right to do business in this state.

§ 5905. Risk retention groups; notice, prohibited solicitation, coverage and ownership. (a) Notice to purchasers. (1) Every insurance policy issued by a risk retention group shall contain in ten point type on the front page and on the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group.
Your risk retention group may not be subject to all
of the insurance laws and regulations of your state.

State insurance insolvency guaranty funds are not available for your risk retention group.

(2) Every application for insurance from a risk retention group shall prominently contain a similar notice.

(b) Prohibited acts regarding solicitation or sale. The following acts by a risk retention group are prohibited:

(1) The solicitation or sale of insurance to any person who is not eligible for membership in such group; and

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(c) Prohibited coverage. The terms of any insurance policy issued or issued for delivery in this state by any such risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

(d) Prohibition on ownership by an insurer. No risk retention group shall do business in this state if an insurer is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurers.

§ 5906. Security funds and compulsory associations. (a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency security fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

(b) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks wherever resident or located shall be covered by any insurance insolvency security fund or similar mechanism in this state.

(c) The superintendent may require risk retention groups not chartered in this state to participate, and may exempt domestic risk retention groups from participation, in any mechanism established or authorized

under the law of this state for the equitable apportionment among insurers of liability insurance risks or of liability insurance losses and expenses incurred on policies written through such mechanism, and such risk retention groups shall submit sufficient information to the superintendent to enable the superintendent to apportion on a non-discriminatory basis the risk retention group's proportionate share of such risks or of such losses and expenses.

§ 5907. Purchasing groups; exemption from certain laws. A purchasing group and its insurer shall be subject to all applicable laws of this state, except that a purchasing group and its insurer shall be exempt, in regard to liability insurance for the purchasing group and any of its members, from any law that would:

(a) prohibit the establishment of a purchasing group;

(b) make it unlawful for an insurer to provide or offer to provide liability insurance on a basis providing, to a purchasing group or its members, advantages, based on their loss and expense experience, not afforded to other persons with respect to rates, policy forms, coverages or other matters;

(c) prohibit a purchasing group or its members from purchasing liability insurance on a group basis described in subsection (b) of this section;

(d) prohibit a purchasing group from obtaining liability insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(e) require that a purchasing group must have a minimum number of members, common ownership or affiliation, or a certain legal form;

(f) require that a certain percentage of a purchasing group must obtain liability insurance on a group basis; or

(g) otherwise discriminate against a purchasing group or any of its members.

§ 5908. Notice and registration requirements of purchasing groups. (a) A purchasing group which intends to do business in this state shall,

prior to doing such business, furnish notice of such intention to the superintendent. This notice shall include the following information:

(1) the state in which the group is domiciled;

(2) the principal place of business of the group;

(3) the kinds and classifications of liability insurance which the purchasing group intends to purchase;

(4) the method by which, and the person or persons if any through whom, insurance will be offered to its members whose risks are resident or located in this state;

(5) the name and chartering jurisdiction of the insurer or risk retention group from which the purchasing group intends to purchase its insurance; and

(6) all other states in which the group intends to do business.

(b) A purchasing group shall, as to any subsequent changes in any of the items set forth in subsection (a) of this section, notify the superintendent within ten days of any such change.

(c) Each purchasing group which is required to give notice pursuant to subsection (a) of this section shall also furnish such information as may be required by the superintendent to:

(1) verify that the entity qualifies as a purchasing group; and

(2) determine compliance with any applicable state law.

(d) A purchasing group which does business in this state shall submit to the superintendent a statement of registration, for which a filing fee shall be imposed in accordance with a regulation to be promulgated by the superintendent, which statement of registration shall include a certified power of attorney designating the superintendent as its agent for the purpose of receiving service of legal documents or process.

(1) The power of attorney shall be accompanied by written designation of the name and address of the officer, agent, or other person to whom such legal documents or process shall be forwarded by the superintendent or his deputy on behalf of such purchasing group. In the event such designation is changed, a new certificate of designation shall be filed with the superintendent within ten days of such change.

(2) Service of legal documents or process upon a purchasing group pursuant to this subsection shall be made by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose with two copies

thereof and the payment of a fee of twenty dollars. The superintendent shall forward a copy of such legal documents or process by registered or certified mail to the purchasing group at the address given in its written certificate of designation, and shall keep a record of all legal documents or process so served upon him. Service of legal documents or process so made shall be deemed made within the territorial jurisdiction of any court in this state.

(3) The registration and designation requirement of this subsection shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the Federal Product Liability Risk Retention Act of 1981; and

(A) was domiciled before April first, nineteen hundred eighty-six and is domiciled on or after October twenty-seventh, nineteen hundred eighty-six in any state;

(B) before October twenty-seventh, nineteen hundred eighty-six, purchased liability insurance only from an insurer licensed in any state and since October twenty-seventh, nineteen hundred eighty-six purchases its liability insurance only from an insurer licensed in any state; and

(C) before October twenty-seventh, nineteen hundred eighty-six, was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981.

(e) Any purchasing group which was doing business in this state prior to the enactment of this article shall, within thirty days after the effective date of this article, furnish notice to the superintendent pursuant to the provisions of subsection (a) of this section and furnish such information as may be required pursuant to subsections (b), (c) and (d) of this section.

§ 5909. Restrictions on insurance obtained by purchasing groups. (a) A purchasing group located in this state shall not purchase liability insurance from a risk retention group not chartered in a state or from an insurer not authorized in this state, unless the purchase is effected pursuant to section two thousand one hundred eighteen of this chapter through an excess line broker licensed pursuant to section two thousand one hundred five of this chapter, except where otherwise permitted pursuant to section two thousand one hundred seventeen of this chapter.

(b) The terms of any liability insurance policy issued or issued for delivery in this state to a purchasing group or any of its members shall not provide, or be construed to provide, insurance coverage prohibited generally by state statute or declared unlawful by the highest court of the state whose law applies to such policy. If the law of this state applies to an insurance policy obtained by a purchasing group, the terms of that policy shall not provide or be construed to provide insurance coverage prohibited generally by state statute or declared unlawful by the highest court of this state which has construed such coverage.

(c) A purchasing group which obtains liability insurance from an insurer not authorized in this state or a risk retention group shall inform each of the members of such group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency security fund in this state, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

(d) No liability insurance policy issued or issued for delivery in this state to a purchasing group or a member of such group with a risk resident or located within this state shall provide for a deductible or self-insured retention shared among purchasing group members or applicable to the group itself.

§ 5910. Administrative and procedural authority regarding risk retention groups and purchasing groups. The superintendent is authorized to make use of any of the powers, established under this chapter to enforce the laws of this state, not specifically preempted by the federal Liability Risk Retention Act of 1986. Such powers include the superintendent's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceeding, or litigation, the superintendent may rely on the procedural law and regulations of this state.

§ 5911. Insurance agents, insurance brokers and excess line brokers. (a) The provisions of article twenty-one of this chapter shall apply to

any risk retention group not chartered and licensed in this state as a property/casualty insurer but which is doing business in this state. Any such risk retention group shall for such purposes be deemed to be a licensed foreign insurer.

(b) If any person, firm, association, or corporation does an act with respect to a purchasing group or any member thereof, which act if done with respect to any other person or entity would require that the person, firm, association, or corporation doing such act be licensed as an insurance agent or broker, then such person, firm, association, or corporation must be appropriately licensed pursuant to this chapter.

(c) Every person, firm, association, or corporation licensed pursuant to the provisions of article twenty-one of this chapter shall, on business placed by such licensee with a risk retention group or with an unauthorized insurer on behalf of a purchasing group or any of its members, inform each prospective insured of the provisions of the notice required by subsection (a) of section five thousand nine hundred five of this article in the case of a risk retention group and subsection (c) of section five thousand nine hundred nine of this article in the case of a purchasing group.

§ 5912. Binding effect of orders issued in United States district court. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states or in any territory or possession of the United States), upon a finding that such a group is in hazardous financial condition or financially impaired shall be enforceable in the courts of this state.

§ 5913. Financial responsibility. Except as provided in sections three hundred eleven and three hundred seventy of the vehicle and traffic law, wherever pursuant to the laws of this state or any political subdivision of this state a demonstration of financial responsibility is required as a condition for obtaining a license or permit to undertake specified activities, if any such requirement may not be satisfied by obtaining insurance coverage from an insurer not authorized to do business in this

state, such requirement may not be satisfied by purchasing insurance from a risk retention group not chartered in this state. Every insurance policy issued by a risk retention group not chartered in this state pursuant to sections three hundred eleven and three hundred seventy of the vehicle and traffic law shall contain the notice set forth in section five thousand nine hundred five of this article.

ARTICLE 61

RECIPROCAL INSURERS AND LLOYDS UNDERWRITERS

Section 6101. Definitions.
6102. Organization of domestic reciprocal insurers.
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§ 6101. Definitions. In this article:

(a) "Advisory committee" means any official body, by whatever name called, which is chosen by the subscribers of a reciprocal insurer and which has, subject to the articles of association and subscribers agreement, ultimate power and responsibility in the management and control of the affairs of a reciprocal insurer.

(b) "Attorney-in-fact" means a person designated and appointed by subscribers to a reciprocal insurer to act for and bind the subscribers in all transactions relating to or arising out of the operations of a

reciprocal insurer, subject to limitations as may be lawfully provided.

(c) "Books, accounts and records" means all working papers, ledgers, and other relevant documents which demonstrate, disclose and support transactions of the reciprocal and each individual subscriber, as distinguished from the attorney-in-fact, and which relate to the operations and activities of the reciprocal. The phrase "books, accounts and records" shall not mean or include working papers, ledgers, or other relevant documents which relate exclusively to the operation and activities of the attorney-in-fact as a separate entity.

(d) "Financial interest" means that a person owns, directly or indirectly, more than one percent of the outstanding stock in the attorney-in-fact, has any outstanding loans from the attorney-in-fact, or earns a commission or other compensation as a producer for the reciprocal.

(e) "Material transaction" means a transaction, other than claim payments, that involves more than one-half of one percent of the reciprocal's admitted assets as of the thirty-first day of December of the prior year.

(f) "Person" means an individual, partnership, firm, association, corporation, not-for-profit corporation, joint-stock company, trust, any similar entity, or any combination of the foregoing acting in concert.

(g) "Subscriber" means a person who has become a member of a reciprocal through the execution of a subscriber's agreement.

(h) "Subscriber's agreement" means a document executed by the subscriber which designates and appoints, through a power of attorney, the attorney-in-fact and, either within the agreement or via a management agreement or an appended set of bylaws, that sets forth the duties of the attorney-in-fact.

*** § 6102. Organization of domestic reciprocal insurers.** (a) Twenty-five or more persons, firms and corporations, each having the qualifications of subscribers as prescribed in this article, may organize a reciprocal insurer to do any one or more of the basic kinds of insurance set forth in subsection (a) of section four thousand one hundred one of this chapter or, in the alternative, twenty-five or more New York counties, towns, cities, villages, district corporations (as

defined in paragraph three of section 2.00 of the local finance law), or school districts and boards of cooperative educational services, each having the qualifications of subscribers as prescribed in this article, may organize statewide municipal reciprocal insurers to provide any one or more of the basic kinds of insurance set forth in subsection (a) of section four thousand one hundred one of this chapter, except workers' compensation and employers' liability, fidelity and surety other than official undertakings conditioned for the faithful performance of official duties as referenced in section eleven of the public officers law and required by related provisions of the county, town, and village laws, credit and marine and inland marine (except as authorized by the provisions of paragraph two of subsection (b) of section four thousand one hundred two of this chapter) insurance. Such an insurer shall be called, for purposes of this chapter, a "municipal reciprocal insurer" and shall be subject to all the provisions of this chapter applicable to a reciprocal insurer, except where the context otherwise requires. However, any reciprocal insurer authorized to do the business of workers' compensation insurance shall be deemed to be a mutual carrier within the meaning of the definition of that term in section one hundred six of the workers' compensation law and shall be subject to the provisions of article six-A of such law.

(b) The original subscribers and the attorney-in-fact shall execute a declaration setting forth the following:

(1) the name of such reciprocal insurer, which shall conform to the provisions of subsection (g) of section one thousand one hundred two of this chapter;

(2) the location of the principal office of such reciprocal insurer, which shall be the same as the principal office of the attorney-in-fact and shall at all times be located in this state;

(3) the kind or kinds of insurance business intended to be done, specified in terms of subsection (a) of section one thousand one hundred thirteen of this chapter;

(4) the names and addresses of the subscribers so proposing to engage in such business;

(5) the designation and appointment of an attorney-in-fact, which may be a person, other than an individual, organized under the laws of this state authorized by the superintendent to act as such for one or more

reciprocal insurers; and having its principal office in this state;

(6) the names and addresses of the officers and directors of the attorney-in-fact, if a corporation, or of its members, if a firm, of whom a majority shall be residents of this state or of contiguous states;

(7) the designation of an advisory committee, all of whose members shall be subscribers or officers or directors of subscriber corporations or members of subscriber firms, to act on behalf of the subscribers, with power to supervise and control the attorney-in-fact and to control the investments of the assets of the reciprocal insurer, and such other powers as may be conferred by the articles of association and the subscriber's agreement;

(8) a declaration (i) that all of the invested assets of such reciprocal insurer, except deposits held by state officials as required by law, shall be held by and in the name of such reciprocal insurer, subject to the control of the advisory committee and to the provisions of this chapter, and (ii) that all monies paid to such reciprocal insurer shall, after deducting any sums payable to the attorney-in-fact, be held by such attorney-in-fact in the name of the reciprocal insurer for the uses specified in the subscriber's agreement;

(9) an exact and complete copy of the articles of association, if any, and the subscriber's agreement;

(10) the amount and kind of insurance for which each subscriber proposes to become a policyholder, and the premium specified therefor; and

(11) such other information as the superintendent may require.

(12) in the case of a municipal reciprocal insurer, a statement electing whether or not the insurer and the contracts of insurance it issues will be subject to the provisions of article seventy-six of this chapter. In the event that the municipal reciprocal insurer elects that it and its contracts of insurance will not be subject to such article, then every such contract and every subscriber's agreement shall disclose the lack of coverage by the property/casualty insurance security fund, the inapplicability of such article, and provide for an unlimited contingent several liability for assessment of the subscriber. The election whether or not to be subject to the provisions of article seventy-six of this chapter shall be irrevocable.

(c) Such declaration shall be subscribed and affirmed as true under the penalties of perjury by each subscriber and by each member of the advisory committee, in the manner required for the acknowledgment of conveyances of real property to be recorded in this state, and shall be filed in the office of the superintendent. Such articles of association and subscriber's agreement shall in all respects conform with the requirements of this article.

(d) If the superintendent finds that such declaration, articles of association and subscriber's agreement are in conformity with law, that the subscribers, the attorney-in-fact and the advisory committee are legally qualified, that each individual is a person of good repute and that each subscriber has a bona fide intention of effecting the amount and kind of insurance therein specified, he may approve such declaration and notify the advisory committee to that effect; but neither the reciprocal insurer nor its attorney-in-fact shall be authorized to do an insurance business until such reciprocal insurer has obtained a license as hereinafter provided.

(e) If within one year thereafter the superintendent finds, after such investigation and examination as he may see fit to make, that each subscriber has deposited in cash with the attorney-in-fact an amount at least equal to the premium specified in such declaration, and that a fund, at least equal to the amount of surplus to policyholders required by paragraph one of subsection (a) of section four thousand one hundred three of this chapter for a newly organized domestic stock property/casualty insurance company doing the same kind or kinds of insurance business, has been advanced by the subscribers as an initial surplus to policyholders, and is in the possession of the attorney-in-fact or invested subject to the control of the advisory committee, and that other requirements of this chapter applicable to such reciprocal insurer have been complied with, he may issue to such reciprocal insurer a license to do business. Thereafter, every such reciprocal insurer shall maintain a surplus to policyholders at least equal to the amount of surplus to policyholders required to be maintained by such paragraph.

(f) The original subscribers and the attorney-in-fact shall be jointly and severally liable for the expenses of organization in the event that such reciprocal insurer does not comply with all the requirements for a

license, and obtain a license, to do an insurance business within one year after the filing of the declaration as specified in subsection (b) hereof. In such event the superintendent may maintain a proceeding under article seventy-four of this chapter to liquidate and dissolve such reciprocal insurer.

(g) (1) A licensed reciprocal insurer may be licensed to do non-basic kinds of insurance as set forth in subsection (b) of section four thousand one hundred one of this chapter, subject to the requirements of subsection (b) of section four thousand one hundred two of this chapter, except that a municipal reciprocal insurer may not be licensed to do accident and health, non-cancellable disability, marine protection and indemnity, and residual value insurance.

(2) It shall also have an initial surplus to policyholders at least equal to the amount required by paragraph one of subsection (a) of section four thousand one hundred three of this chapter for the organization of a stock property/casualty insurance company doing the same kinds of insurance and shall thereafter maintain a surplus to policyholders at least equal to the amount required to be maintained by such paragraph for a similarly licensed stock property/casualty insurance company.

(h) A licensed reciprocal insurer may be licensed (except with respect to the kinds of insurance defined respectively in the following paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter: life insurance (1), annuities (2) and title insurance (18)) to (i) reinsure risks of every kind or description, and (ii) insure property or risks of every kind or description located or resident outside of the United States, its territories and possessions, provided such insurer maintains a surplus to policyholders of at least thirty-five million dollars. The provisions of this subsection shall not apply to a municipal reciprocal insurer.

(i) The financial requirements of subsections (e) and (g) hereof shall be reduced by fifty percent for a reciprocal insurer initially licensed to do business in this state prior to July first, nineteen hundred eighty-two. Such reduction shall not apply to the specified financial requirements in order to write paragraph twenty-two, twenty-four or twenty-six of subsection (a) of section one thousand one hundred thirteen of this chapter.

(j) A municipal reciprocal insurer shall:

(1) comply with all applicable provisions of this chapter;

(2) comply with such additional standards as the superintendent may by regulation prescribe;

(3) not refuse to issue, renew or cancel a policy for any eligible, insurable risk based solely on geographical location;

(4) not refuse to write coverages afforded by such insurer for any eligible risk in accordance with standards of insurability filed with and approved by the superintendent; and

(5) establish and promote a risk management program among subscribers to identify and reduce risks by implementation of loss control, safety programs and other methods of risk management.

(k) With respect to a municipal reciprocal insurer, the amount of the initial surplus to policyholders required by the provisions of subsection (e) of this section, in order for such an insurer to obtain a license to do business, may be collected from the subscribers as follows: within one year from the date a license to do business was granted twenty percent shall be so collected, within two years from such date forty percent shall be so collected, within three years from such date sixty percent shall be so collected, within four years from such date eighty percent shall be so collected, and within five years from such date one hundred percent shall be so collected. The amount of surplus to policyholders to be maintained by such an insurer during such five year period shall be the amount collected from subscribers pursuant to the schedule contained in this subsection.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

*** § 6103. Deposits.** (a) Before being licensed, every domestic reciprocal insurer shall comply with the provisions of subsection (a) of section four thousand one hundred four of this chapter imposed upon a

domestic property/casualty insurance company doing the same kind or kinds of insurance. Notwithstanding the foregoing, every municipal reciprocal insurer may comply with such provisions within one year from the date a license to do business was granted.

(b) Before being licensed pursuant to subsection (h) of section six thousand one hundred two of this article to do insurance on risks outside of the United States, its territories and possessions, or to do reinsurance, a domestic reciprocal insurer shall comply with the provisions of subsection (b) of section four thousand one hundred four of this chapter imposed upon a domestic property/casualty insurance company.

(c) Before being licensed to issue non-assessable policies pursuant to section six thousand one hundred eight of this article, a domestic reciprocal insurer shall comply with the provisions of subsection (c) of section four thousand one hundred four of this chapter imposed on a domestic mutual property/casualty insurance company.

(d) The financial requirements of subsections (a) and (c) hereof shall be reduced by fifty percent for a reciprocal insurer initially licensed to do business in this state prior to July first, nineteen hundred eighty-two.

(e) Before being granted any license or renewal license, every foreign reciprocal insurer shall comply with the provisions of subsection (d) of section four thousand one hundred four of this chapter imposed on a foreign property/casualty insurance company.

* SPECIAL NOTE.--Notwithstanding that Chapter 585 of the Laws of 1984:

Bill sections 2, 3, 5, 6, 7, and 9 of such chapter amend provisions of the former Insurance Law that are not possible to juxtapose at this time due to the highly technical nature of such changes and will need future corrective legislation to implement such provisions into the new Insurance Law as enacted by such Chapter 367 of the Laws of 1984.

§ 6104. Qualifications of subscribers. (a) (1) No authorized reciprocal insurer shall make any new agreement for insurance containing a provision for contingent liability of subscribers with any subscriber who or which does not have assets in his, their or its own right in an

amount not less than fifty thousand dollars in excess of liabilities as shown by a commercial agency report as hereinafter provided, or by a sworn statement on file with the attorney-in-fact, verified by such subscriber or by an officer of a corporation subscriber.

(2) (A) Before renewing a contract of insurance with a subscriber, containing a provision for contingent liability of subscribers, similar proof of financial responsibility shall be required unless the subscriber has accumulated and maintains the subscriber's operating reserve required by section six thousand one hundred nine of this article.

(B) The report of an established commercial agency having one hundred thousand or more subscribers shall be deemed presumptive evidence of the financial condition of a subscriber.

(b) (1) All corporations and the directors or any representative thereof and all persons, firms or corporations holding property in trust may insure the same in reciprocal insurers and by so doing such directors, representatives or trustees, in their representative capacity, may assume the liabilities and be entitled to the rights of a subscriber of such reciprocal insurer.

(2) Such directors, representatives or trustees shall not be personally liable as individuals upon such contract of insurance or subscriber's agreement.

§ 6105. Licensing. (a) No person, firm, corporation or association as an underwriter or underwriters, and no reciprocal insurer, shall do any insurance business in this state, nor shall any person, firm, corporation or association as attorney-in-fact or other representative of any reciprocal insurer do or cause to be done within this state any act which effects, aids or promotes the doing of an insurance business in this state by any reciprocal insurer, unless authorized so to do pursuant to the provisions of this article.

(b) Every license to do an insurance business issued by the superintendent to any reciprocal insurer pursuant to the provisions of this article shall specify its name, the location of its principal office, the name and principal address of its attorney-in-fact, and the kind or kinds of insurance business, specified in terms of subsection

(a) of section one thousand one hundred thirteen of this chapter, which it is authorized to do in this state.

(c) No person shall act in the capacity of an attorney-in-fact for a subscriber whose risk is located in this state or for a reciprocal licensed to do business in this state, unless such person is authorized as such by the superintendent.

(d) The superintendent may require the attorney-in-fact, or any person to which its functions, in whole or in part, have been delegated, unless wholly owned or controlled by the reciprocal to:

(1) provide a bond issued by an insurer and in an amount acceptable to the superintendent for the protection of the subscribers to the reciprocal; and

(2) maintain an errors and omissions policy, providing coverage in an amount and issued by an insurer acceptable to the superintendent.

(e) The attorney-in-fact authorized as such pursuant to subsection (c) of this section shall not, merely by virtue of such authorization, be thereby deemed to be doing business in this state within the meaning of any laws of this state applicable to general business corporations.

(f) An attorney-in-fact of a reciprocal insurer licensed in this state shall, on or before June first of each year, file with the superintendent an audited financial report of its financial condition and the results of its operations as related to its management of the reciprocal, covering the previous calendar year, prepared in accordance with generally accepted accounting principles by an independent certified public accountant who certified to the reciprocal's annual statement pursuant to section three hundred seven of this chapter. In lieu of such a report, an attorney-in-fact of a foreign reciprocal who is an individual, shall file a statement prepared by such independent certified public accountant stating that its audit of the reciprocal discloses any direct or indirect compensation or benefit paid by the reciprocal to the attorney-in-fact. The report or statement filed pursuant to this subsection shall be a confidential document, not subject to disclosure pursuant to this chapter or article six of the public officers law.

(g) An attorney-in-fact of a reciprocal licensed in this state shall submit to examination by order of the superintendent for the purposes of determining compliance with this article and all other relevant

provisions of this chapter relating to the operations of the reciprocal or its attorney-in-fact, which the superintendent determines (as specified in the order) cannot be obtained by examination of the reciprocal. The cost of the examination shall be assessed against the attorney-in-fact and no portion thereof shall be reimbursed directly or indirectly by the reciprocal or its subscribers.

(h) The advisory committee shall meet at least annually and shall consist of at least nine individuals elected by the subscribers, at least two-thirds of whom are subscribers or officers or directors of subscribers and, except for a municipal reciprocal or a reciprocal which wholly owns its attorney-in-fact, not more than one-third of whom may be:

(1) the attorney-in-fact; or

(2) an employee, officer, director, or affiliate of the attorney-in-fact; or

(3) any person having a financial interest in the attorney-in-fact; or

(4) any person representing any of the foregoing.

(i) Members of the advisory committee may be elected and re-elected to a term of office of not less than one year nor more than four years, and terms may be staggered to provide for continuity.

(j) The chair of the advisory committee of a domestic reciprocal, who shall not be any of those persons enumerated in paragraphs one through four of subsection (h) of this section, shall be elected by the other members of the committee and the committee of a domestic reciprocal shall adopt rules consistent with its purposes, as approved by the superintendent.

(k) Special meetings of the advisory committee may be called by the attorney-in-fact, the chair of the committee, any three members of the committee, or a signed petition of at least one percent of the subscribers as of the most recent annual report of the reciprocal.

§ 6106. Subscriber's agreement. (a) (1) Every subscriber of an authorized reciprocal insurer shall have executed a subscriber's agreement, and every subscriber executing such a subscriber's agreement containing a provision for contingent liability of subscribers shall execute and duly acknowledge the same, in a manner sufficient for the

acknowledgment of conveyances of real property to be recorded in the state in which such subscriber is domiciled.

(2) Every subscriber's agreement shall be identical in terms, except as to the date and the name and address of the subscriber, with all other subscriber's agreements currently in force and effect with all other subscribers of such reciprocal insurers. However, in the case of any reciprocal insurer authorized pursuant to section six thousand one hundred eight of this article to issue non-assessable policies or agreements, or having a corporate attorney-in-fact wholly owned by the subscribers at such reciprocal insurer, the acceptance of a policy or binder of insurance containing the subscriber's agreement printed at the end of the standard policy provisions or the binder, as the case may be, preceded by the words printed upon the policy or binder:

> "The acceptance of this policy or binder shall constitute that insured designated therein is a subscriber of the reciprocal insurer and shall constitute the execution and delivery by the insured of the subscriber's agreement which is appended to this policy or binder, and hereby made a part thereof",

shall constitute the execution and delivery of said subscriber's agreement by that insured as fully and to the same extent as though said agreement had been signed and acknowledged by that insured.

(3) Every such subscriber's agreement shall contain in substance the following provisions:

(A) A designation and appointment of the attorney-in-fact to act for and bind the subscriber in all transactions relating to or arising out of the operations of such reciprocal insurer, subject to such limitations as may be lawfully provided.

(B) An agreement that service of summons or other legal process on the attorney-in-fact or on any other person appointed by the attorney-in-fact to receive such process, shall, in any action, suit or proceeding arising out of any contract, agreement or transaction of such reciprocal insurer, be equivalent to personal service of such summons or other legal process on each and every subscriber.

(C) Unless the reciprocal insurer is authorized to issue non-assessable policies under section six thousand one hundred eight of this article an agreement for the contingent liability of the

subscriber, which shall state that such subscriber agrees to pay on demand such subscriber's proportionate share of any assessment lawfully ordered or levied by the advisory committee or by the superintendent under article seventy-four of this chapter.

(D) A provision that there shall be an annual meeting of the subscribers, in person or by proxy, at a time and place to be determined in accordance with such agreement, of which each subscriber shall be duly notified and at which each subscriber shall have power to vote in person or by proxy for all members of the advisory committee to be chosen or appointed at such time, except that in the case of a foreign reciprocal insurer, the superintendent may permit a modification of such provision provided that he is satisfied that the interests of the subscribers are properly protected.

(E) A provision specifying the powers and duties of the advisory committee, which shall include the power and duty to regulate the compensation, powers and duties of the attorney-in-fact, if not specifically provided in the subscriber's agreement, and shall also include the power to make regulations for the effective control and custody of the funds and investments of the reciprocal insurer. In addition, the advisory committee of a municipal reciprocal insurer shall establish procedures to prevent any conflicts of interest between the attorney-in-fact and such insurer. Such procedures shall be submitted to and approved by the superintendent, who shall also approve the attorney-in-fact for a municipal reciprocal insurer.

(F) Provisions setting forth the rights, privileges and obligations of the subscriber as an underwriter, and as a policyholder subject to the terms of insurance contracts required or permitted by law to be issued.

(G) General provisions relating to the operations of the reciprocal insurer, including the subscriber's operating reserve requirements, regulations for the return of savings or dividends, for withdrawals and refunds and such other matters as may be necessary to maintain the operation of such reciprocal insurer in compliance with the provisions of this chapter. In the case of a municipal reciprocal insurer, such agreement shall include procedures to: (i) establish and promote loss control, safety programs and other methods of risk management; (ii) establish equitable risk classifications; and (iii) establish uniform recordkeeping and reporting procedures.

(4) The following provisions shall be contained in either the subscriber's agreement or a separate management agreement between the attorney-in-fact and the advisory committee or the attorney-in-fact and any person to which its functions have been delegated after approval of the advisory committee:

(A) A provision that the attorney-in-fact shall provide written notification of, and make all necessary arrangements as provided in the subscriber's agreement, for the election, in person or by proxy, of the members of the advisory committee. The cost of notification, ballot, or proxy for any meeting of the advisory committee and for any meeting which may be called for the election shall be incurred by the reciprocal.

(B) A provision that the attorney-in-fact shall provide written notification to the members of the advisory committee of not less than ten days for any regular meeting or five days for any special meeting called pursuant to subsection (k) of section six thousand one hundred five of this article. The cost of such notification shall be incurred by the reciprocal.

(C) A provision that the advisory committee may, upon a vote of a majority of its members at any regular or special meeting thereof and upon written notice to the superintendent and the attorney-in-fact, recommend termination of the attorney-in-fact for a stated cause and appointment of a new attorney-in-fact, subject to the provisions of any management agreement approved by the superintendent. Termination of the attorney-in-fact shall require the approval of a two-thirds majority of the subscribers present in person or by proxy at a special meeting called for that purpose. The attorney-in-fact shall provide by mail not less than thirty days prior written notification of such meeting to all subscribers. The mailing of notification shall include the recommendation of termination and replacement as prepared by the advisory committee, and any other appropriate documents submitted by the attorney-in-fact. A copy of all documents mailed and certification of their mailing to all subscribers shall be provided to all members of the advisory committee. The cost of notification and proxy for any such meeting shall be incurred by the reciprocal. For reciprocals with less than two thousand five hundred subscribers, at least twenty-five percent of all subscribers shall be required to constitute a quorum. For all

other reciprocals, the greater of twenty-five hundred subscribers or five percent of all subscribers shall constitute a quorum.

(D) A provision that the attorney-in-fact shall cause all assets of the reciprocal and its subscribers to be invested in accordance with investment guidelines approved by the advisory committee and shall be properly accounted for on the financial records of the reciprocal as being held for or on behalf of the subscribers. All cash assets of the reciprocal and its subscribers, not otherwise invested in short term securities such as money market funds, covering policy obligations arising out of policies issued or issued for delivery in the United States shall be held in one or more appropriately identified accounts in banks that are members of the federal reserve system. These accounts shall be drawn on by the attorney-in-fact, or by employees or representatives of the reciprocal authorized by the attorney-in-fact for all payments on behalf of the reciprocal.

(E) A provision that if the attorney-in-fact is acting for more than one reciprocal, separate records and accounts shall be maintained for each reciprocal.

(F) A provision that the attorney-in-fact may not assign its responsibilities as detailed in the subscriber's agreement in whole or part or enter into management agreements delegating its duties in whole or part to another party without the prior approval of the advisory committee and the superintendent.

(G) A provision that the attorney-in-fact shall establish and maintain underwriting procedures and manuals, setting forth the rates and conditions for the acceptance or rejection of risks.

(H) A provision that the attorney-in-fact shall make a report to the advisory committee at each regular meeting of the committee on the financial condition of the reciprocal and all material transactions during the period since the last meeting.

(I) A provision that the attorney-in-fact shall annually provide to each member of the advisory committee:

(i) On or before March first of each year, a copy of the reciprocal's annual statement and the accompanying statement of actuarial opinion filed with the superintendent pursuant to section three hundred seven of this chapter; and

(ii) On or before June first of each year, a copy of:

(I) The certified statement filed with the superintendent pursuant to subsection (f) of section six thousand one hundred five of this article; and

(II) The certified annual statement of the reciprocal filed with the superintendent pursuant to section three hundred seven of this chapter.

(J) A provision specifying all forms and amounts (or formulas to determine the amounts) of compensation the attorney-in-fact will receive for services rendered and, if all or part of the compensation will be contingent upon the reciprocal's profits, a provision that such compensation shall not be paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other kind of insurance and, in no event shall the compensation be paid until the adequacy of reserves on outstanding claims has been independently verified by the same actuary who opined on the latest annual statement filed with the superintendent pursuant to section three hundred seven of this chapter.

(K) A provision that the independent certified public accountant who will prepare the annual report required by subsection (f) of section six thousand one hundred five of this article and the independent actuary who will prepare the opinion accompanying the annual statement pursuant to section three hundred seven of this chapter shall be selected by the attorney-in-fact, subject to the approval of the advisory committee.

(L) A provision that the books, accounts and records of the reciprocal shall be maintained by the attorney-in-fact to clearly and accurately disclose the nature and details of all transactions including all information necessary to determine that the compensation received by, or owing to, the attorney-in-fact is provided in a manner consistent with the subscriber's agreement and any management agreement. The books, accounts and records of the reciprocal shall be the sole property of the reciprocal.

(M) A provision that the attorney-in-fact shall conduct the affairs of the reciprocal in accordance with the provisions of this chapter.

(b) (1) The subscriber's agreement may contain such further provisions as may be necessary or proper; but neither the subscriber's agreement nor the articles of association, if any, of an authorized reciprocal insurer shall contain any provisions inconsistent with the provisions of subsection (a) hereof.

(2) The superintendent may, if he finds it necessary to carry out the purpose and intent of this article, by regulation prescribe additional provisions, not inconsistent with any law of this state, to be contained in the subscriber's agreement of reciprocal insurers.

(c) Every subscriber to a municipal reciprocal insurer shall agree to participate in a risk management program established by the attorney-in-fact. The attorney-in-fact of each insurer shall, with the approval of the advisory committee, establish, promote and manage a risk management program among the subscribers. Each program shall include identifying and reducing risks through the implementation of loss control, safety programs and other methods of risk management. The attorney-in-fact may enter into contracts with any person, firm, or corporation for services necessary to perform and administer the risk management program or to perform or administer other functions deemed necessary by the advisory committee and approved by the superintendent. An individual subscriber may enter into contracts with any person, firm or corporation for services necessary to perform and administer any function which that subscriber shall deem necessary.

§ 6107. Changes and amendments. (a) (1) No reciprocal insurer shall change its name or amend its subscriber's agreement without first obtaining the written approval of the superintendent.

(2) No such insurer shall establish branch offices under other or different names or titles.

(b) The superintendent shall approve any change or substitution in the attorney-in-fact of any such insurer and there shall be filed in the office of the new attorney-in-fact new subscriber's agreements or amendments to the existing subscriber's agreements containing the new powers of attorney signed by every subscriber of such reciprocal insurer. Notwithstanding the foregoing, a foreign reciprocal that primarily provides coverage to former and current military officers and their families shall notify the superintendent of any change or substitution in the attorney-in-fact of such insurer and the new attorney-in-fact shall apply for licensure pursuant to section six thousand one hundred five of this article within thirty days of such change or substitution.

(c) After any reciprocal insurer is authorized to do business in this state, it may be joined by other and additional subscribers who have been accepted and are qualified and have executed a subscriber's agreement and power of attorney identical with the instruments in effect at that time and which all other subscribers have executed.

(d) (1) No such change and no amendment or modification in the provisions of the subscriber's agreement shall be submitted to the subscribers for execution unless approved by the advisory committee at a meeting duly called for such purpose.

(2) Every such change, amendment or modification shall be submitted for execution to all existing subscribers contemporaneously and shall take effect, as to all subscribers executing the same, at the expiration of one year from the date of such submission.

(3) Any subscriber failing to execute any new subscriber's agreement or any amendment to an existing subscriber's agreement within one year after its submission to such subscriber shall be deemed to have withdrawn from membership in such reciprocal.

(4) Notwithstanding paragraphs one, two and three hereof, in the case of any reciprocal insurer which shall have issued its policies, or binders, with the subscriber's agreement and statement printed thereon pursuant to paragraph two of subsection (a) of section six thousand one hundred six of this article, or a reciprocal insurer having a corporate attorney-in-fact wholly owned by the subscribers at such reciprocal insurer who provides with such submission a copy of the subscriber's agreement in force, the failure of any subscriber at such reciprocal to object in writing thereto within sixty days after the date of such submission shall constitute such subscriber's acceptance of such change, amendment or modification as fully and to the same extent as though acceptance of such change, amendment or modification had been signed and acknowledged by that subscriber and such change, amendment or modification shall take effect, as to all subscribers at such reciprocal who have not objected thereto in writing, at the expiration of sixty days from the date of submission. Any subscriber at such reciprocal who objects in writing, within sixty days from the date of such submission, to such change, amendment or modification shall be deemed to have withdrawn from membership in such reciprocal.

§ 6108. Contingent liability; non-assessable policies. (a) Every contract of insurance and subscriber's agreement under or by which contracts of insurance are issued or exchanged by any authorized reciprocal insurer shall provide for a contingent several liability for assessment of the subscriber as an inter-insurer on the risks of every other subscriber in an amount not less than one nor more than ten times the annual premium and in addition to the annual premium expressed in such contracts of insurance issued to the subscriber by the reciprocal insurer.

(b) If the admitted assets of any such insurer are at any time insufficient for the payment of losses and expenses after providing for all other liabilities of such insurer and the minimum surplus to policyholders required by this chapter, the advisory committee shall, within thirty days thereafter, order an assessment for the amount necessary to pay such losses and expenses, and authorize the attorney-in-fact to collect from each subscriber liable therefor a pro rata share of the amount of such assessment, subject to the limit specified in the contract of such subscriber and to maintain an action therefor in the name of the attorney-in-fact.

(c) Every policy issued by any such insurer shall clearly state whether or not the holder of the policy is subject to liability for assessment. All policies issued by any such insurer which are subject to liability for assessment shall contain a clear statement of the liability of the policyholder for payment of a proportionate share of any deficiency or impairment as provided by law within the limit provided by the policy, and shall further state that any assessment shall be for the exclusive benefit of holders of policies which provide for such a contingent liability, and the holders of policies subject to assessment shall not be liable to assessment in an amount greater in proportion to the total deficiency than the ratio that the deficiency attributable to the assessable business bears to the total deficiency.

(d) Any reciprocal insurer, except a municipal reciprocal insurer which issues policies not covered by the property/casualty insurance security fund, may with the permission of the superintendent issue non-assessable policies or agreements in this state upon compliance with the following requirements:

(1) It shall have and maintain a surplus to policyholders at least equal to one hundred fifty percent of the amount of surplus to policyholders which such insurer is required to maintain by the provisions of section six thousand one hundred two of this article. Such surplus shall be inclusive of any surplus required by any other sections of this chapter.

(2) It shall have submitted a copy of its proposed non-assessable policy or policies for approval of the superintendent, and shall have obtained his approval thereof.

§ 6109. Subscriber's operating reserve. (a) (1) Every subscriber of an authorized reciprocal insurer in which subscribers are subject to contingent liability shall accumulate a minimum operating reserve, to be credited to such subscriber on the books and records of such reciprocal insurer, by authorizing the attorney-in-fact to credit to such account at the end of the fiscal year of such reciprocal insurer, an amount not less than one quarter of such subscriber's underwriting earnings during such period.

(2) Such accumulation shall be made so long as such subscriber's operating reserve is less than twice the amount of annual premiums in force.

(3) Notwithstanding the foregoing, the superintendent may, upon application from the attorney-in-fact:

(A) approve other methods for accumulating such subscriber's operating reserve; or

(B) permit the suspension of the accumulation of the operating reserve for a fiscal year provided that those earnings are returned to the subscriber in accordance with subparagraph (B) of paragraph two of subsection (c) of this section; or

(C) in the case of a municipal reciprocal insurer, authorize the return of any outstanding subscriber operating reserve balance upon the municipal reciprocal insurer's demonstration that it will retain sufficient surplus to support its obligations and writings.

(b) Any authorized reciprocal insurer may, pursuant to the terms of the subscriber's agreement and to any action of its advisory committee authorized thereunder, require its subscribers to accumulate

subscriber's operating reserves in excess of the minimum specified in subsection (a) of this section and may require a longer period of notice for the withdrawal of all or any part of such reserve than that herein specified.

(c) (1) No subscriber shall have a secured or preferred claim against any assets of the reciprocal insurer arising out of such operating reserve, but all assets held by such insurer shall be available for the payment of claims of policyholders and creditors of such reciprocal insurer in preference to any claim for withdrawal by a subscriber as such.

(2) Any subscriber's operating reserve accumulated by any such reciprocal insurer shall be maintained at all times, except that:

(A) a subscriber may, upon withdrawal from membership and cancellation of all insurance contracts held by the subscriber in such insurer, and after giving to the attorney-in-fact written notice of withdrawal at least sixty days in advance, withdraw the amount of the subscriber's operating reserve less such surrender charges as may be deducted pursuant to the subscriber's agreement; or

(B) where the superintendent has determined that the suspension of the accumulation of the operating reserve would not be harmful to policyholders or the people of this state, the attorney-in-fact may, in the fiscal year following the year for which the suspension of the accumulation of the operating reserve was authorized, return to each subscriber an amount equal to the underwriting earnings that would have otherwise been credited to the subscriber's operating reserve.

(3) No withdrawal shall be permitted after an order of liquidation of, or the appointment of a receiver or liquidating trustee for, any such reciprocal insurer or, notwithstanding any other provision of law to the contrary, where there is an authorized control level event or a mandatory control level event as defined in section thirteen hundred twenty-four of this chapter.

§ 6110. Limitation of risk. Every reciprocal insurer authorized to do business in this state shall be subject to the provisions of sections one thousand one hundred fifteen and four thousand one hundred eighteen of this chapter.

§ 6111. Assets, liabilities and surplus. (a) All of the assets of any reciprocal insurer including subscribers' operating reserves shall be liable primarily for payment of all liabilities incurred under its policies or other contracts.

(b) No part of the surplus funds of such reciprocal insurer shall be subject to the claims of general creditors of any of the individual subscribers of such insurer until all policies under which any such subscriber is obligated have been terminated and in no event beyond the amount of such subscriber's operating reserve.

(c) The contingent liability of subscribers for additional premiums or assessments shall not be included as an asset in the financial statement of a reciprocal insurer.

(d) Subscribers' operating reserves for which notice of withdrawal has been given shall be reported as liabilities until paid.

(e) In any statement or report of the financial condition of a reciprocal insurer filed in this state, the surplus to policyholders, after providing for the unearned premium reserves, loss reserves and other liabilities, as required by this chapter, shall be reported as follows:

(1) special contingent surplus;

(2) subscribers' operating reserves, if required;

(3) all other surplus, if any.

(f) Unless the reciprocal is subject to the provisions of article fifteen of this chapter or substantially similar legislation in its state of domicile, all material transactions between or among the reciprocal, its subscribers, the attorney-in-fact and any affiliate of the attorney-in-fact shall not be entered into, unless they have been filed with the superintendent at least thirty days prior thereto and the superintendent has not disapproved them; provided, however, that any such transaction involving five percent or more of the reciprocal's admitted assets shall be subject to prior approval of the superintendent and all transactions shall meet the following standards:

(1) The terms shall be fair and equitable;

(2) Charges or fees for services performed shall be reasonable; and

(3) Expenses incurred and payments received shall be allocated to the

reciprocal on an equitable basis in conformity with statutory insurance accounting practices consistently applied.

§ 6112. Subscribers' accounts. (a) The attorney-in-fact, in addition to the books of account of the collective transactions of all subscribers of the reciprocal insurer, shall keep and maintain a separate account for each individual subscriber setting forth the entries determining the operating reserve, if any, of such subscriber.

(b) Each subscriber's account shall be credited with the premiums earned by him as an underwriter on the policies issued by the insurer, and charged with his proper share of all losses incurred under such policies as well as with the expenses incurred by the insurer.

(c) Earnings and interest income from investments of all subscribers' operating reserves shall be apportioned and credited to subscribers on the basis of their accumulated operating reserves and all other interest and investment income may be apportioned and credited to the subscribers on the basis of their premiums earned as underwriters.

(d) The subscriber's agreement of an authorized reciprocal insurer may with the permission of the superintendent contain provisions which modify the credits, charges and apportionments to the subscribers' account, as required by subsections (b) and (c) of this section.

§ 6113. Foreign or alien reciprocal insurers. (a) The superintendent may, in his discretion, pursuant to section one thousand one hundred six of this chapter, issue a license to a reciprocal insurer domiciled in, or organized under the laws of another state or of any province of Canada, to do in this state such kind or kinds of insurance business as a domestic reciprocal insurer may be authorized to do in this state.

(b) Such foreign or alien reciprocal insurer shall comply with substantially the same requirements of this chapter which are applicable to domestic reciprocal insurers organized and authorized to do the same kind or kinds of insurance business and in addition every such alien reciprocal shall be subject to the provisions of this chapter relating to alien insurance companies authorized to do the same kind or kinds of insurance business.

(c) Nothing herein contained shall be deemed to require that the attorney-in-fact of a foreign or alien reciprocal insurer shall be resident or domiciled in this state, or shall maintain his or its principal office in this state, or shall be organized under the laws of this state; but every authorized reciprocal insurer shall maintain at least one office in this state.

(d) Every foreign or alien reciprocal insurer shall maintain a minimum surplus to policyholders in an amount at least equal to that required of a similar domestic reciprocal insurer organized and licensed to do the same kind or kinds of insurance.

(e) The superintendent shall pursuant to section one thousand two hundred twelve of this chapter be appointed the true and lawful attorney for every such foreign or alien reciprocal insurer and any service upon him shall be equivalent to the personal service within this state of such process on each and every of the individual subscribers or underwriters, by whatever name called, of such reciprocal insurer.

(f) (1) The superintendent may accept the statement of the duly authorized attorney-in-fact, or of any officer of a corporation attorney-in-fact, or of any member of a firm attorney-in-fact, subscribed and affirmed by him as true under the penalties of perjury, that all of the subscribers have executed the subscriber's agreement used by such reciprocal insurer, which agreement shall authorize the attorney-in-fact to designate and appoint the superintendent as attorney in this state and the supervisory insurance officials of other jurisdictions upon whom legal process may be served.

(2) Whenever any change, amendment or modification of the power of attorney or subscriber's agreement has been submitted for execution to subscribers, in the manner prescribed by section six thousand one hundred seven of this article, a certified copy thereof shall be filed with the superintendent and within thirteen months thereafter there shall be filed with the superintendent a statement similarly subscribed to the effect that it has been signed by all subscribers of record.

(3) The attorney-in-fact shall annually with the filing of the annual statement of such foreign or alien reciprocal insurer certify that all other and additional subscribers which have joined such insurer have executed the subscriber's agreement as last amended and on file with the superintendent.

(g) The subscriber's agreement and articles of association, if any, of every foreign reciprocal insurer licensed to do business in this state on January first, nineteen hundred forty shall conform to the requirements applicable to a domestic reciprocal insurer organized and licensed after such date.

§ 6114. Application of other sections. (a) Except as otherwise provided in this article, and except where the context otherwise requires, all of the provisions of this chapter relating to all insurers and those relating to insurers transacting the same kind or kinds of insurance which reciprocal insurers are permitted to transact, shall be applicable to reciprocal insurers authorized to do business in this state.

(b) Where any of such sections refer to a corporation, company or insurer, the same, when read in connection with and applicable to this article, shall mean a reciprocal insurer.

§ 6115. Merger. (a) (1) Two or more reciprocal insurers may, by a two-thirds affirmative vote of the subscribers of each insurer, merge in accordance with the provisions of article seventy-one of this chapter.

(2) The powers of such new reciprocal insurer under this article shall not be greater than those possessed hereunder by the merging insurers.

(3) The operating reserve accumulations of the respective subscribers shall be transferred and credited to such subscribers as members of the new reciprocal insurer and all other reserves, guaranty funds and other undistributed funds shall be transferred to the corresponding reserve or guaranty fund accounts of the new insurer.

(b) (1) If after examination, the superintendent finds that the merger of any such insurers is in conformity with law, and that the new reciprocal insurer meets with the requirements of this chapter, he may issue a license to such insurer to do business under the provisions of this chapter. Thereupon, the remaining assets shall be forthwith transferred to it, and the predecessor reciprocal insurers shall cease to have authority to do business as such and shall be deemed extinguished.

(2) Every such new reciprocal insurer formed by merger shall assume and succeed to all of the obligations and liabilities of the respective merging reciprocal insurers and shall be held liable to pay and discharge all such debts and liabilities in the same manner as if they had been incurred or contracted by it, but the subscribers of such predecessor reciprocal insurers shall continue subject to all the liabilities, claims and demands which shall then exist, or which may thereafter accrue against them, or any of them, by reason of any obligations incurred by them or on their behalf as such subscribers before the date of merger.

(3) Upon the merger of any reciprocal insurer, dissenting subscribers shall be entitled to the conditional withdrawal of their accumulated operating reserves on deposit with the predecessor insurer as of the date of merger but a sufficient amount thereof shall be retained by the new reciprocal insurer as a deposit until all of the obligations incurred on their behalf have been extinguished.

(4) When all of such obligations have been paid, discharged or terminated, and the superintendent after an examination shall have so certified, the said subscribers' deposits or the balances thereof remaining to their credit shall be returned and released, whereupon the powers of the attorney-in-fact relating thereto shall cease and terminate.

§ 6116. Lloyds underwriters. (a) Any existing Lloyds underwriters heretofore organized under any law of this state and authorized to do an insurance business herein, which has exercised its powers of issuing insurance policies continuously during each of the two years immediately prior to January first, nineteen hundred forty, may, by maintaining a minimum surplus at least equal to the amount maintained prior to January first, nineteen hundred forty, continue to do an insurance business in this state of the kind or kinds which it was authorized to do on January first, nineteen hundred forty, and shall be entitled to exercise all of the powers granted by its existing charter or articles of association.

(b) Except as the context otherwise requires, every such Lloyds underwriters shall be subject to all of the provisions of this chapter which are applicable to reciprocal insurers.

(c) No Lloyds underwriters shall hereafter be organized in this state and no foreign or alien Lloyds underwriters shall be licensed to do an insurance business in this state.

(d) This section shall not alter or abridge any rights of the New York insurance exchange as set forth in article sixty-two of this chapter.

ARTICLE 62

NEW YORK INSURANCE EXCHANGE

Section 6201. New York insurance exchange.
6202. Constitution and by-laws.
6203. Miscellaneous.

§ 6201. New York insurance exchange. (a) Notwithstanding the provisions of section six thousand one hundred sixteen of this chapter, the New York insurance exchange, shall be continued, subject to such regulations as may be promulgated by the superintendent.

(b) The purposes of the exchange shall be:

(1) to provide a facility for the underwriting of:

(A) reinsurance of all kinds of insurance;

(B) direct insurance of all kinds on risks located entirely outside the United States;

(C) direct insurance of all kinds on risks located in the United States other than in this state, provided that such risk qualifies for placement pursuant to the excess and surplus lines requirements of the jurisdiction in which the risk is located; the superintendent may permit the exchange or its syndicates, or both, to take such steps as may be necessary to qualify as an excess and surplus lines insurer in such jurisdiction;

(D) risks which shall have been submitted to and certified as having been rejected by a committee representative of insurers licensed by the superintendent under article sixty-three of this chapter, subject to conditions imposed by the superintendent pursuant to regulation; and

(2) to manage the facility authorized by this article, in accordance with regulations promulgated by the superintendent.

§ 6202. Constitution and by-laws. (a) The exchange shall function under its constitution and by-laws which it may amend pursuant to the terms thereof.

(b) Notwithstanding the authority granted to the exchange pursuant to the provisions of the constitution and by-laws to amend, replace or add provisions, the constitution and by-laws shall at all times provide for but not be limited to:

(1) the election of no less than six nor more than thirteen governors at least one-third of whom shall not be members of the exchange and who shall be public representatives;

(2) the location of the principal offices of the exchange and its members to be within this state for the purpose of the transaction of the types of business described in subsection (b) of section six thousand two hundred one of this article;

(3) the submission by members and all applicants for membership on the exchange of such financial information required by the superintendent;

(4) the establishment by the exchange of a security fund in a form and amount approved by the superintendent;

(5) the voting power of members who are underwriting syndicates;

(6) the voting power and other rights granted under the provisions of the not-for-profit corporation law to participate in the conduct and management of the affairs of the exchange by brokers, agents and intermediaries transacting business on the exchange, each of whom shall be considered "members" only under the provisions of such law; and

(7) the rights and duties of exchange members, which may include but shall not be limited to the manner and form of conducting business, financial stability, dues, membership fees, mandatory arbitration and all other matters necessary or appropriate to conduct any business permitted by this article.

(c) Any amendments to the constitution and by-laws shall be subject to the approval of the superintendent.

(d) At least two-thirds of the governors shall be citizens of the United States.

(e) For the purposes of this section, a principal office shall be one where officers and qualified personnel who are engaged in the administration, underwriting, claims, policyholders' service, marketing,

accounting, record-keeping and all supportive services shall be located.

§ 6203. Miscellaneous. (a) The New York insurance exchange shall not be subject to any state or local taxes or fees measured by income, premiums or gross receipts, except that for purposes of taxation under section one thousand five hundred ten of the tax law, direct premiums written, procured or received by a member or members through the exchange on risks located in this state shall be deemed written, procured or received by the exchange and the premium tax due on said premium shall be reported and paid by the exchange.

(b) The exchange shall reimburse the superintendent for any expenses incurred by him relating to the regulation of the exchange and its members.

(c) This chapter and regulations thereunder shall apply to the exchange, its members, and the insurance or reinsurance written through the exchange, except as may be exempted by the superintendent pursuant to regulation; provided that no such exemption shall be unfairly discriminatory or detrimental to the solvency of licensed insurers.

(d) The superintendent may establish limitations on investments in members of the exchange. The investment in any member by brokers, agents and intermediaries transacting business on the exchange, and the investment in any such broker, agent or intermediary by any member, directly or indirectly, all as defined by regulation, shall in each case be limited in the aggregate to less than twenty percent (or such lesser amount as determined by the superintendent) of the total investment in such member, broker, agent or intermediary.

(e) For purposes of paragraph nine of subsection (a) of section one thousand three hundred one of this chapter, reinsurance written by members of the exchange shall be deemed to have been written by an insurer authorized to transact insurance in this state.

(f) The performance of the contractual obligations of the exchange or its members entered into pursuant to section six thousand two hundred one of this article shall not be covered by any of the New York state security or guaranty funds.

ARTICLE 63

SPECIAL RISKS; FILING EXEMPTION

Section 6301. Special risks; filing exemption.
6302. Special license.
6303. Limitations.
6304. Special regulations.

§ 6301. Special risks; filing exemption. (a) Notwithstanding any provision of this chapter, the superintendent shall, pursuant to regulations promulgated by the superintendent, permit exemption from filing requirements only with respect to rates and policy forms, where applicable, for any of the kinds of insurance specified in subsection (b) of this section.

(b) An exemption pursuant to subsection (a) hereof shall be permitted in relation to the kinds of insurance set forth in paragraphs four through fourteen, sixteen, seventeen, nineteen through twenty-two, twenty-seven and twenty-nine, of subsection (a) of section one thousand one hundred thirteen of this chapter and such insurance as the superintendent deems to be substantially similar to one of the foregoing kinds, except no exemption may be permitted for: (1) coverage for personal lines to natural persons for non-business purposes; (2) insurance specified in subsection (b) of section two thousand three hundred five of this chapter, except medical malpractice insurance, or section two thousand three hundred twenty-eight of this chapter; (3) insurance required to satisfy any financial responsibility requirement of this state; or (4) a policy written on a group basis. However, any risk pursuant to paragraph one, two or three of such subsection of such section of this chapter or personal lines risk (except motor vehicle insurance coverage to natural persons for non-business purposes) shall be exempt pursuant to subsection (a) hereof if it is included by the superintendent on the list maintained by the superintendent pursuant to subsection (a) of section six thousand three hundred three of this article.

(c) An exemption granted pursuant to this section shall apply only to authorized insurers complying with this chapter, except that it shall not apply to insurers subject to article sixty-six of this chapter. The

exemption shall not be an exemption for joint underwriting or joint reinsurance transactions pursuant to section two thousand three hundred seventeen of this chapter.

(d) Nothing in this article shall exempt any insurer, or any policy issued pursuant to this article, from any applicable provision or standard in this chapter, regulations promulgated thereunder, or other requirements of state law.

(e) In this article, "medical malpractice insurance" has the meaning set forth in subsection (b) of section five thousand five hundred one of this chapter.

§ 6302. Special license. (a) An authorized insurer, as a condition precedent to the obtaining of such exemption, shall obtain a special license from the superintendent.

(b) Before such special license shall be issued or renewed the prospective licensee shall file in the office of the superintendent an application in such form and supplements thereto as the superintendent prescribes. Such license shall be subject to annual renewal with an annual fee of two thousand dollars.

(c) Such license may only be issued to:

(1) an authorized insurer that maintains at all times a surplus to policyholders of at least two hundred percent of the authorized control level as set forth in article thirteen of this chapter, except that with respect to a policy issued pursuant to paragraph three of subsection (a) of section six thousand three hundred three of this article, an authorized insurer that maintains at all times a surplus to policyholders of at least two hundred fifty percent of the authorized control level as set forth in article thirteen of this chapter; or

(2) a United States branch that maintains at all times a trusteed surplus of at least two hundred percent of the authorized control level as set forth in article thirteen of this chapter, except that with respect to a policy issued pursuant to paragraph three of subsection (a) of section six thousand three hundred three of this article, a United States branch that maintains at all times a trusteed surplus of at least two hundred fifty percent of the authorized control level as set forth in article thirteen of this chapter; or

(3) until June thirtieth, two thousand twenty-seven, a domestic property/casualty insurance company that maintains at all times a surplus to policyholders of at least twice the minimum surplus to policyholders required to be maintained for the kinds of insurance that it is authorized to write in this state, or an insurer licensed pursuant to article sixty-one of this chapter as a reciprocal insurer that maintains at all times a surplus to policyholders of at least the minimum surplus to policyholders required to be maintained for the kinds of insurance that it is authorized to write in this state, provided that the domestic property/casualty insurance company or reciprocal insurer: (A) has total direct premiums comprised of at least ninety percent medical malpractice insurance; (B) assumes reinsurance premiums in an amount that is less than five percent of total direct premiums written; and (C) writes ninety percent of its total direct premiums in this state.

(d) The superintendent may revoke, suspend, or refuse to renew such license if, after notice and a hearing, the superintendent finds that such action will protect the best interests of the people of this state.

§ 6303. Limitations. (a) The exemption that may be granted pursuant to this article shall apply only if:

(1) the risk, as defined in regulations of the superintendent, produces a minimum annual premium in excess of one hundred thousand dollars or such higher amount as the superintendent may prescribe by regulation;

(2) the coverage is for a risk or class of risks which is of an unusual nature, a high loss hazard, or difficult to place, pursuant to a list promulgated or amended by the superintendent; or

(3) until June thirtieth, two thousand twenty-seven, the policy, other than a medical malpractice insurance policy, is issued to a large commercial insured that employs or retains a special risk manager to assist in the negotiation and purchase of a policy exempted under this article, provided, however, that:

(A)(i) the special risk manager is not employed by the insurer issuing the policy or any person in the insurer's holding company system; and

(ii) the special risk manager is licensed as an insurance producer in

this state pursuant to article twenty-one of this chapter, unless exempted from licensing therein; and

(B) a policy form that has not been previously filed with the superintendent shall be filed with the superintendent for informational purposes within three business days after first delivery of a policy using such form, but no later than sixty calendar days after the inception date of such policy.

(b) For the purposes of this section:

(1) "Large commercial insured" means an entity that generates annual commercial risk insurance premium, other than for medical malpractice insurance, in excess of twenty-five thousand dollars with respect to the kinds of insurance specified in paragraphs four through fourteen, sixteen, seventeen, nineteen through twenty-two, twenty-seven and twenty-nine of subsection (a) of section one thousand one hundred thirteen of this chapter and such insurance as the superintendent deems to be substantially similar to one of the foregoing kinds and:

(A) has a net worth of at least seven million five hundred thousand dollars as of the insured's fiscal year end immediately preceding the policy's effective date;

(B) has gross assets exceeding ten million dollars and a net worth of at least one million five hundred thousand dollars as of the insured's fiscal year end immediately preceding the policy's effective date;

(C) is a for-profit business entity that generates annual gross revenues exceeding fifteen million dollars, and has a net worth of at least one million five hundred thousand dollars as of the insured's fiscal year end immediately preceding the policy's effective date;

(D) is a for-profit business entity that has gross assets exceeding ten million dollars and generates annual gross revenues exceeding fifteen million dollars as of the insured's fiscal year end immediately preceding the policy's effective date;

(E) is a not-for-profit organization or public entity with an annual budget exceeding twenty million dollars for each of its three fiscal years immediately preceding the policy's effective date;

(F) has fifty employees or, together with its parent, subsidiaries and affiliates, one hundred employees, as of the insured's fiscal year end immediately preceding the policy's effective date; or

(G) is a municipality with a population of fifty thousand or more

persons.

(2) "Special risk manager" means a person who meets all of the following requirements:

(A) the person is an employee of, or third-party consultant retained by, the large commercial insured;

(B) the person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis and assessment, and purchase of insurance; and

(C) the person:

(i)(I) has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the superintendent to demonstrate minimum competence in risk management; and

(II)(aa) has five years of experience in risk financing, loss prevention, risk and insurance coverage analysis and assessment, or purchasing commercial risk insurance; and

(bb) has:

(aaa) a designation as a chartered property and casualty underwriter (in this clause referred to as a "CPCU") issued by the American Institute for CPCU/Insurance Institute of America;

(bbb) a designation as an associate in risk management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;

(ccc) a designation as certified risk manager (CRM) issued by the National Alliance for Insurance Education & Research;

(ddd) a designation as a Risk and Insurance Management Society (RIMS) fellow (RF) issued by the Global Risk Management Institute; or

(eee) any other designation, certification, or license determined by the superintendent to demonstrate minimum competency in risk management;

(ii)(I) has at least seven years of experience in risk financing, loss prevention, risk and insurance coverage analysis and assessment, or purchasing commercial risk insurance; and

(II) has any one of the designations specified in subclauses (aaa) through (eee) of subitem (bb) of clause (II) of item (i) of this subparagraph;

(iii) has at least ten years of experience in risk financing, loss prevention, risk and insurance coverage analysis and assessment, or purchasing commercial risk insurance; or

(iv) (I) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the superintendent to demonstrate minimum competence in risk management; and

(II)(aa) has at least three years of experience in risk financing, loss prevention, risk and insurance coverage analysis and assessment, or purchasing commercial risk insurance; or

(bb) has any one of the designations specified in subclauses (aaa) through (eee) of subitem (bb) of clause (II) of item (i) of this subparagraph.

(3) "Municipality" shall mean any county, city, town or village.

(c) Effective on the fifth January first occurring after the date of the enactment of this subsection and each fifth January first occurring thereafter, the amounts specified in paragraph one of subsection (b) of this section may be adjusted to reflect the percentage change for such five-year period in the consumer price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor. The superintendent may conduct a public hearing to determine whether such increase is necessary.

(d) (1) Except as provided in paragraph two of this subsection, every policy issued pursuant to the provisions of this article shall contain a notice to the policyholder that the rate and policy form are not subject to the filing requirements of this state and such other notices required by the superintendent pursuant to regulation.

(2) Every policy issued pursuant to paragraph three of subsection (a) of section six thousand three hundred three of this article shall contain a notice to the policyholder that the rates are not subject to the filing requirements of this state and the policy forms are not subject to the approval requirements of this state, and such other notices required by the superintendent pursuant to regulation.

(e) The superintendent may by regulation prescribe limitations on the total amount of business that an insurer may transact pursuant to this article or reimpose filing or approval requirements where and to the extent that the superintendent deems it in the interest of the policyholders.

§ 6304. Special regulations. The superintendent, by regulation, shall provide for the implementation of the provisions of this article by establishing methods, procedures and reports for licensing and for facilitating, monitoring and verifying compliance with this article.

ARTICLE 64

TITLE INSURANCE CORPORATIONS

Section 6401. Definitions.
6402. Organization; financial requirements.
6403. Management and powers of title insurance corporation.
6404. Assets; title plant; valuation.
6405. Reserves.
6406. Investments; exception.
6407. Restrictions on dividends.
6408. Prohibition on engaging in certain business activities.
6409. Filing of policy forms; rates; classification of risks; commissions and rebates prohibited.
6410. Merger.
6411. Merger of parent corporation and wholly-owned subsidiary.

§ 6401. Definitions. In this article, the following definitions apply except as otherwise specified:

(a) "Title insurance corporation" means a corporation exercising any of the powers described in paragraph one or two of subsection (b) of section six thousand four hundred three of this article.

(b) "Title insurance policy" means any policy or contract insuring or guaranteeing the owners of real property and chattels real and other persons interested therein, or having liens thereon, against loss by reason of encumbrances thereon and defective titles.

§ 6402. Organization; financial requirements. A title insurance corporation may be organized and licensed in the manner prescribed in subsection (e) of section one thousand one hundred two and section one thousand two hundred one of this chapter, except as hereinafter

prescribed, to do the kind of insurance business, and with the incidental powers, specified in section six thousand four hundred three of this article, with a paid-in capital of at least five hundred thousand dollars and a paid-in initial surplus at least equal to fifty percent of its paid-in capital, and it shall at all times thereafter maintain a capital at least equal to five hundred thousand dollars, except that any such corporation organized before July first, nineteen hundred eighty-two, shall at all times maintain a minimum capital of two hundred fifty thousand dollars. In the organization of any such corporation the provisions of section one thousand two hundred one of this chapter shall be superseded or supplemented by the following provisions:

(a) The duration of such corporation shall be perpetual.

(b) Its principal office shall be located in this state.

(c) The purposes for which such corporation shall be organized shall only be such as are specified in section six thousand four hundred three of this article.

(d) Its incorporators shall be natural persons, not less than seven in number, and shall possess the qualifications of directors prescribed in subsection (e) hereof.

(e) Its directors shall be natural persons, not less than seven in number, all citizens of the United States, a majority of whom shall be citizens and residents of this state at the time of their election and during their continuance in office.

(f) Before a license to do business shall be issued to such corporation a list of its shareholders shall be filed in the office of the superintendent, subscribed and affirmed as true under the penalties of perjury by two of its principal officers, giving the name, residence and post-office address of, and number of shares held by, each shareholder.

(g) No foreign or alien insurer shall be granted a license or renewal of a license to do in this state the kind of business specified in paragraph eighteen of subsection (a) of section one thousand one hundred thirteen of this chapter if it may exercise any powers or conduct any business without this state not authorized by such paragraph, or unless its surplus to policyholders, of which not more than five percent of its admitted assets shall be represented by title plant or plants, is at the

time of initial licensing not less than the sum of (i) the minimum capital and initial surplus required of a similar domestic insurer, and (ii) an amount by which reserves computed in accordance with paragraphs one and two of subsection (a) of section six thousand four hundred five of this article on business within and without the state exceed its reserves of a comparable nature, whether statutory or voluntary, and unless such insurer at all times thereafter maintains a surplus to policyholders, similarly limited as to value of title plant or plants, at least equal to the sum of such minimum capital and reserves determined as hereinabove set forth, or if it fails to meet any other requirements of this chapter applicable to a domestic title insurance corporation except that any such insurer initially licensed on or after July first, nineteen hundred eighty-two, shall have a surplus to policyholders at least equal to the sum of (i) minimum capital and initial surplus required of a like domestic insurer initially licensed on or after July first, nineteen hundred eighty-two, and (ii) reserves as hereinabove required; and shall maintain a surplus to policyholders at least equal to the sum of (i) the reserves hereinabove required and (ii) the minimum capital required of a domestic insurer initially licensed on or after July first, nineteen hundred eighty-two.

§ 6403. Management and powers of title insurance corporation. (a) The business and affairs of every title insurance corporation shall be managed under the direction of its board of directors.

(b) Every title insurance corporation shall, subject to the exceptions and restrictions contained in this chapter, have power to do, in addition to the powers granted by the business corporation law, only the following kinds or any of the kinds of business, of which those specified in paragraphs one and two hereof shall be deemed doing an insurance business:

(1) To make and to guarantee the correctness of searches for all instruments affecting titles to real property, chattels real, and cooperative units and proprietary leases, and for all liens or charges affecting the same.

(2) To issue title insurance policies.

(3) To examine titles to real property and chattels real and to

procure and furnish information in relation thereto and to personal property used in connection therewith.

(4) To invest in, purchase and sell mortgages upon improved and unencumbered real property appraised for at least fifty per centum more than the amount loaned thereon or obligations secured by such mortgages or senior participations or interests therein, without guaranteeing the performance of any contract in respect thereto or the guaranteeing of payment of taxes, penalties, foreclosure costs or other expenses with respect to the same. "Senior participation", in this section, means all that portion or portions of the obligation secured by a first mortgage which has legal priority over all other portion or portions of such obligation, known as junior participation.

(5) To invest in or acquire for resale, (i) obligations secured by a mortgage (including any part of an issue of such obligations) which are insured or committed to be insured by the Federal Housing Administrator, or (ii) debentures lawfully issued by the Federal Housing Administrator.

(6) To act as agent in fact for investors in, and the holders of, mortgages or obligations mentioned in paragraphs four and five hereof, and interests therein, in the purchase, sale and servicing thereof; to act as agent in fact for investors in supervising and inspecting land and buildings for the purpose of loans to be made thereon, and in recommending, without any guaranty or similar undertaking as to the amounts of such loans and amounts to be advanced thereon, but not to engage in the business of making real estate appraisals.

(c) No title insurance corporation doing business in this state shall expose itself to any loss on any one risk in an amount exceeding the sum of its capital, surplus, statutory premium and any voluntary reserves, all as shown in its most recent quarterly or annual statement filed with the superintendent. Any risk or portion thereof which shall have been reinsured with an assuming insurer authorized to do such business in this state shall be deducted in determining the limitation of risk prescribed in this subsection. Credit to the ceding insurer for reinsurance with an unauthorized insurer shall be allowed to the extent permitted by a regulation of the superintendent.

§ 6404. Assets; title plant; valuation. In determining the financial

condition of any corporation doing business under this article, the superintendent shall allow as admitted assets only such assets as are prescribed by section one thousand three hundred one of this chapter and as are not excluded by section one thousand three hundred two of this chapter, except as follows:

(a) The superintendent may allow as an admitted asset of such corporation its title plant or plants covering real property located within or without the state of New York, at its fair value as determined by him; provided, however, that with respect to any title plant or plants acquired after December thirty-first, nineteen hundred fifty-four, such value shall be reduced by not less than ten percent of the amount thereof on December thirty-first of the third year following the acquisition of such title plant or plants, and be further reduced by ten percent of said original amount on the thirty-first day of December of each succeeding calendar year, and provided further that in no event shall the aggregate amount allowed for any title plant or plants acquired after December thirty-first, nineteen hundred sixty-nine, exceed five percent of the total admitted assets of such corporation.

(b) The superintendent shall allow as admitted assets premiums and fees for title examination and insurance and for abstracts and searches, not more than ninety days past due. Such premiums and fees shall be deemed to be due when the services for which such premiums and fees are chargeable shall have been performed, except that with respect to abstracts and searches, not later than the closing of the transaction for which the services were rendered, and with respect to examinations on a closed title basis premiums and fees shall be deemed due when title is closed.

§ 6405. Reserves. (a) Every title insurance corporation organized and doing an insurance business under this article shall establish, segregate and maintain a reinsurance reserve during the period and for the uses and purposes hereinafter provided which shall at all times and for all purposes be deemed and shall constitute unearned portions of the original premiums and shall be charged as a reserve liability of such corporation in determining its financial condition.

(1) Beginning June first, nineteen hundred forty-five, the amount of

such reserve shall be cumulative and shall consist of (i) one dollar fifty cents for each risk assumed under a binder or policy of insurance or any certificate or agreement issued under either of them, plus one-eightieth of one percent of the face amount of insurance effected thereby; and (ii) three percent of the gross fees and premiums received by it for guaranteed certificates of title, guaranteed searches and guaranteed abstracts of title not included in item (i) of this paragraph. That portion of the reinsurance reserve established as required by this paragraph more than one hundred eighty months prior shall be released and shall no longer constitute part of the reinsurance reserve and may be used for any corporation purpose.

(2) Beginning January first, nineteen hundred eighty-six, the amount of such reserve provided shall consist of (i) one dollar fifty cents for each risk assumed under a binder or policy of insurance or any certificate or agreement issued under either of them, plus one-eightieth of one percent of the face amount of insurance effected thereby; and (ii) three percent of the gross fees and premiums received by it for guaranteed certificates of title, guaranteed searches and guaranteed abstracts of title not included in item (i) of this paragraph. "Risk assumed" and "insurance effected", as used in this paragraph, shall not include the face amount of a policy insuring a lender to the extent of the face amount of a policy insuring the owner of an interest in the same land under an owner's policy which provides that any amount paid under the lender's policy shall reduce the amount of, and be deemed a payment under, the owner's policy. A title insurer shall release from the reinsurance reserve established as required by this paragraph a sum equal to five percent of the amount added to the reserve during each year following the year in which the sum was added, until the entire amount added has been released.

(b) Every title insurance corporation organized or authorized to do business in this state shall on or before March first each year, file a report in such form as may be prescribed by the superintendent of all unpaid losses and claims upon title insurance policies, guaranteed certificates of title, guaranteed searches and guaranteed abstracts of title (such policies, certificates, searches and abstracts being hereafter in this section called "guarantees") of which the corporation has received due notice in writing from or on behalf of the insured or

the guaranteed and keep such records thereof as may be prescribed by the superintendent. Every title insurance corporation doing business under this article shall set up and maintain a loss reserve at least equal to the aggregate estimated amounts due or to become due on account of all such unpaid losses and claims.

(c) The reinsurance reserve required by subsection (a) of this section shall be maintained as follows:

Admitted assets of a value at least equal to the amount required for such reserve shall be continuously held by the corporation as a segregated reserve fund at all times distinct and separate from all its other assets. Cash paid into such fund shall, unless invested, be kept in legal tender or deposited in a separate account. Securities which are a part of such fund shall be kept separate from all other securities and shall be clearly identified as securities belonging to such fund. The net income and profits derived from such fund investments shall be transferred to the general assets of the corporation. Such corporation shall at all times keep a separate record of the cash and securities in such fund, giving complete identification of the assets belonging at any time to such fund and showing full particulars as to withdrawals and additions. No assets of such fund shall be taken or used in satisfaction of any claim against such corporation except as hereinafter provided and such fund shall be held solely for the purpose of satisfying such claims.

(d) The funds constituting the reinsurance reserve required by subsection (a) of this section shall be held in cash or invested only in the types of reserve investments that meet the requirements of paragraphs one, two, and three of subsection (a) of section one thousand four hundred four of this chapter. In no event shall the investment made under such paragraph three exceed twenty percent of the reinsurance reserve at preceding year-end.

(e) If at any time the superintendent finds from the report of any examiner filed pursuant to section three hundred eleven of this chapter or otherwise, after reasonable notice to and hearing of such corporation, that the value of the cash and investments lawfully in the reserve fund required to be established, segregated and maintained by subsection (c) of this section is less than the amount required to be

maintained at such time pursuant to subsection (a) of this section, the superintendent shall determine the amount of such impairment and issue a written requisition to such corporation to remove, repair or make good such impairment within such period as he shall designate, not less than thirty nor more than ninety days from the service of such requisition. If at the expiration of such designated period such impairment has not been removed, repaired or made good, the superintendent shall order such corporation in writing to cease doing any new business. If such corporation, or any officer thereof, having notice of such order of the superintendent, shall thereafter transact or participate in the transaction of any new business, such corporation or person shall be in violation of the provisions of this chapter.

(f) The reinsurance reserve fund required to be maintained pursuant to subsection (c) of this section shall constitute a separate and distinct trust fund for the security of holders of guarantees of the corporation as hereinafter provided.

(g) In the event the superintendent, pursuant to the provisions of article seventy-four of this chapter, obtains an order for the rehabilitation or liquidation of a title insurance corporation, he shall have the power:

(1) to pay out of such reinsurance reserve fund, subject to the approval of the court, the claims for losses sustained by the holders of guarantees of such corporation pending at the time of the making of such order or arising subsequently thereto and up to the time reinsurance is effected, and

(2) to negotiate and enter into a contract with one or more solvent corporations authorized to transact the business of title insurance, subject to the approval of the court, for the reinsurance of the obligations under such outstanding guarantees in accordance with their terms, covenants and conditions, and

(3) to pay the cost of reinsurance out of said reinsurance reserve fund of such corporation.

(h) After the payments hereinbefore authorized shall have been made by the superintendent, he shall transfer any balance in said reinsurance reserve fund to the general assets of the corporation in rehabilitation or liquidation. The reinsuring corporation shall segregate and maintain the reinsurance reserve fund acquired from the superintendent under the

terms of the agreement of reinsurance except that on the first day of the month next succeeding such acquisition and on the first day of each month thereafter, one one-hundred-eightieth of the amount of the said fund so acquired shall be released therefrom and shall no longer constitute part of the reinsurance reserve fund so acquired and may be used for any corporate purpose of the reinsuring corporation.

(i) In the event the superintendent shall be unable to effect a contract for reinsurance as provided in subsection (g) of this section, for the reinsurance of the outstanding guarantees of a title corporation in rehabilitation or liquidation, the reinsurance reserve fund of such corporation shall constitute a separate and distinct trust fund for the payment therefrom by the superintendent, on the approval of the court, in the following order of preference, (i) of all expenses of proceedings incurred under this subsection, (ii) of all allowed claims for losses sustained by the holders of guarantees of such corporation which are unpaid or pending at the time fixed by the court for the filing of claims and (iii) of all allowed claims for losses which shall be asserted at any time within twenty years from the date of the entry of such order of rehabilitation or liquidation and which shall be paid in the order of the date of their allowance by the court. Any balance in the reinsurance reserve fund of a title insurance corporation after payment of allowed claims asserted within twenty years from the date of the entry of the order of rehabilitation or liquidation shall be transferred to the general assets of such corporation. The superintendent shall keep and retain for such period of twenty years all title records of the corporation which he in his discretion shall deem necessary to effectuate the purposes of this trust.

(j) The payments out of the reinsurance reserve fund which shall have been made by the superintendent on allowed claims for losses which shall have been filed within the time fixed by the court for the filing of claims in a rehabilitation or liquidation proceeding, shall constitute an allowed claim in favor of the reinsurance reserve fund of such corporation entitled to share with general creditors in the dividends directed to be paid and the dividends so paid on such claim shall fall into such reinsurance reserve fund.

(k) In proceedings for the rehabilitation or liquidation of a title insurance corporation which shall not have been declared insolvent, no

assets of such corporation shall be distributed to the shareholders of such corporation (i) until all claims allowed in the rehabilitation or liquidation proceedings have been paid in full, and (ii) if such distribution is within twenty years from the date of the entry of the order of rehabilitation or liquidation such distribution shall not be made unless prior to or at the time of the making of such distribution there shall be transferred to the reinsurance reserve fund general assets of the corporation sufficient to restore such fund to its amount on the date of the entry of such order. Upon the expiration of twenty years from the date of the entry of such order of rehabilitation or liquidation any balance in such reinsurance reserve fund after payment of all allowed claims asserted within such twenty year period shall be transferred to the general assets of such corporation.

§ 6406. Investments; exception. (a) Every title insurance corporation organized and doing business under this article shall invest and keep invested an amount at least equal to its required minimum capital in the types of investments specified in section one thousand four hundred two of this chapter, except that it shall invest and keep invested at least thirty-five percent of its minimum capital in those types of investments specified in paragraphs one and two of subsection (b) of such section.

(b) Every title insurance corporation organized and doing a title insurance business under this article shall confine its investment of all of its funds, other than those specified in subsection (a) hereof, to investments permitted by paragraph two of subsection (a) of section one thousand four hundred three of this chapter except as follows:

(1) No loan secured by mortgage on any one piece or parcel of property (excluding any part guaranteed under title three of the Servicemen's Readjustment Act of 1944 (38 U.S.C. § 1801)) shall at the time of investment exceed (i) three-fourths of the value of the real property securing the same if (I) such real property is primarily improved by a single family residence, (II) the aggregate principal amount of the loan or loans secured by such real property does not exceed thirty thousand dollars, and (III) the evidences of indebtedness provide for amortization of principal over a period of not more than thirty years, or (ii) two-thirds of the value of the real property securing the same

in all other cases, as shown by the appraisal of one or more competent and experienced appraisers.

(2) Any such corporation may invest in loans secured by mortgages on real property guaranteed as to principal or interest by the United States.

(3) No title insurance corporation shall at any time have invested in bonds, notes or other evidences of indebtedness secured by deeds of trust or real estate mortgages, as specified in this paragraph except bonds or notes secured by mortgage or trust deed guaranteed or insured by the federal housing administration under an act of congress of the United States of June 27, 1934, entitled the "National Housing Act,"(12 U.S.C. § 1701). Notwithstanding the provisions of clause (I) of item (v) of subparagraph (A) of paragraph four of subsection (a) of section one thousand four hundred four of this chapter, the aggregate investments held by a title insurance corporation of the types described in such subparagraph and in purchase money mortgages received by it in part payment of the consideration for the sale or exchange of real property owned by it, shall not exceed seventy percent of its admitted assets as shown by its last statement on file with the superintendent.

(4) No title insurance corporation shall invest in or lend upon the security of any one parcel of property an amount exceeding seven percent of its total admitted assets, except that such corporation may invest in or lend upon an obligation or obligations secured by a mortgage or mortgages on property guaranteed as to principal or interest by the United States, or guaranteed or insured under the National Housing Act (12 U.S.C. § 1701), an amount not exceeding twenty-five percent of its total admitted assets, if at the time of the making of the commitment for such investment or loan such corporation shall have entered into an agreement in writing with a mortgagee approved under the provisions of the National Housing Act, for the sale of such investment or loan for an amount in cash not less than the full amount of such investment or loan.

(5) Notwithstanding the provisions of paragraph eight of subsection (a) of section one thousand four hundred four of this chapter, no title insurance corporation shall invest in, or otherwise acquire or loan upon in any one institution's outstanding equity interests an amount which exceeds two percent of the admitted assets of such title insurance corporation as shown by its last statement on file with the

superintendent. The aggregate cost of all investments in equity interests then held by any title insurance corporation pursuant to this paragraph, paragraph six hereof, section one thousand four hundred three and paragraph eight of subsection (a) of section one thousand four hundred four of this chapter shall not exceed the lesser of twenty-five percent of the insurer's total admitted assets or one-half of the insurer's surplus to policyholders as shown by its last statement on file with the superintendent.

(6) Notwithstanding the provisions of paragraph eight of subsection (a) of section one thousand four hundred four of this chapter and paragraph five hereof, a title insurance corporation may invest in the shares of other insurance corporations and in the shares and obligations of any corporation which is engaged exclusively in a kind of business properly incidental to the insurance business of such title insurance corporation, amounts which do not in total exceed ten percent of its total admitted assets as shown by its last statement on file with the superintendent.

(7) No title insurance corporation shall hold a direct or indirect ownership interest in a risk retention group, as defined in article fifty-nine of this chapter, other than in a risk retention group all of whose members are insurance companies.

§ 6407. Restrictions on dividends. (a) No title insurance corporation shall declare or pay any cash or property dividend on its capital shares, or declare or distribute a stock dividend except out of earned surplus, meaning, for the purpose of this section, surplus not attributable to contributions made to surplus within five years next preceding or to appreciation in value of investments not sold or otherwise disposed of.

(b) No such corporation shall declare or pay any cash or property dividend to shareholders which, together with all such dividends declared or paid by it during the next preceding twelve months, exceeds ten percent of its then outstanding capital shares unless, after deducting such dividends, it has a surplus to policyholders at least equal to fifty percent of its reinsurance reserve or a surplus at least equal to fifty percent of the minimum capital required of such insurer

to transact the business of title insurance, whichever shall be greater. For the purpose of this section, "surplus" means the amount of the insurer's admitted assets in excess of (i) all of its liabilities, including its reinsurance reserve, and (ii) its outstanding capital shares.

(c) No such corporation shall declare or distribute any stock dividend which shall reduce surplus to an amount less than fifty percent of its then outstanding capital shares.

§ 6408. Prohibition on engaging in certain business activities. (a) No person, firm, association or corporation shall engage in business as a title insurance corporation except pursuant to the provisions of this article. This prohibition shall not prevent the making, issuing, or furnishing of any abstract, search, examination, survey or certificate of title without guarantee or insurance thereof, nor the doing of any business specified in paragraphs three, four, five and six of subsection (b) of section six thousand four hundred three of this article.

(b) Except as in this article provided, no corporation organized or doing business under this article shall engage in the business of selling certificates or participations in obligations secured by mortgages.

(c) Except as provided in this article or in article sixty-five of this chapter, no person, firm, association or corporation shall, in this state, engage, or make any public proposal to engage, in the business of guaranteeing mortgages of real or personal property, or of selling any guaranteed mortgage or interest therein.

(d) Notwithstanding any other provisions of this article, no person, firm, association or corporation organized or qualified under this article shall in this state hereafter engage, or make any public proposal to engage, in the business of selling any mortgage, certificate of participation or interest in any mortgage or mortgages, or certificate secured by the deposit of any cash, mortgage or mortgages or other securities, coupled with any agreement to repurchase.

§ 6409. Filing of policy forms; rates; classification of risks;

commissions and rebates prohibited. (a) No title insurance policy shall be issued or delivered in this state, unless it has been filed with the superintendent in accordance with article twenty-three of this chapter.

(b) Title insurance rates and rate filings shall be subject to article twenty-three of this chapter.

(c) Notwithstanding any other provision of this article, every title insurance corporation shall offer, at or prior to title closing, an optional policy form that insures the title of owner-occupied real property used predominantly for residential purposes that consists of not more than four dwelling units for an amount equal to the market value of the property at the time a loss is discovered. Such policy form shall be filed with, and approved by, the superintendent in accordance with article twenty-three of this chapter. Rates for such coverage shall be filed and approved pursuant to article twenty-three of this chapter.

(d) No title insurance corporation, title insurance agent, or any other person acting for or on behalf of the title insurance corporation or title insurance agent, shall offer or make, directly or indirectly, any rebate of any portion of the fee, premium or charge made, or pay or give to any applicant, or to any person, firm, or corporation acting as agent, representative, attorney, or employee of the owner, lessee, mortgagee or the prospective owner, lessee, or mortgagee of the real property or any interest therein, either directly or indirectly, any commission, any part of its fees or charges, or any other consideration or valuable thing, as an inducement for, or as compensation for, any title insurance business, nor shall any applicant, or any person, firm, or corporation acting as agent, representative, attorney, or employee of the owner, lessee, mortgagee or of the prospective owner, lessee, or mortgagee of the real property or anyone having any interest in real property knowingly receive, directly or indirectly, any such rebate or other consideration or valuable thing. Any person or entity who violates this section shall be subject to a penalty of (1) five thousand dollars; or (2) up to ten times the amount of any compensation or rebate received or paid in the case of a title insurance corporation or title insurance agent; or (3) up to five times the amount of any compensation or rebate received or paid; or (4) in the case of an applicant for title insurance that covers real property used predominantly for residential purposes, and which consists of not more than four dwelling units, other than

hotels and motels, an amount not to exceed the compensation or rebate received or paid, when such applicant knew that it was a violation to receive such rebate, or other consideration or valuable thing; provided, however, if such applicant did not know that it was a violation to receive such rebate, or other consideration or valuable thing, he or she shall not be assessed a penalty under this subdivision.

(e) Premium rates for coverage shall fully reflect the foregoing prohibitions of subsection (d) of this section.

§ 6410. Merger. The merger of two or more corporations organized pursuant to section six thousand four hundred two of this article or organized under the laws of this state for the purpose set forth in section six thousand four hundred three of this article, unless it be a merger governed by section six thousand four hundred eleven of this article, shall be governed by those provisions of article seventy-one of this chapter which relate to the merger of two or more domestic stock insurance corporations and which are not inconsistent with any of the provisions of this article, except that:

(a) the proposed charter of the surviving company shall provide for not less than thirteen nor more than thirty directors;

(b) in addition to delivery in person or by mail, the notice of the shareholders meeting provided for in subsection (a) of section seven thousand one hundred four of this chapter shall be published for at least two successive weeks in one of the newspapers in each of the counties of this state in which either of the constituent companies shall have its principal place of business;

(c) in lieu of the provisions of section seven thousand one hundred nineteen of this chapter, if any shareholder not voting in favor of such agreement of merger shall, at such meeting or within twenty days thereafter, object to such merger and demand payment for his shares, he may, at any time within sixty days after such merger, apply to the supreme court at any special term thereof, held in the district in which the county is situated, in which the surviving company has its principal place of business, upon at least eight days' notice to said company for the appointment of three persons to appraise the value of his shares, and the court shall appoint such appraisers and designate the time and

place of their first meeting, with such directions in regard to their proceedings as shall be deemed proper. The court may fill any vacancies in the board of appraisers occurring by refusal or neglect to hold such office. The appraisers shall meet at the time and place designated and after being duly sworn, shall honestly and faithfully discharge their duties and estimate and certify the value of such shares, and deliver one copy to such company and another to such shareholder, if demanded; the charges and expenses of the appraisers shall be paid by the company. When the company shall have paid the appraised value of such shares, as directed by the court, said shares shall be canceled and such shareholder shall cease to have any interest in such shares and in the company property, and such shares may be held and disposed of by the company for its own benefit; and

(d) the sum of the capital stock of the surviving company shall not exceed the limit permitted to either constituent company at the time of merger.

§ 6411. Merger of parent corporation and wholly-owned subsidiary. (a) Notwithstanding the provisions of section six thousand four hundred ten of this article and article fifteen of this chapter, and any rights conferred therein or obligations imposed thereby, any corporation organized under section six thousand four hundred two of this article, or organized under the laws of this state for the purposes set forth in section six thousand four hundred three of this article, owning all the shares of any title insurance corporation may file in the office of the superintendent a certificate of such ownership in its name and under its corporate seal, signed by its president or a vice president and its secretary or treasurer and setting forth a duly certified copy of the resolution of its board of directors to merge such other corporation, and to assume all of its obligations, and the date of the adoption thereof. A duplicate or certified copy of such certificate with the approval required by subsection (b) hereof endorsed thereon or annexed thereto shall be filed in the office of the clerk of the county wherein the principal office of the parent corporation is located. Upon the filing of such certificate, all of the estate, property, rights, privileges and franchises of such other corporation shall vest in and be

held and enjoyed by the parent corporation as fully and entirely and without change or diminution as the same were before held and enjoyed by such other corporation, and be managed and controlled by the parent corporation, and, in its name, but subject to all liabilities and obligations of such other corporation and the rights of all creditors thereof which the parent corporation shall be deemed to have assumed and become liable for in the same manner as if it had itself incurred such liabilities and obligations. The parent corporation shall not thereby acquire power to engage in any business or to exercise any right, privilege or franchise of a kind which it could not lawfully engage in or exercise under the provisions of the law by or pursuant to which such parent corporation is organized.

(b) Such merger shall not become effective unless and until the superintendent shall give his approval thereto. Such approval shall be endorsed upon or annexed to the certificate of merger before filing and the certificate filed as required by subsection (a) hereof.

ARTICLE 65
MORTGAGE GUARANTY INSURANCE COMPANIES

Section 6501. Definitions.
6502. Financial requirements.
6503. Limitations.
6504. Required approvals; prohibitions.
6505. Licensing of agents.
6506. Advertising.
6507. Reinsurance.
6508. Additional powers of superintendent.

§ 6501. Definitions. In this article:

(a) "Mortgage guaranty insurance" means insurance against financial loss by reason of nonpayment of any sum required to be paid under the terms of any instrument of indebtedness secured by a lien on real estate.

(b) "Mortgage insurer" means a person licensed to transact the business of mortgage guaranty insurance in this state.

(c) "Authorized real estate security" means:

(1) an amortized instrument of indebtedness evidencing a loan secured by a first lien on real estate which at the time the loan is made is not less than eighty percent but not more than one hundred three percent of the fair market value of the real estate with any percentage in excess of one hundred percent being used to finance the fees and closing costs on such indebtedness, except, however, for reverse mortgage loans made pursuant to sections two hundred eighty and two hundred eighty-a of the real property law; provided that:

(A) the loan is one which a regulated mortgage investor is authorized to make;

(B) the improvement is a residential building or buildings designed for occupancy by not more than four families or is a condominium unit;

(C) the lien may be subordinate to:

(i) the lien of any public bond, assessment, or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent; and

(ii) outstanding mineral, oil or timber rights, easements or other restrictions on use, or leases under which rents or profits are reserved;

(2) an amortized instrument of indebtedness evidencing a loan secured by a junior lien on real estate which, when combined with all existing mortgage loan amounts at the time the loan is made, is not more than one hundred percent of the fair market value of the real estate; provided that:

(A) in determining the foregoing one hundred percent limitation, if the loan securing the junior lien is an equity line of credit loan, the full amount of the line of credit to be secured by the junior lien shall be considered the amount of the loan;

(B) the loan is one which a regulated mortgage investor is authorized to make;

(C) the improvement is a residential building or buildings designed for occupancy by not more than four families or is a condominium unit;

(D) in addition to any senior liens securing any amortized instruments of indebtedness on real estate, qualifying under paragraph one of this subsection, the junior lien may be subordinate to:

(i) the lien of any public bond, assessment, or tax, when no

installment, call or payment of or under such bond, assessment or tax is delinquent; and

(ii) outstanding mineral, oil or timber rights, easements or other restrictions on use, or leases under which rents or profits are reserved;

(3) an amortized instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate in this state and which at the time the loan is made is not less than eighty percent nor more than one hundred percent of the purchase price of the ownership interest and the proprietary lease, if the loan is one which a regulated mortgage investor is authorized to make. In this article unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest;

(4) an amortized instrument of indebtedness, evidencing a loan which otherwise conforms to the requirements of paragraph one or three of this subsection, and which has been amortized to less than eighty percent of the fair market value of the real estate at the time said loan was made; provided the borrower is not obligated directly or indirectly to pay any premium for mortgage guaranty insurance authorized under this article, and the instrument would be ineligible for sale to the Federal National Mortgage Association, the Government National Mortgage Association, the Federal Home Loan Mortgage Corporation or any other secondary mortgage market instrumentality or facility as the superintendent of financial services determines, without such mortgage guaranty insurance; or

(5) where a loan is being made as part of the state of New York mortgage agency's forward commitment program as defined in title seventeen of article eight of the public authorities law, the lesser percentage set forth in paragraphs one and three of this subsection shall be sixty percent and the range of such percentages shall apply to the fair market value at the time the loan was made of the real estate or the ownership interest in a corporation or partnership formed for the purpose of cooperative ownership of real estate, as the case may be.

(d) "Contingency reserve" means an additional premium reserve

established to protect policyholders against the effect of adverse economic cycles.

(e) "Policyholders surplus" means the aggregate of capital, surplus and contingency reserve if a stock insurance company or, if a mutual insurance company, the aggregate of surplus and contingency reserve.

(f) "Regulated mortgage investor" means a bank, trust company, savings bank, savings and loan association or insurance company, which is supervised by a department of this state or an agency of the federal government and which invests in authorized real estate securities.

(g) "Segregated trust" is a trust which:

(1) is established by a reinsurer for the benefit of a mortgage insurer;

(2) has a trustee domiciled in the mortgage insurer's state of domicile, domiciled in New York or approved by the superintendent;

(3) is funded by assets permitted by article fourteen of this chapter for the loss reserve required by paragraph three of subsection (a) of section six thousand five hundred two of this article and for the unearned premium reserve required by section one thousand three hundred five of this chapter;

(4) is funded by either cash, the types of reserve investments specified in paragraphs one and two of subsection (a) of section one thousand four hundred four of this chapter or by tax and loss bonds purchased pursuant to § 832(e) of the Internal Revenue Code, for the greater of the amount of the contingency reserve required by paragraph two of subsection (a) of section six thousand five hundred two of this article or paragraph one of subsection (b) of section six thousand five hundred two of this article;

(5) makes quarterly and annual reports to the superintendent;

(6) is subject to withdrawals only by, and under the control of, the ceding mortgage insurer;

(7) permits examination by the superintendent;

(8) designates the superintendent for service of process;

(9) is governed by an agreement which, together with all amendments, shall be approved by the commissioner or superintendent of insurance of the mortgage insurer's domicile, and shall be provided to the superintendent, who shall have the right to disapprove of the agreement. Such agreement shall be deemed approved by the superintendent unless

disapproved within thirty days from the date provided to the superintendent; and

(10) is in compliance with any other regulations or requirements of the superintendent relating to trust agreements.

§ 6502. Financial requirements. (a) A mortgage insurer shall not transact business unless:

(1) if a stock insurance company, it has paid-in capital of at least one million dollars and paid-in surplus of at least one million dollars or, if a mutual insurance company, a minimum initial surplus of two million dollars. A stock company shall at all times thereafter maintain a minimum surplus of at least five hundred thousand dollars, a mutual company shall at all times thereafter maintain a minimum surplus of at least one million five hundred thousand dollars;

(2) it establishes a contingency reserve out of net premiums (gross premiums less premiums returned to policyholders) remaining after establishing the unearned premium reserve. The company shall contribute to the contingency reserve an amount equal to fifty percent of such remaining earned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of one hundred and twenty months, except that withdrawals may be made by the company with the prior approval of the superintendent in any year in which the actual incurred losses exceed thirty-five percent of the corresponding earned premiums. The unearned premium reserve shall be computed as required by section one thousand three hundred five of this chapter except that on policies covering a risk period of more than one year it shall be computed in accordance with standards promulgated by the superintendent; and

(3) in addition to the contingency reserve, the case basis method or other method as may be prescribed by the superintendent shall be used to determine the loss reserve in a manner consistent with section one thousand three hundred three of this chapter. It shall include a reserve for claims reported and unpaid and claims incurred but not reported, including:

(A) estimated losses on insured loans which have resulted in the conveyance of property which remains unsold;

(B) insured loans in the process of foreclosure; and

(C) insured loans in default for four or more months.

(b) A mortgage insurer shall not:

(1) have outstanding a total liability under its aggregate insurance policies exceeding twenty-five times its policyholders' surplus, computed on the basis of the company's liability under its election as provided in subsection (c) of section six thousand five hundred three of this article. Total liability shall be calculated net of applicable reinsurance. No company which has outstanding total liability exceeding twenty-five times its policyholders' surplus shall transact new business until its total liability no longer exceeds twenty-five times its policyholders' surplus;

(2) declare dividends except from undivided profits remaining on hand above the aggregate of its paid-in capital, paid-in surplus and contingency reserve or, if a mutual insurance company, its initial surplus and contingency reserve; or

(3) invest its contingency reserve except in tax and loss bonds purchased pursuant to § 832(e) of the Internal Revenue Code, to the extent of the tax savings resulting from the deduction for federal income tax purposes equal to the annual contributions to the contingency reserve. The contingency reserve shall otherwise be held in cash or invested only in the types of reserve investments specified in paragraphs one and two of subsection (a) of section one thousand four hundred four of this chapter.

§ 6503. Limitations. (a) Mortgage guaranty insurance may be transacted in this state only by a company licensed to do so and shall be written only:

(1) to insure loans secured by authorized real estate securities; or

(2) to insure pools of loans secured by instruments constituting a first lien on real estate and evidenced by pass-through certificates or other instruments, provided no part of the premiums for such insurance shall be paid directly or indirectly by the mortgagors and mortgage guaranty insurance for such pools of loans shall not be subject to the provisions of subsection (c) of this section; or

(3) to insure a portfolio of loans secured by instruments constituting

a junior lien on real estate.

(b) A mortgage insurer shall not insure exposure on loans secured by liens on properties in a single housing tract or a contiguous tract in excess of ten percent of its policyholders surplus. In calculating such exposure, the applicable claim settlement option shall be applied and applicable reinsurance shall be deducted. "Contiguous" means not separated by more than one-half mile.

(c) A mortgage insurer providing coverage on loans secured by a first lien on real estate may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security. A mortgage insurer providing coverage on loans secured by a junior lien on real estate may elect to insure a portfolio of loans secured by instruments constituting a junior lien on real estate.

(d) Except for loans made pursuant to the state of New York mortgage agency's forward commitment program as defined in title seventeen of article eight of the public authorities law, a mortgagor shall not be required to pay, directly or indirectly, the cost of continuing mortgage guaranty insurance on a loan secured by a first lien on real estate when the unpaid principal amount of the real estate loan represents seventy-five percent or less of the real estate's appraised value at the time the loan was made or such higher percentage of such appraised value as may be established from time to time by general regulation of the superintendent of financial services, which shall consider:

(1) the cost to mortgagors and the necessity of maintaining insurance;

(2) the applicable mortgage insurance requirements of the Federal National Mortgage Association, the Government National Mortgage Association and the Federal Home Loan Mortgage Corporation to be met as a precondition to the sale thereto by a regulated mortgage investor; and

(3) the need in light of prevailing economic conditions for regulated mortgage investors to resell such security.

(e) For loans made pursuant to the state of New York mortgage agency's forward commitment program as defined in title seventeen of article eight of the public authorities law, a mortgagor shall not be required to pay, directly or indirectly, the cost of continuing mortgage guaranty insurance on a loan secured by a first lien on real estate when the unpaid principal amount of the real estate loan represents sixty percent or less of the fair market value of the real estate at the time the loan

was made.

(f) A mortgagor shall not be required to pay, directly or indirectly, the cost of mortgage guaranty insurance on a loan secured by a junior lien on real estate when the indebtedness evidencing that loan, combined with all existing mortgage loan amounts at the time the loan is made, is less than sixty percent of the fair market value of the real estate at the time the junior loan is made.

(g) A mortgage insurer may not obtain a deficiency judgment against a borrower in the event of foreclosure.

(h) This article shall not limit the right of any mortgage insurer to impose reasonable requirements upon the lender with regard to the terms of any note or bond or other evidence of indebtedness secured by a mortgage or deed of trust.

§ 6504. Required approvals; prohibitions. (a) Every mortgage insurer shall file with the superintendent for his approval in accordance with article twenty-three of this chapter its premium rates, forms of policies, certificates, applications and other forms pertaining to mortgage guaranty insurance. The premium rate charged for mortgage guaranty insurance shall not be deemed to be interest for the purposes of section 5-501 of the general obligations law.

(b) No mortgage insurer shall pay:

(1) to any person who is acting as agent, representative, attorney or employee of the owner, mortgagee of the prospective owner, or mortgagee of the real property or any interest therein, either directly or indirectly, any consideration as an inducement for or as compensation on any mortgage guaranty insurance business; or

(2) any compensation to any person for transacting insurance for or with it based in whole or in part upon a commission basis unless such person is licensed pursuant to this chapter.

(c) In connection with the placement or renewal of any insurance, a mortgage insurer shall not permit any compensation to be paid to, or received by: any insured lender; any officer, director, or employee of the insured; any member of their immediate family; any corporation, partnership, trust, or trade association in which an insured is a member; or other entity in which an insured or any such officer,

director, or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee, or other agent or representative of any of the foregoing.

(d) The superintendent may, after a hearing, suspend or revoke the license of any mortgage insurer which, after ten days written notice from the superintendent requiring it to cease and desist, continues to pay any consideration in willful violation of this article.

§ 6505. Licensing of agents. The standards in subsections (d) through (k), (m) and (o) of section two thousand one hundred three of this chapter shall apply to the licensing of agents for a mortgage insurer. Such license may be limited to mortgage guaranty insurance. In such event, the superintendent may, in his discretion, provide a special examination for such license.

§ 6506. Advertising. No regulated mortgage investor, any of whose authorized real estate securities are insured by mortgage guaranty insurance pursuant to this article may state in any form of report or advertising that the real estate loans of the investor are "insured loans" unless the report or any form of advertising also clearly states that the loans are insured by private insurers and the names of such insurers are given. A regulated mortgage investor also shall not make any such statement unless such insurance is by a company authorized to transact mortgage guaranty insurance business in this state.

§ 6507. Reinsurance. (a) A mortgage insurer may, by contract, reinsure any insurance it transacts and receive credit for such reinsurance as an asset or as a reduction from liabilities, including its contingency reserve liability, in its financial statements where such reinsurance is placed with another mortgage insurer licensed under this article.

(b) Notwithstanding any provision of law to the contrary, mortgage guaranty insurance may, by contract, be reinsured, provided that any reinsurance arrangements entered into by a mortgage insurer and an assuming insurer comply with the provisions of this article. The

unearned premium reserve required by section one thousand three hundred five of this chapter, the contingency reserve required by paragraph two of subsection (a) of section six thousand five hundred two of this article and loss reserve required by paragraph three of subsection (a) of section six thousand five hundred two of this article shall be established and maintained by the mortgage insurer or by the assuming insurer so that the aggregate reserves shall not be less than the reserves required by such subsection.

(c) Where a mortgage insurer cedes any insurance to an insurer that insures or reinsures other lines of insurance in addition to mortgage guaranty insurance, the amount of insurance so ceded shall not exceed thirty-five percent of the total exposure insured by the mortgage insurer after deducting insurance ceded to any other mortgage insurer.

(d) Where a mortgage insurer cedes any insurance to a mortgage insurer not licensed under this article or an insurer that insures or reinsures other lines of insurance in addition to mortgage guaranty insurance, in order for the mortgage insurer to receive credit for such reinsurance as an asset or as a reduction from liabilities, including its contingency reserve liability, in its financial statements, such assuming insurer must maintain a surplus to policyholders of at least thirty-five million dollars and the following must occur;

(1) the insurer must establish and maintain in a segregated trust an amount equal to the greater of either the contingency reserve required by paragraph two of subsection (a) of section six thousand five hundred two of this article, or four percent of the outstanding total liability under the aggregate insurance policies assumed from the mortgage insurer;

(2) the insurer must establish and maintain in a segregated trust, or provide a letter of credit in a form approved by the superintendent, an amount equal to the unearned premium and loss reserves;

(3) any such aggregated trust shall be funded by assets permitted by article fourteen of this chapter for the loss reserve required by paragraph three of subsection (a) of section six thousand five hundred two of this article and for the unearned premium reserve required by section one thousand three hundred five of this chapter, and shall be funded by either the types of assets specified in paragraphs one, two and three of subsection (b) of section one thousand four hundred two and

paragraphs one, two and twelve of subsection (a) of section one thousand four hundred four of this chapter or by tax and loss bonds purchased pursuant to § 832(e) of the Internal Revenue Code for the greater of the amount of reserves required by paragraph two of subsection (a) of section six thousand five hundred two of this article or paragraph one of subsection (b) of section six thousand five hundred two of this article;

(4) the reinsurance agreement must be submitted to the commissioner or superintendent of insurance of the mortgage insurer's domicile for approval; and

(5) the reinsurance agreement must provide that:

(A) it is not valid until approved by the commissioner or superintendent of insurance of the mortgage insurer's domicile;

(B) any amendments to the reinsurance agreement must be submitted to the commissioner or superintendent of insurance of the mortgage insurer's domicile for approval prior to becoming effective;

(C) the ceding mortgage insurer has a right to terminate the ceding of additional insurance under the reinsurance agreement if so ordered by the superintendent;

(D) the superintendent has the right to request from the assuming reinsurer information concerning its financial condition;

(E) the assuming reinsurer shall notify the superintendent of any material change in its financial condition; and

(F) such agreements and any amendments thereto shall be provided to the superintendent, who shall have the right to disapprove of any agreement. Such agreements and any amendments thereto shall be deemed approved by the superintendent unless disapproved within thirty days from the date provided to the superintendent. If the superintendent disapproves of any reinsurance agreement or amendments thereto the mortgage insurer shall not receive credit for such reinsurance as an asset or as a reduction from liabilities in its financial statement.

(e) Nothing contained herein shall be deemed to permit an insurer that insures or reinsures other lines of insurance in addition to mortgage guaranty insurance to write directly mortgage guaranty insurance.

(f) Any reinsurance agreement that was valid under this chapter at the time entered into shall not be invalidated by this section.

§ 6508. Additional powers of superintendent. The superintendent may adopt regulations necessary to carry out this article including restrictions on investments, giving full consideration to the desirability of high liquidity.

ARTICLE 66

CO-OPERATIVE PROPERTY/CASUALTY INSURANCE COMPANIES

Section 6601. Scope of article; other provisions.
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6624. Voting by members and meetings of boards of directors; co-operative property/casualty insurance companies.
6625. Merger; consolidation.
6626. Qualification of membership.

§ 6601. Scope of article; other provisions. (a) All insurers formed pursuant to chapter seven hundred thirty-nine of the laws of eighteen hundred fifty-seven, chapter five hundred seventy-three of the laws of eighteen hundred eighty-six, or the laws of which the last mentioned chapter was a consolidation, article nine of chapter six hundred ninety of the laws of eighteen hundred ninety-two, and chapter three hundred twenty-eight of the laws of nineteen hundred ten, the same constituting article nine of former chapter twenty-eight of the consolidated laws as in effect immediately before January first, nineteen hundred forty and article XI-B of the former insurance law as in effect immediately before the effective date of this chapter, are hereby continued in existence and, together with all insurers organized or licensed under this article, are made subject to the provisions of this article and not to any other provisions of this chapter except as provided in subsection (b) hereof.

(b) Except as otherwise specifically provided in this article, the provisions of this chapter insofar as they are applicable to domestic mutual property/casualty insurance companies, shall, unless the context otherwise requires, apply to co-operative property/casualty insurance companies.

§ 6602. Classification of insurers; foreign and alien insurers. (a) Cooperative property/casualty insurance companies operating under or subject to this article shall be either advance premium co-operative property/casualty insurance companies or assessment co-operative property/casualty insurance companies.

(b) (1) "Advance premium corporation" means an advance premium co-operative property/casualty insurance company which charges premiums in advance on the basis of applicable provisions of article twenty-three of this chapter and which maintains unearned premium reserves as

required by section one thousand three hundred five of this chapter and loss and loss expense reserves as required by section four thousand one hundred seventeen of this chapter.

(2) "Assessment corporation" means an assessment co-operative property/casualty insurance company which levies upon its members regular assessments, the amount of which is determined by giving due cognizance, along with other relative factors, either to the incurred liabilities of such insurer, or to its estimated liabilities likely to become incurred before the next regular assessment, or both, and which maintains unearned premium reserves as required by section one thousand three hundred five of this chapter and loss and loss expense reserves as required by section four thousand one hundred seventeen of this chapter.

(c) No insurer operating under or subject to the provisions of this article shall do a part of its business on the advance premium plan and another part on the assessment plan; but this shall not be construed to affect the contingent liability of members of advance premium corporations nor to affect the liability of members of assessment corporations for extraordinary assessments, as hereinafter provided.

(d) No foreign or alien insurer or insurance organization shall be licensed or permitted to do in this state any kind or kinds of insurance business specified in this article on the assessment plan, or on any mutual plan, other than as a mutual property/casualty insurance company or as a reciprocal insurer as elsewhere provided in this chapter.

§ 6603. Incorporation of co-operative property/casualty insurance companies. (a) A corporation may be organized and licensed as an advance premium corporation or as an assessment corporation in the manner prescribed in this section and subject to any other applicable requirements of this chapter. The successive steps shall be as follows:

(1) The proposed incorporators, who shall be natural persons not less than thirty in number, shall submit to the superintendent in writing, the proposed name of the corporation, which shall include the word "co-operative," and the county in which its principal office will be located, and the name and address of a public newspaper of general circulation in said county. Such proposed incorporators shall also submit at the same time statements subscribed and affirmed by them as

true under the penalties of perjury, in such form as the superintendent may require, which shall show that each incorporator is the true and bona fide owner of improved real property worth not less than two thousand dollars; that the real property so owned by such incorporators is worth in the aggregate not less than two hundred thousand dollars; and that such real property is located wholly within the territory wherein the corporation desires to do business.

(2) If the superintendent approves the proposed name of the corporation and the designated newspaper, each as conforming to the requirements of law, and if he finds that the affidavits required by paragraph one hereof are sufficient in form and substance, he shall notify the proposed incorporators, or their representative, in writing. Such approval shall become void if within six months from the date thereof the declaration and charter have not been filed pursuant to this section. However, upon application made prior to the expiration of such six months, the superintendent for good cause shown in such application may extend such approval for an additional period not to exceed six months.

(3) The proposed incorporators shall cause to be published in the approved newspaper, twice a week for three successive weeks, or once a week for six successive weeks, a notice of intention to form such a corporation, stating its proposed name, the kind or kinds of insurance business to be transacted and whether on the advance premium plan or assessment plan, the names and respective residence addresses of the proposed incorporators, and the location of its principal office in this state.

(4) The proposed incorporators shall submit to the superintendent proof of such publication by the statement of the publisher or of his foreman or clerk, subscribed and affirmed by him as true subject to the penalties of perjury, and a declaration subscribed and affirmed as true under the penalties of perjury by each and all of the incorporators, setting forth the items hereinafter specified.

(5) Such declaration shall be in the English language, and shall state the intention of the proposed incorporators to form a corporation for the purpose of doing one or more kinds of insurance business specified in subsection (a) of section one thousand one hundred thirteen of this chapter and shall specify the provision or provisions of such section

defining the kind or kinds of insurance business, insofar as such kinds of insurance are specifically available to such a corporation by section six thousand six hundred four or six thousand six hundred five of this article, whichever is applicable. Such declaration shall also set forth a copy of the proposed charter of the corporation, which shall contain:

(A) The name of the proposed corporation.

(B) The territory in this state wherein the corporation desires to do business.

(C) The kind or kinds of insurance to be transacted, specified as above required, and whether on the advance premium or assessment plan.

(D) The mode and manner in which its corporate powers are to be exercised.

(E) The number of its directors, which shall be not less than seven, and a provision that in no case shall the number of directors be less than seven.

(F) The times and manner of electing its directors and officers, the manner of filling vacancies in such offices, and a provision that at all times a majority of the directors shall be citizens and residents of this state and that not less than one shall be a resident within the territory in which the corporation is licensed to do business.

(G) The names and the residence addresses of the directors who shall serve until the first annual meeting of the members of the corporation.

(H) Such other particulars as may be necessary to explain the objects, purposes, management and control of the corporation. The superintendent may by regulation prescribe the additional information to be required, pursuant to this subparagraph.

(6) The superintendent shall transmit such proof of publication, declaration, and charter to the attorney general. If the same be approved by the attorney general, as conforming to the requirements of law, upon receipt of such approval the superintendent shall file such declaration, charter and proof of publication in his office, and shall issue a certified copy thereof to the incorporators. If requested by such incorporators, the superintendent shall also issue to them a certificate of incorporation executed by him in the name of the people of the state. Such incorporators shall thereupon become a body corporate and shall then have the powers enumerated in paragraph seven hereof, but such corporation shall not be authorized to do the business of insurance

until it shall have obtained a license therefor.

(7) (A) Such a corporation shall have power to receive such monies as are necessary to comply with the requirements of this article relative to the initial surplus fund of such corporation and to borrow monies in accordance with section one thousand three hundred seven of this chapter.

(B) Any such corporation shall have power to open books to receive applications for insurance in such corporation from persons desiring and eligible to become members thereof, and to keep them open until the minimum number and amount of such applications, together with the premium payments or advance payments thereon as required by section six thousand six hundred four or six thousand six hundred five of this article, whichever is applicable, have been received; to invest the monies so received in the manner prescribed in section one thousand four hundred two of this chapter; and to expend money or incur liabilities necessary or proper as organization expenses, such expenses not to exceed the maximum amount prescribed in the permit hereinafter mentioned.

(C) No such corporation shall solicit applications for insurance or receive premium payments thereon or advance payments, as the case may be, until it has received a permit therefor from the superintendent.

(D) Such permit shall be issued after:

(i) the superintendent is satisfied, by such evidence as he may require or by such examination as he may deem expedient, that the corporation holds in trust for prospective policyholders and creditors a fund, in cash or securities eligible for investment under section one thousand four hundred two of this chapter, at least equal to the amount required of such a corporation as its cash organization or initial surplus fund, such trust to terminate if and when a license to do an insurance business of the kind or kinds provided in its corporate charter has been obtained; and

(ii) the corporation shall have submitted to the superintendent an estimate of the total amount to be expended for organization expenses, and the superintendent shall have approved the same. Such estimate shall be recited in the permit, which shall also fix the maximum amount, to be prescribed by the superintendent, which may be expended for organization expenses.

(E) The directors and incorporators of any co-operative property/casualty insurance company shall be jointly and severally liable for all debts or liabilities of such corporation until it shall have been licensed to do an insurance business of the kind or kinds proposed.

(8) (A) Before licensing any such corporation to do any insurance business, the superintendent shall require proof, by statements of at least three incorporators subscribed and affirmed by such incorporators as true under the penalties of perjury and by such investigation or examination of the affairs of such corporation as he may deem it expedient to make pursuant to article three of this chapter, that:

(i) the corporation has fully complied with this chapter applicable to such corporations;

(ii) that it has the required cash organization or initial surplus fund in cash or in investments as prescribed in this chapter;

(iii) that it has the required number and amount of bona fide applications for insurance;

(iv) that the membership list is genuine; and

(v) that every member has paid in cash the required amount of premium or advance payment, as the case may be, on the insurance applied for and will take the contracts as agreed within sixty days after a license has been issued to such corporation.

(B) If the superintendent finds the proof of the facts itemized in subparagraph (A) hereof to be sufficient, he shall file the same in his office and notify the corporation thereof.

(C) Upon payment of the appropriate fees by such corporation, the superintendent shall cause a copy of its declaration and charter, certified by him, to be filed and recorded in the office of the clerk of the county in which such corporation has its principal office.

(D) The superintendent may refuse a license to any such corporation if he finds, after notice and hearing, that any of the proposed incorporators or directors of such corporation has been convicted of any crime involving fraud, dishonesty, or like moral turpitude, or is otherwise an untrustworthy person.

(9) Upon compliance with the foregoing and any other lawful prerequisites for the issuance of an insurer's license, the superintendent may, in accordance with the provisions of section one

thousand one hundred two of this chapter, grant a license to such corporation to do the kind or kinds of insurance business specified in its charter.

(b) No person shall participate as an incorporator in the organization of more than one assessment corporation within a period of five years from the date of incorporation of the assessment corporation of which he was an incorporator.

§ 6604. Organization of advance premium corporations. (a) An advance premium corporation may be organized and licensed in the manner prescribed in section six thousand six hundred three of this article and may do, in addition to the kind of insurance specified in paragraph four of subsection (a) of section one thousand one hundred thirteen of this chapter, any one or more of the kinds of insurance specified in paragraphs five, six, twelve, nineteen and twenty (inland marine only), of such subsection, and in conjunction with insurance under the same policy, the kinds of insurance specified in paragraphs seven, eight, nine, thirteen, fourteen and fifteen (excluding workers' compensation insurance) of such subsection, provided the whole risk for all the perils as specified in such paragraphs is reinsured in an insurer authorized to do business in this state or in an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter, insofar as specified in its charter, on compliance with the following prerequisites:

(1) It shall have, in order to be licensed to do business in this state as specified in its charter, not less than four hundred bona fide applications for insurance of such kind or kinds, on real property located in this state, and from not less than four hundred separate applicants who have paid premiums of not less than ten thousand dollars on insurance aggregating not less than one million dollars, and each member of such corporation shall be subject to a contingent liability in an amount at least equal to that provided in section six thousand six hundred fourteen of this article.

(2) It shall have a cash organization or initial surplus fund of not less than three hundred thousand dollars, which may be used in the manner provided for in paragraph nine of subsection (a) of section one

thousand two hundred one of this chapter, and shall maintain at all times, a surplus of at least two hundred thousand dollars.

(3) A licensed advance premium corporation may apply for an amended license to do any one or more of the kinds of insurance specified in subsection (a) of section one thousand one hundred thirteen of this chapter, except those specified in paragraphs one, two, eighteen and twenty-three thereof, provided it has a surplus to policyholders equal in the aggregate to the surplus required on organization by section four thousand one hundred seven of this chapter for all of the kinds of insurance for which it is to be licensed, and shall thereafter maintain a surplus to policyholders equal to the amount specified in such section, and if licensed to do any of the kinds of insurance set forth in subsection (a) of section four thousand one hundred nine of this chapter such company shall be subject to the provisions of such section and to the provisions of subsection (a) of section four thousand one hundred four of this chapter.

(b) (1) An advance premium corporation may also be organized and licensed in the manner prescribed in section six thousand six hundred three of this article to do in this state, as an assuming insurer, solely reinsurance business of a kind or kinds specified in its license, on compliance with all of the provisions of this chapter applicable to an advance premium corporation organized and licensed pursuant to the provisions of subsection (a) hereof, except as provided in paragraph two hereof.

(2) It shall have not less than ten bona fide applications for reinsurance of such kind or kinds on real property located within this state, and from not less than ten separate applying insurers authorized to do business in this state, providing for the payment of gross annual reinsurance premiums of not less than twenty-five thousand dollars and providing that such ceding insurer shall, as a member of such assuming insurer, be subject to a contingent mutual liability in an amount at least equal to that provided for in section six thousand six hundred fourteen of this article.

(3) Such a corporation shall, pursuant to such license, do only the business of reinsurance as herein provided, but may upon meeting the requirements of paragraph one of subsection (a) of this section and upon evidence satisfactory to the superintendent that it is complying with

paragraph two of subsection (a) of this section, relative to minimum surplus, be licensed, pursuant to section one thousand one hundred two of this chapter, to do the kind or kinds of insurance business as above designated, both as a direct writer and as a reinsurer.

(c) The financial and deposit requirements set forth in subsection (a) of this section shall be reduced by fifty percent for a cooperative property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two.

§ 6605. Organization of assessment corporations. (a) An assessment corporation may be organized and licensed in the manner prescribed in section six thousand six hundred three of this article and may do, in addition to the kind of insurance specified in paragraph four of subsection (a) of section one thousand one hundred thirteen of this chapter, any one or more of the kinds of insurance specified in paragraphs five, six, seven and eight of such subsection solely in conjunction with fire insurance written under the same policy and covering the same premises and insurance against loss or damage to property caused by aircraft or vehicles in compliance with the following prerequisites:

(1) It shall have not less than two hundred bona fide applications for insurance of such kind or kinds on real property located within the territory in which it desires to be licensed as above provided, and from not less than two hundred separate applicants who shall have paid advance payments of estimated annual assessments of at least two thousand dollars for insurance aggregating not less than two hundred thousand dollars in each county of such territory and each member shall be subject to assessments, in addition to required advance payments, sufficient to meet incurred losses, expenses and other legal obligations for such insurer.

(2) It shall have a cash organization fund of not less than one hundred fifty thousand dollars, which may be used in the manner provided for in paragraph nine of subsection (a) of section one thousand two hundred one of this chapter, and shall maintain at all times, a surplus of at least one hundred thousand dollars. For an assessment corporation licensed to do the kinds of insurance specified in paragraph nine of

subsection (a) of section one thousand one hundred thirteen of this chapter, except as herein provided, the corporation must maintain an additional surplus of fifty thousand dollars. The additional surplus is not necessary if the whole risk for this peril is reinsured in an insurance company authorized to do business in this state, or in an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter.

(3) Any assessment corporation licensed on the effective date of this article which does not possess surplus of one hundred thousand dollars shall be restricted to the kinds of insurance for which it was licensed immediately prior to the effective date of this article until such time as the required minimum surplus specified in paragraph two above is accumulated. In no event shall the surplus of such corporation fall below fifty thousand dollars.

(b) (1) Any licensed assessment corporation may amend its charter and be licensed to do the kinds of insurance specified in paragraphs nine, thirteen, fourteen and fifteen (except workers' compensation insurance) of subsection (a) of section one thousand one hundred thirteen of this chapter solely in conjunction with fire insurance written under the same policy and covering the same premises, except as provided in paragraph two of this subsection, and may be licensed to do the kinds of insurance specified in paragraphs twelve, nineteen (excluding aircraft physical damage insurance) and twenty (inland marine only) of such subsection.

(2) An assessment corporation licensed to write the kinds of insurance specified in paragraphs thirteen and fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter is authorized to write personal or commercial umbrella liability insurance.

(c) An assessment corporation may also be organized and licensed in the manner prescribed in section six thousand six hundred three of this article to do within all the counties of the state (except the counties of New York, Kings, Queens, Bronx and Richmond) as an assuming insurer, reinsurance business of a kind or kinds referred to in this section, and, as specified in its charter, on compliance with the following prerequisites:

(1) It shall have not less than ten bona fide applications for reinsurance of such kind or kinds on real property located within such counties, and from not less than ten separate applying assessment

corporations of this state providing for the payment of advance payments in the form of estimated annual assessments of not less than ten thousand dollars, and providing that each such ceding insurer shall, as a member of such assuming insurer, be subject to additional assessments sufficient to meet incurred losses, expenses and other legal obligations for such insurer.

(2) It shall comply with the financial requirements set forth in paragraph two of subsection (a) of this section.

(3) Such a corporation shall, pursuant to such license, do only the business of reinsurance, and may not at any time qualify as a direct writing assessment corporation.

(d) An assessment corporation licensed to write the kinds of insurance specified in paragraphs thirteen and fourteen of subsection (a) of section one thousand one hundred thirteen of this chapter authorized to write personal or commercial umbrella liability insurance shall maintain an additional surplus of six hundred thousand dollars if the corporation writes personal or commercial umbrella liability insurance.

(e) Nothing in this section shall prohibit a licensed assessment corporation from writing coverage pursuant to subsection (a) or (b) of this section for any leaseholder of the premises.

§ 6606. Reinsurance. (a) (1) Subject to the provisions of section six thousand six hundred ten of this article, any co-operative property/casualty insurance company shall have the power, whether or not expressed in its charter, to accept reinsurance of the kind or kinds of insurance it is licensed to do directly, and to cede reinsurance subject to applicable provisions of section one thousand three hundred eight of this chapter.

(2) Unless otherwise permitted by the superintendent, an assessment corporation may assume reinsurance only from other authorized assessment corporations but may cede reinsurance to any other licensed insurer if such insurer is authorized to reinsure such kind or kinds of insurance in this state or to an accredited reinsurer, as defined in subsection (a) of section one hundred seven of this chapter.

(3) Any co-operative property/casualty insurance company may assume reinsurance on property located wholly or partially without the

territory in which it is licensed to do a direct writing business provided, however, that an assessment corporation may only assume reinsurance on property located in the state of New York with the exception of the counties of New York, Kings, Queens, Bronx and Richmond.

(b) Every assessment corporation doing business as a direct writer, which assumes reinsurance, may, in levying assessments on its members, assess ceding insurer members as a separate group on the basis of actual or estimated experience in that classification.

§ 6607. Duration of charter. Subject to the provisions of article seventy-four of this chapter, the charter of every co-operative property/casualty insurance company shall be perpetual.

§ 6608. Extension of territory. (a) The superintendent, upon application by any advance premium corporation may issue a license pursuant to section one thousand one hundred two of this chapter to such corporation to do the business in counties additional to those in which it is then authorized or in the entire state if such corporation is in possession of a surplus to policyholders of one hundred thousand dollars or more, and is maintaining full unearned premium reserves in accordance with section one thousand three hundred five of this chapter.

(b) The superintendent, upon application by any assessment corporation, may issue a license pursuant to section one thousand one hundred two of this chapter to such corporation to do business in adjoining counties additional to those in which it is then authorized or in the entire state with the exception of the counties of New York, Kings, Queens, Bronx and Richmond, if such corporation is in possession of a surplus to policyholders of one hundred thousand dollars or more, and is maintaining full unearned premium reserves in accordance with section one thousand three hundred five of this chapter.

(c) Every license issued by the superintendent pursuant to this section shall include the county in which the corporation to which it is issued maintains its principal office.

(d) Applications made to the superintendent pursuant to this section

shall be in such form as he may by regulation require.

§ 6609. Policy forms. (a) (1) Every form of policy issued by any co-operative property/casualty insurance company shall indicate in words prominently displayed at the top of the first page, and in type of which the face shall not be smaller than twelve point, that such policy is issued on the co-operative plan.

(2) Each form of policy issued by such a corporation shall also include on the page following that concluding the policy proper and under appropriate caption all provisions of the corporation's by-laws, whether required or permitted, relative to meetings of members, election of directors, rights and obligations of members, extraordinary assessments, and contingent liability.

(b) No policy form shall be delivered or issued for delivery by an assessment corporation unless it has been filed by said assessment corporation with the superintendent and he has approved it.

(c) The standard fire insurance policy, insofar as required for use by domestic mutual property/casualty insurance companies by section three thousand four hundred four of this chapter, shall also be required for use by all co-operative property/casualty insurance companies, with such modifications therein as shall be permitted by regulation of the superintendent.

(d) Two or more advance premium corporations or two or more assessment corporations may issue a combination policy, as provided for in section three thousand four hundred four of this chapter, with such modifications permitted by regulation of the superintendent, upon property located in territory wherein all the participating corporations named in such policy are licensed to do business.

§ 6610. Limitation of risk. (a) Subject to the other provisions of this section, the maximum amount of insurance less reinsurance in other authorized insurers or in accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter which may be assumed by a co-operative property/casualty insurance company on a single risk for every kind of insurance it is authorized to write shall not exceed, in

accordance with section one thousand one hundred fifteen of this chapter, ten percent of its surplus to policyholders as shown in its last sworn statement filed with the superintendent.

(b) The maximum amount of insurance less reinsurance in other authorized insurers or in accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter which may be assumed by an advance premium corporation on property not protected by automatic sprinklers, situated within the boundaries of one city block or on one group of buildings composed of attached or adjacent buildings which have less than sixty feet of clear space at all points between such buildings and other buildings, shall not exceed ten percent of its surplus to policyholders as shown in its last sworn statement filed with the superintendent.

(c) The maximum amount of insurance less reinsurance in other authorized insurers or in accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter which may be assumed by an assessment corporation on a single risk for the kinds of insurance listed below shall not exceed three percent of its surplus as shown in its last sworn statement filed with the superintendent or fourteen thousand dollars, whichever is greater.

Kinds of insurance specified in the following numbered paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter:

(4) fire insurance;

(5) miscellaneous property insurance (excluding insurance against windstorm, tornado, cyclone, flood, earthquake or volcanic eruption);

(6) water damage insurance;

(7) burglary and theft insurance;

(8) glass insurance;

(9) boiler and machinery insurance;

(12) collision insurance;

(20) marine and inland marine insurance (inland marine insurance only; except insurance within paragraph twenty against windstorm, tornado, cyclone, flood, earthquake or volcanic eruption).

The term "risk" means property which is situate less than sixty feet

from other property except property consisting of or located in a building of fire resistive construction or fully protected by automatic sprinklers.

(d) The maximum amount of insurance (including the obligation to pay outside loss adjustment expense) less reinsurance in other authorized insurers or accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter which may be assumed by an assessment corporation on a single risk for the kinds of insurance listed below shall not exceed two percent of its surplus as shown in its last sworn statement filed with the superintendent.

Kinds of insurance specified in the following numbered paragraphs of subsection (a) of section one thousand one hundred thirteen of this chapter:

(13) personal injury liability insurance;

(14) property damage liability insurance;

(15) workers' compensation and employers' liability insurance (excluding workers' compensation insurance, but not excluding workers' compensation insurance required by subsection (j) of section three thousand four hundred twenty of this chapter);

(19) motor vehicle and aircraft physical damage insurance (excluding aircraft physical damage insurance).

(e) The maximum amount of insurance less reinsurance in other authorized insurers or in accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter which may be assumed by an assessment corporation on a single risk for insurance against windstorm, tornado, cyclone, flood, earthquake or volcanic eruption shall not exceed two percent of its surplus as shown in its last sworn statement filed with the superintendent, provided however, that the aggregate amount incurred, after deducting such reinsurance, with respect to losses due to a single occurrence of such insured peril which exceeds ten percent of the company's surplus as shown in its last sworn statement filed with the superintendent shall be reinsured in other authorized insurers or in accredited reinsurers as defined in subsection (a) of section one hundred seven of this chapter. The term "single occurrence" means all losses occasioned by the perils of windstorm, tornado, cyclone, flood, earthquake or volcanic eruption arising from

the same continuous atmospheric disturbance or other physical disturbance occurring within a seventy-two hour period.

§ 6611. Records. (a) (1) Every co-operative property/casualty insurance company shall keep and maintain books of account and records in such manner as will show fully and truly the condition, affairs and business of such corporation and facilitate the preparation and verification of its annual statements.

(2) Such records shall be available for inspection by any policyholder of the corporation during ordinary business hours.

(3) The secretary shall maintain a minute book recording the proceedings of all meetings of the corporation, its board of directors and the principal committees thereof.

(4) (A) The books of account shall include a cash book and general ledger together with the necessary supplemental and subsidiary records including a loss register showing all losses of which the corporation has had notice and the disposition or settlement thereof and a record of its investments.

(B) All cash and checks collected including policy and survey fees shall be reported as income.

(C) All checks issued shall be signed either by two officers or by one officer upon the written order of another officer, except as otherwise provided by resolution of the corporation's board of directors or in its by-laws for handling of miscellaneous expenses.

(D) Checkbook stubs, bank statements and cancelled checks shall be kept on file for at least seven years.

(b) The records of a co-operative property/casualty insurance company shall also include a policy register in such form as will show all policies issued in consecutive numerical order in one or more series, and a register of gross premiums or assessments in force and reinsurance premiums in force summarized by terms and expirations and supported by monthly or quarterly tabulations of the premiums written and cancelled during such periods.

(c) The records of an assessment corporation shall also include an assessment register which may be combined with the policy register, showing the rates and amount charged and dates of collections, and a

loan or note record showing all such transactions.

§ 6612. Rebating and discrimination; accounts and statistics; assessment corporations. Notwithstanding anything to the contrary in this chapter, the provisions of sections two thousand three hundred twenty-four and two thousand three hundred twenty-five of this chapter are applicable to assessment corporations.

§ 6613. Limitation of expenses; co-operative property/casualty insurance companies. (a) The expenses of management of any co-operative property/casualty insurance company shall not exceed in any one calendar year forty-two and one-half percent of its net premiums written for such year. The term "net premiums written" means direct premiums written plus reinsurance assumed less return premiums and reinsurance ceded. In the event expenses incurred in making a new system upgrade result in this subsection's management expenses limit being exceeded, then the insurer shall inform the superintendent sixty days in advance of the expense limit being exceeded. Subject to approval by the superintendent, the limit shall be temporarily raised to the amount necessary to encompass the aforestated new system upgrade, provided that in no event shall the limit be raised more than five percentage points and shall not be in effect for more than three years, and provided further that an insurer may submit to the superintendent, for the superintendent's prior approval, a written request to temporarily raise the limit for up to an additional three years, for a total of no more than six years. An insurer shall submit such written request to the superintendent at least sixty days but not more than one hundred twenty days before the expiration of the initial period during which the limit was raised. The insurer shall not increase premiums solely as a result of the management expenses cap limit being exceeded. For purposes of this subsection, a new system upgrade is defined as the acquisition of electronic data processing apparatus and related equipment constituting a data processing, record keeping or accounting system and operating and non-operating software.

(b) Management expenses shall include all the expenses of such

company, except expenses incurred in the investigation, adjustment and settlement of claims, taxes, fees, expenses of examination, and taxes, repairs, and expenses on real estate.

(c) This section shall not apply to any assessment corporation which is limited to the business permitted under subsection (a) of section six thousand six hundred five of this article. Furthermore, the superintendent may grant an annual exemption from compliance with the provisions of subsection (a) of this section to any co-operative property/casualty insurance company which, in the next preceding calendar year, had net premiums written of less than three million dollars. A written application for such an exemption must be submitted by the first day of June in the year for which the exemption is requested and shall contain such information as is deemed necessary by the superintendent.

§ 6614. Contingent liability of members; advance premium corporations. (a) Any advance premium corporation may limit the contingent liability of a member thereof to not less than once the amount of, and in addition to, the premium which would be charged for insurance for one year or the advance premium stated in the policy, whichever is the lesser.

(b) The contingent liability of a member of an advance premium corporation shall be subject to enforcement and collection by the corporation for the purpose of removing any impairment in the reserves required by this article. Such contingent liability shall apply only to such impairments which occur during the member's tenure as a policyholder.

(c) No assessment premised upon the contingent liability of members shall be made by any such corporation until after approval by the superintendent and shall, subject in all cases to the limitation contained in the contracts thereby affected, as to the maximum amount of such contingent liability, be in each case an amount equal to the member's proportionate share of such impairment.

§ 6615. Annual assessments; borrowed money. (a) (1) Every assessment corporation may, if so directed by its board of directors levy an

assessment upon all of its members. Such assessment shall be sufficient to provide for the payment of losses, expenses, and other obligations, incurred, or likely to be incurred during the fiscal year for which the assessment is levied.

(2) If issuing policies on but one class of property, such assessment shall be in proportion to the several amounts of insurance held by each member.

(3) If issuing policies on more than one class of property, rates of assessment shall be in proportion to the several amounts of insurance held by each member and on the basis of classifications adopted by its board of directors to express the relative hazards of the properties insured.

(b) (1) Every such corporation may borrow money, except by means of a mortgage, to pay incurred losses and expenses; but in the calculation of its next assessment following the time, or times, at which such a loan or loans were effected, due provision shall be made for the liquidation of such loan or loans.

(2) An assessment corporation may borrow money for a period of more than one year with the written approval of the superintendent and under such conditions as he may prescribe.

(c) (1) Every such corporation may levy annual assessments in advance sufficient to discharge its estimated losses, expenses, and other valid obligations for which it may reasonably be expected to become liable during the period prior to the end of its fiscal year.

(2) At any time after the institution of such assessments, new members may be admitted to any such corporation upon paying such fees and other sums as may be provided for by the corporation's by-laws and upon paying their proportionate shares of the last preceding assessment.

(d) On and after the effective date of any change from the post assessment basis to the advance assessment basis as permitted herein, every assessment corporation may collect advance assessments, as herein provided, from each person applying for or renewing a policy or policies and only those persons who were admitted as new members during the period prior to such effective date and subsequent to the levying of the final post assessment shall be assessed on a pro rata basis for the losses, expenses, and other valid obligations incurred during such period.

§ 6616. Extraordinary assessments; assessment corporations. (a) The members of every assessment corporation shall be contingently liable for extraordinary assessments sufficient to remove any impairment in the reserves required by this article.

(b) Any assessment corporation if issuing policies on but one class of property, may levy an extraordinary assessment upon all its members in proportion to the several amounts of insurance held by each.

(c) Any assessment corporation if issuing policies on more than one class of property, may levy an extraordinary assessment at rates of assessment determined in proportion to the amounts of insurance held by each on the basis of classifications adopted by its board of directors to express the relative hazards of the properties insured.

(d) Any assessment corporation if collecting assessments in advance on the initial and anniversary dates of policies may levy an extraordinary assessment determined by applying to the assessment earned on the members' policy or policies in force during the fiscal year next preceding the levy of additional assessment, the ratio of the total additional assessment to the total assessment earned during said period on all policies.

(e) No extraordinary assessment shall be made by any such assessment corporation until after approval by the superintendent and if made shall be in each case, an amount equal to the members' proportionate share of such impairment as specified herein.

(f) Any assessment corporation which levies annual assessments in advance may if its by-laws provide, limit the contingent liability of a member thereof to not less than once the amount of and in addition to the annual assessment which would be charged for insurance for one year.

§ 6617. Notice of assessment; assessment corporations. (a) It shall be the duty of the secretary of every assessment corporation, whenever an assessment shall have been made by it, to notify, not more than forty-five days thereafter, every person to which such assessment is applicable.

(b) Such notice may be given personally, by an agent, or by a written

or printed notice mailed, postage prepaid, to such person's last known post office address, and shall state the purpose of the assessment, the sum due from such person, and the time when and to whom payment thereof is to be made; but such time shall not be more than ninety days from the date of such notice.

§ 6618. Suits to recover assessments. (a) An assessment corporation may maintain a civil action against any member or former member of such corporation for the unpaid amount of any extraordinary or post assessment lawfully levied against him, or against any former member of such corporation for the earned portion of any advance assessment which he has failed to pay.

(b) In any such action the corporation may recover, in addition to such sum or sums, legal interest thereon and the amount of any penalty imposed by such corporation's by-laws for failure to pay such assessments; but no such corporation shall provide in its by-laws for such a penalty in excess of fifty percent of such an assessment.

§ 6619. Special reserve or emergency funds; co-operative property/casualty insurance companies. (a) (1) Ten or more co-operative property/casualty insurance companies may enter into an agreement to make deposits in special reserve or emergency funds.

(2) Any deposit with accretions thereon made pursuant to any such agreements shall be kept deposited with a solvent trust company of this state and shall remain the property of the depositing corporations and shall be subject to the provisions of this chapter governing the investments of such corporations.

(b) (1) Such special reserve or emergency funds shall be subject to examination by the superintendent in like manner as the other assets and property of any depositing corporation and shall be used only for the purpose of enabling any depositing corporation to comply with any requirement of this article, and then only with the consent of at least two-thirds of the membership of such fund in proportion to its ownership.

(2) Loans thus authorized from such a fund may be made pursuant to

agreements as prescribed in section one thousand three hundred seven of this chapter or in such other form as approved by the membership.

(c) Any such depositing corporation may, with the consent of the superintendent, withdraw all or a part of its share therein, upon giving at least thirty days notice in writing to the custodian or custodians of such fund.

§ 6620. Non-assessable policies; advance premium corporations. (a) Any advance premium corporation may issue insurance contracts which do not impose any liability upon members for any assessments in addition to the advance premium paid upon compliance with the following requirements:

(1) If authorized to issue non-assessable policies prior to the first day of January, nineteen hundred eighty-seven, such a corporation may issue such contracts if:

(A) It shall have and at all times maintain a surplus to policyholders of at least one hundred thousand dollars.

(B) It shall maintain a deposit of an amount equal to its unearned premium reserves but not less than one hundred thousand dollars nor more than two hundred fifty thousand dollars, subject to the provisions of article thirteen of this chapter.

(2) If authorized to issue non-assessable policies subsequent to the first day of January, nineteen hundred eighty-seven, such a corporation may issue such contracts if:

(A) It shall maintain a surplus as determined from its latest filed statement, which together with its unearned premium reserve from its latest filed statement is at least equal to the surplus to policyholders required to be maintained by a domestic stock property/casualty insurance company licensed to write the same kind or kinds of insurance.

(B) It shall maintain a deposit of five hundred thousand dollars subject to the provisions of article thirteen of this chapter.

(C) It shall have submitted a copy of its proposed non-assessable policy or policies for approval of the superintendent, and shall have obtained his approval.

(b) Every policy issued by any such corporation shall clearly state whether or not the holder of the policy is subject to a liability for assessment.

(c) Any surplus or deposit required for the purposes specified in this section shall be inclusive of any surplus required by any other sections of this chapter.

§ 6621. Unabsorbed portions of premium payments. (a) Subject to the requirements of this article for the accumulation and maintenance of minimum surplus, the surplus of any advance premium corporation shall be eligible for equitable distribution to its members as unabsorbed portions of premium payments; but no unabsorbed portion of premium payments shall be returned or distributed until authorized by the corporation's board of directors nor until approved by the superintendent.

(b) In authorizing any such return of unabsorbed portion of premium payments, the board of directors of such a corporation may provide for an apportionment thereof among separate groups of members on the basis of earned premiums equitably classified according to major kinds of insurance.

(c) This section shall not prohibit the return of the unabsorbed portion of premium payments on an equitable basis to policyholders in other states or under reinsurance contracts.

§ 6622. Refunds from surplus; assessment corporations. (a) Subject to the requirements of this article for the accumulation and maintenance of minimum surplus, the surplus of any assessment corporation shall be eligible for equitable distribution to its members, but no distribution shall be made until authorized by the corporation's board of directors nor until approved by the superintendent.

(b) In authorizing any such distribution the board of directors of an assessment corporation may provide for apportionment thereof among separate groups of members on the basis of underwriting experience equitably classified according to major kinds of insurance.

§ 6623. Investments. (a) The funds of every co-operative property/casualty insurance company shall be invested only as permitted

by subsection (c) of section one thousand four hundred three of this chapter, except as otherwise provided herein.

(b) The minimum capital investments of a domestic insurer as set forth in section one thousand four hundred two of this chapter shall be applicable to an:

(1) Assessment corporation in an amount equal to the lesser of such corporation's total liabilities or two hundred fifty thousand dollars.

(2) Advance premium corporation in an amount equal to the greater of the minimum capital required by law or the minimum surplus to policyholders required to be maintained by law for a domestic stock property/casualty insurance company authorized to transact the same kinds of insurance. The foregoing requirement shall be reduced by fifty percent for a co-operative property/casualty insurance company initially licensed to do business in this state prior to July first, nineteen hundred eighty-two. Any advance premium corporation not meeting its applicable minimum capital investment requirement on January first, nineteen hundred eighty-seven shall be required to meet such requirement before investing its funds, after such date, in any other permissible investment.

(c) Notwithstanding the limitation of investments in certificates of deposit set forth in subsection (a) of section one thousand four hundred nine of this chapter, an assessment corporation may invest in certificates of deposit of any one institution in an amount not to exceed the amount guaranteed by the Federal Deposit Insurance Corporation.

§ 6624. Voting by members and meetings of boards of directors; co-operative property/casualty insurance companies. (a) A member of any co-operative property/casualty insurance company may vote at any regular or special meeting of the corporation in person or he may vote by proxy, if the by-laws of the corporation so provide.

(b) (1) The board of directors of every co-operative property/casualty insurance company shall hold regular meetings at least four times in each calendar year.

(2) Compliance with paragraph one hereof, except as to the annual meeting, may be made by an executive committee of at least four members,

duly authorized to act on behalf of the board of directors.

§ 6625. Merger; consolidation. (a) Two or more advance premium corporations may, in accordance with applicable provisions of article seventy-one of this chapter, merge or consolidate.

(b) Two or more assessment corporations licensed to do business either wholly or substantially in a common territory may, in accordance with applicable provisions of article seventy-one of this chapter, merge or consolidate.

(c) (1) If, after investigation and examination, the superintendent finds that the proceedings for merger or consolidation, as the case may be, have been regularly taken in conformity with law and that the continuing or resulting corporation meets the requirements of this chapter, he may issue a license to such corporation to do business under this chapter.

(2) Every such continuing or new corporation shall assume and succeed to all the obligations and liabilities of the merging corporations and shall be liable to pay and discharge all such debts and liabilities in the same manner as if they had been incurred or contracted by it.

§ 6626. Qualification of membership. (a) In addition to the legal ability of any natural person to insure in any advance premium or assessment corporation property located in the territory in which such corporation is licensed to do business and in which property he has an insurable interest, it shall also be lawful for any corporation, board, estate, or association to insure in any co-operative property/casualty insurance company property located in the territory in which such corporation is licensed to do business, and in which property it has an insurable interest.

(b) Any officer, trustee, board member, or legal representative of such corporation, board, estate, or association may be recognized for or on its behalf for the purpose of membership, but shall not be personnally liable upon such contract or contracts of insurance by reason of acting in such representative capacity.

ARTICLE 67

NONPROFIT PROPERTY/CASUALTY INSURANCE COMPANIES

Section 6701. Purpose; construction.
6702. Definitions.
6703. Organization of nonprofit property/casualty insurance companies.
6704. Licensing of nonprofit property/casualty insurance companies.
6705. Relevant criteria.
6706. Applicability of other provisions of this chapter.
6707. Tax exemption; residual market participation exemption; security funds.
6708. Rules and regulations.

§ 6701. Purpose; construction. (a) The purpose of this article is to provide for the organization and licensing of a nonprofit property/casualty insurance company that insures nonprofit organizations and that will qualify, and continue to qualify, as a "qualified charitable risk pool" as defined in subsection (n) of section 501 of the Internal Revenue Code.

(b) This article shall be liberally construed to effect the purpose under subsection (a) of this section which shall constitute an aid and guide to interpretation.

§ 6702. Definitions. As used in this article, the following terms shall have the following meanings:

(a) "Member" shall, in the case of a nonprofit property/casualty insurance company organized as a type B corporation pursuant to paragraph (b) of section two hundred one of the not-for-profit corporation law, have the meaning set forth in paragraph (a) of section one hundred two of the not-for-profit corporation law or, in the case of a nonprofit property/casualty insurance company organized as nonprofit reciprocal insurer under article sixty-one of this chapter, have the meaning set forth in subsection (g) of section six thousand one hundred

one of this chapter.

(b) "Nonmember charitable organization" shall have the meaning set forth in subsection (n) of section 501 of the Internal Revenue Code.

(c) "Nonprofit organizations" means organizations described in paragraph (3) of subsection (c), and exempt from taxation under subsection (a), of section 501 of the Internal Revenue Code, including, if qualified thereunder, type B or D organizations formed pursuant to paragraph (b) of section two hundred one of the not-for-profit corporation law, and organizations described in section two hundred sixteen-a of the education law.

(d) "Startup capital" shall have the meaning set forth in subsection (n) of section 501 of the Internal Revenue Code.

§ 6703. Organization of nonprofit property/casualty insurance companies. (a) A corporation may be organized as a charitable corporation pursuant to paragraph (a) of section two hundred one of the not-for-profit corporation law or as a nonprofit reciprocal insurer under article sixty-one of this chapter to write the kinds of insurance specified in subsection (a) of section one thousand one hundred thirteen of this chapter other than (1) those types of insurance specified in paragraphs one, two, eighteen, twenty-two, twenty-three and twenty-five of such subsection, (2) insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability arising out of death or injury of any person, due to medical or hospital malpractice by any licensed physician or hospital, and (3) insurance subject to section three thousand four hundred twenty-five of this chapter.

(b) A corporation organized pursuant to subsection (a) of this section shall (1) be organized and operated exclusively for a purpose or purposes for which a corporation may be formed under the not-for-profit corporation law and this chapter, not for pecuniary profit or financial gain, and no part of its assets, income or profit is distributable to or enures to the benefit of its members, directors or officers except to the extent permitted under the not-for-profit corporation law and this chapter, in a manner acceptable to the superintendent, and (2) insure no organizations or corporations other than nonprofit organizations.

(c) Notwithstanding any provision of the not-for-profit corporation law, no nonprofit property/casualty insurance company licensed pursuant to this article shall be converted into a corporation or other entity organized for pecuniary profit or into a for-profit organization of any kind.

§ 6704. Licensing of nonprofit property/casualty insurance companies. (a) No person, firm, corporation or association as an underwriter or underwriters, and no nonprofit property/casualty insurance company, shall do any insurance business in this state, unless authorized to do so pursuant to the provisions of this article.

(b) The superintendent may pursuant to this article issue a license to a nonprofit property/casualty insurance company that is organized as a charitable corporation as defined in paragraph (a) of section one hundred two (Definitions) of the not-for-profit corporation law if such company:

(1) complies with (A) the applicable requirements of section one thousand one hundred two of this chapter, and (B) the provisions of article forty-one of this chapter applicable to stock property/casualty insurance companies (other than sections four thousand one hundred three, four thousand one hundred five and four thousand one hundred nineteen) and, in each case, the rules and regulations of the superintendent promulgated pursuant thereto except insofar as such provisions of law, rules and regulations may be inconsistent with the provisions of this article, and

(2) has an initial surplus to policyholders at least equal to the amount of applicable paid-in capital and additional amount of paid-in surplus required by paragraph one of subsection (a) of section four thousand one hundred three of this chapter for a newly organized domestic stock property/casualty insurance company doing the same kind or kinds of insurance business.

Thereafter, every such nonprofit property/casualty insurance company shall maintain a surplus to policyholders at least equal to the amount of applicable paid-in capital required to be maintained by paragraph one of subsection (a) of section four thousand one hundred three of this

chapter for a domestic stock property/casualty insurance company doing the same kind or kinds of insurance business.

(c) The superintendent may issue a license to a nonprofit property/casualty insurance company pursuant to this article that is a nonprofit reciprocal insurer organized pursuant to article sixty-one of this chapter if such company complies with the requirements of section one thousand one hundred two of this chapter and article sixty-one of this chapter and, in each case, the rules and regulations of the superintendent promulgated pursuant thereto except insofar as such provisions of law, rules and regulations may be inconsistent with the provisions of this article and except that the provisions of subsection (a) of section six thousand one hundred four of this chapter shall not apply with respect to nonprofit organizations that are or seek to become subscribers of such a nonprofit property/casualty insurance company, provided that such a nonprofit property/casualty insurance company either (1) has an initial surplus to policyholders and thereafter maintains a surplus to policyholders in an amount acceptable to the superintendent which amount shall be substantially greater than the initial surplus to policyholders and surplus to policyholders to be maintained by a reciprocal insurer under article sixty-one of this chapter, or (2) submits a reinsurance or other financial plan, which adequately addresses the provisions of subsection (a) of section six thousand one hundred four of this chapter and which reinsurance or other financial plan is acceptable to the superintendent.

(d) Every license to engage in an insurance business issued by the superintendent to any nonprofit property/casualty insurance company pursuant to the provisions of this article shall specify the company's name, the location of its principal office, the name and principal address of its attorney-in-fact, if any, and the kind or kinds of insurance business specified in terms of subsection (a) of section one thousand one hundred thirteen of this chapter, which it is authorized to engage in in this state.

§ 6705. Relevant criteria. (a) In applying this article, the superintendent shall consider the provisions of paragraph (3) of subsection (c) of section 501 of the Internal Revenue Code and

subsection (n) of section 501 of the Internal Revenue Code.

(b) Notwithstanding any other provision of law, a nonprofit property/casualty insurance company shall:

(1) be operated solely to insure risks of its members.

(2) directly provide information to its members with respect to loss control and risk management.

(3) obtain at least one million dollars in startup capital from nonmember charitable organizations. Such startup capital may take the form of subventions as authorized pursuant to section five hundred four of the not-for-profit corporation law or advancements or borrowings as authorized pursuant to section one thousand three hundred seven of this chapter. Startup capital may be used to satisfy the financial requirements contained in this chapter applicable to a nonprofit property/casualty insurance company only to the extent the superintendent determines that it complies with such requirements. Subventions will qualify as advancements or borrowings authorized pursuant to section one thousand three hundred seven of this chapter only if they meet the requirements of advancements or borrowings authorized pursuant to such section.

(4) be controlled by a board of directors elected by the members of the nonprofit property/casualty insurance company.

(5) require, in its organizational documents that:

(A) each member of such nonprofit property/casualty insurance company shall at all times be an organization described in paragraph (3) of subsection (c) of section 501 of the Internal Revenue Code and exempt from tax under subsection (a) of section 501 of the Internal Revenue Code.

(B) any member which receives a final determination that it no longer qualifies as an organization described in paragraph (3) of subsection (c) of section 501 of the Internal Revenue Code shall immediately notify the nonprofit property/casualty insurance company of such determination and the effective date of such determination.

(C) each policy of insurance issued by the nonprofit property/casualty insurance company shall provide that such policy will not cover the insured with respect to events occurring after the date such final determination was issued to the insured.

(c) A nonprofit property/casualty insurance company shall:

(1) not refuse to issue, renew or cancel a policy of any insurable nonprofit organization based solely on geographic location,

(2) not refuse to write coverages afforded by such insurer for any insurable nonprofit organization in accordance with subsection (d) of this section,

(3) establish and promote a risk management program among its members to identify and reduce risks by implementation of loss control, safety programs and other methods of risk management,

(4) establish equitable risk classifications for all types of nonprofit organizations, and

(5) establish recordkeeping and reporting procedures.

(d) A nonprofit property/casualty insurance company shall, subject to regulatory standards, offer to provide coverage following application by an eligible nonprofit organization, provided that the nonprofit organization has not:

(1) violated applicable laws, regulations and rules;

(2) been involved in financial, management or operational acts, omissions or conditions that substantially and materially increase the hazards to the nonprofit insurer, its solvency, its policyholders, its creditors, or the public;

(3) engaged in fraud or material misrepresentation;

(4) refused to cooperate with reasonable risk management in accordance with risk management standards, approved by the nonprofit insurer's board of directors, for the purpose of protecting the nonprofit organization itself and all participating nonprofit organizations insured by the nonprofit insurer; or

(5) violated such other standards of insurability as the nonprofit insurer's board of directors and the superintendent may approve.

The nonprofit property/casualty insurance company, in any instance of declination of coverage, shall inform the nonprofit organization and the superintendent of the reasons for such declination.

§ 6706. Applicability of other provisions of this chapter. (a) Except as otherwise provided in this article, where inconsistent with this article, or where the context otherwise requires, all of the provisions

of this chapter and the rules and regulations of the superintendent, relating to all insurers and those relating to property/casualty insurance companies transacting the same kind or kinds of insurance shall be applicable to a nonprofit property/casualty insurance company organized as a charitable corporation as defined in paragraph (a) of section one hundred two (Definitions) of the not-for-profit corporation law and formed pursuant to paragraph (a) of section two hundred one of the not-for-profit corporation law and licensed pursuant to subsection (b) of section six thousand seven hundred four of this article. Where any of such provisions of law refer to a corporation, company or insurer, such references, when read in connection with and applicable to this article, shall mean such a nonprofit property/casualty insurance company.

(b) Except as otherwise provided in this article, where inconsistent with this article, or where the context otherwise requires, all of the provisions of this chapter and the rules and regulations of the superintendent, relating to all insurers and those relating to reciprocal insurers transacting the same kind or kinds of insurance shall be applicable to a nonprofit property/casualty insurance company organized as a reciprocal insurer pursuant to article sixty-one of this chapter and licensed pursuant to subsection (c) of section six thousand seven hundred four of this article. Where any of such provisions of law refer to a corporation, company or insurer, such references, when read in connection with and applicable to this article, shall mean such a nonprofit property/casualty insurance company.

(c) (1) Every nonprofit property/casualty insurance company shall be subject to liquidation, dissolution or rehabilitation pursuant to the provisions of article seventy-four of this chapter, and such proceeding shall be under the supervision of the superintendent, who shall have such powers granted pursuant to the provisions of such article as are applicable to domestic insurance companies.

(2) Articles ten, eleven and twelve of the not-for-profit corporation law shall not apply to nonprofit property/casualty insurance companies.

§ 6707. Tax exemption; residual market participation exemption; security funds. (a) Every nonprofit property/casualty insurance company

subject to the provisions of this article shall be exempt from any fees, taxes, special ad valorem levies or assessments of any kind, including, but not limited to, franchise taxes, sales taxes or other taxes, upon or with respect to any property owned by it or under its jurisdiction, control or supervision, or upon the uses thereof, or upon or with respect to its activities or operations in furtherance of the powers conferred upon it by this article, or upon or with respect to any revenues or other income received by the nonprofit property/casualty insurance company, except that every nonprofit property/casualty insurance company licensed pursuant to this article shall be subject to the assessment upon domestic insurers under section two hundred six of the financial services law, the assessments upon insurance carriers under sections one hundred fifty-one and two hundred twenty-eight of the workers' compensation law and all special fund assessments upon insurance carriers under the workers' compensation law.

(b) Every nonprofit property/casualty insurance company subject to the provisions of this article shall be exempt from participation in the plan pursuant to article fifty-three of this chapter, the association pursuant to article fifty-four of this chapter and the association pursuant to article fifty-five of this chapter.

(c) A nonprofit property/casualty insurance company and the contracts it issues will be subject to the provisions of article seventy-six of this chapter and article six-A of the workers' compensation law.

§ 6708. Rules and regulations. The superintendent shall promulgate such rules and regulations as may be necessary for the implementation of this article. Such regulation may be necessary in light of the nonprofit property/casualty insurance company being owned by nonprofit organizations that it insures, including the proprietary nature of the information relating to the nonprofit property/casualty insurance company's operations.

ARTICLE 68

BAIL BONDS

Section 6801. Bail bond business.

6802. Professional bondsmen; licensing.
6803. Bail bond business; cities in excess of one hundred seventy-five thousand.
6804. Premium or compensation.
6805. Charitable bail organization.

§ 6801. Bail bond business. (a) (1) Any person, firm or corporation in any court having criminal jurisdiction or in any criminal action or proceeding who shall for another deposit money or property as bail or execute as surety any bail bond who within a period of one month prior thereto shall have made such a deposit or given such bail in more than two cases not arising out of the same transaction shall be deemed to be doing a bail business and doing an insurance business as defined in article eleven of this chapter.

(2) Except for a corporation authorized to write fidelity and surety insurance and to do a bail business pursuant to the provisions of article eleven of this chapter and otherwise in compliance with all other requirements of this chapter to do such business or a charitable bail organization holding a certificate issued by the superintendent pursuant to section six thousand eight hundred five of this article and otherwise in compliance with all other requirement of this chapter, no person, firm or corporation shall engage in a bail business in this state.

(b) (1) No person, firm or corporation shall in this state do an insurance business or a bail business as defined in subsection (a) of this section unless authorized by a license issued and in force as provided under article eleven of this chapter.

(2) The superintendent may authorize a property/casualty insurance company which is authorized to write fidelity and surety insurance to do a bail business in accordance with the provisions of article eleven of this chapter, but no individual shall be licensed to do such business.

§ 6802. Professional bondsmen; licensing. (a) No person, firm or corporation or any officer or employee thereof shall act in this state as an agent or solicitor of an insurer or charitable bail organization

doing a bail business in soliciting, negotiating or effectuating any such deposit or bail bond by such insurer or charitable bail organization unless licensed by the superintendent as an agent pursuant to the provisions of this section. Any person, firm or corporation so acting without being duly licensed shall be guilty of a misdemeanor.

(b) Every corporation or charitable bail organization engaging as an insurer doing a bail business in this state shall procure a license pursuant to the provisions of this section for each of its employees, officers and agents acting for it in soliciting, negotiating or effectuating any such deposit or bail bond.

(c) The superintendent may, in the superintendent's discretion, issue to any person, firm or corporation a license to act as an agent of an authorized insurer or charitable bail organization, in soliciting, negotiating or effectuating any such deposit or bail bond by such insurer or any such deposit by such charitable bail organization.

(d) Any such license issued to a firm or corporation shall authorize only the members named in such license as sublicensees, to act individually as agents thereunder. Any sublicense issued to a corporation shall authorize only the officers and directors named in such license as sublicensees, to act individually as agents thereunder. Every sublicensee, acting as insurance agent pursuant to a license issued to a firm or corporation, shall be authorized to act only in the name of such firm or corporation.

(e) Before the issuance of a license every applicant shall satisfy the superintendent as to his trustworthiness and competence and otherwise comply with the conditions set forth in this section. The superintendent may refuse to issue any such license if in his judgment such refusal will best promote the interests of the people of this state.

(f) At the time of the application for every license a twenty-five dollar fee shall be paid to the superintendent for each year or fraction of a year in which a license shall be valid for each individual applicant and for each proposed sublicensee.

(g) Every applicant for a license hereunder shall file with the superintendent written evidence by those who know his character and reputation and by such other proof as the superintendent may require, including his fingerprints, that he is a person of good character and reputation and has never been convicted of any offense involving moral

turpitude or of any crime. If such applicant is a firm or corporation such proof must be made with respect to every member, shareholder, officer and director of such firm or corporation. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check.

(h) In order to determine the competence of each applicant for a license or a sublicense, the superintendent shall require every applicant to pass to the satisfaction of the superintendent a written examination to be prepared by the superintendent and appropriate to the doing of a bail business. If the applicant or any proposed sublicensee intends to maintain an office or solicit, negotiate, effectuate or deposit bail on behalf of another in any city containing a population of more than one hundred seventy-five thousand, such written examination may inquire into the applicant's knowledge of the pertinent provisions of the criminal procedure law and the pertinent rules and practices of the courts and district attorneys' offices within the area of the applicant's proposed operations. Such examination shall be held at such times and places as the superintendent shall determine.

(i) Every individual applying to take any written examination shall at the time of applying pay to the superintendent, or at the discretion of the superintendent, directly to any organization that is under contract to provide examination services, an examination fee of an amount which is the actual documented administrative cost of conducting the examination as certified by the superintendent from time to time. An examination fee represents an administrative expense and is not refundable.

(j) Every applicant for any such license shall file with the superintendent a qualifying bond, approved by the attorney general as to form and by the superintendent as to sufficiency, in a penalty of five thousand dollars, conditioned upon the faithful performance of the duties of such licensee. No such qualifying bond shall be subject to termination or cancellation by either party in less than sixty days after the giving of written notice to the other party and to the superintendent. A termination or cancellation shall not affect the

liability of the surety or sureties on such bond incurred prior to the effective date of such termination or cancellation. If during the term of such bond such licensee shall be guilty of fraudulent or dishonest conduct or other misconduct or malfeasance in his dealings with any court or magistrate or with any person or corporation in connection with any deposit or bail bond, the attorney general may maintain an action on such qualifying bond in the name of the people of this state and either recover the full amount of the penalty or recover for the use and benefit of the person or persons aggrieved, the amount of loss or injury sustained by such person or persons by reason of such misconduct. No such recovery or recoveries shall exceed in the aggregate five thousand dollars, exclusive of interest and costs.

(k) The superintendent may, upon notice and after a hearing, revoke or suspend, for such period as he may determine, any such license or sublicense issued pursuant to the provisions of this section if, after notice and hearing as specified in this chapter, he determines that the licensee or any sublicensee or any member of a firm or corporation which is so licensed has:

(1) violated any provision of, or any obligation imposed by, the insurance law, or has violated any other law of the state;

(2) has made a material misstatement in the application for such license;

(3) has been guilty of any fraudulent or dishonest practices or other misconduct or malfeasance;

(4) has charged or received, as premium or compensation for the making of any deposit or bail bond, any sum in excess of that permitted by law;

(5) has required, as a condition of his executing a bail bond, that the principal agree to engage the services of a specified attorney; or

(6) has demonstrated his incompetency or untrustworthiness to act as a licensee.

(l) The superintendent, in lieu of revoking or suspending a license in accordance with the provisions of this article, may, in any one proceeding, by order, require the licensee to pay to the people of this state a penalty in a sum not exceeding five hundred dollars for each offense, and a penalty in a sum not exceeding twenty-five hundred dollars in the aggregate for all offenses. Upon failure of such licensee to pay such penalty within twenty days after the mailing of such order,

postage prepaid, registered, and addressed to the last known place of business of such licensee, unless such order is stayed by a court of competent jurisdiction, the superintendent may revoke the license of such licensee or may suspend the same for such period as he may determine.

(m) Every license issued to an officer, employee, or agent of an insurer or charitable bail organization doing a bail business pursuant to this section shall be for a term expiring on the thirty-first day of December of even numbered years and may be renewed for the ensuing two calendar years upon the filing of a renewal application. The superintendent may refuse to issue any such license if in the superintendent's judgment such refusal will best promote the interests of the people of this state. Every such licensee and sublicensee shall file an information statement on or before the thirty-first day of December of each even numbered year, the form and subject matter of which may be prescribed by the superintendent.

(n) Any domestic, foreign or alien surety company which was licensed to do a bail bond business in this state before January first, nineteen hundred forty shall so long as its license or any renewal remains in force, be deemed licensed as an insurer to do such business within the meaning of paragraph one of subsection (b) of section six thousand eight hundred one of this article and article eleven of this chapter.

(o) This section shall not apply to any insurer authorized in this state to execute and issue policies of motor vehicle and aircraft insurance as specified in paragraphs thirteen, fourteen and nineteen of subsection (a) of section one thousand one hundred thirteen of this chapter or to any agent of such insurer or to any broker who, as an incident to the execution and issuance of any such policy or to the solicitation, negotiation or procurement thereof undertakes to pay, in addition to the applicable limits of liability, the cost of bail bonds required of the insured because of accident or asserted traffic law violations arising out of the use of a vehicle insured under the terms of the policy, provided the cost of each such bail bond does not exceed one hundred dollars, or who otherwise arranges for the execution of a bail bond or deposit in lieu of cash bail on behalf of the insured in the event of the insured's arrest or detention by reason of an asserted violation of any law relating to the use of a motor vehicle.

(p) The superintendent may issue a replacement for a currently in force license which has been lost or destroyed. Before such replacement license shall be issued, there shall be on file in the office of the superintendent a written application for such replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of fifteen dollars.

§ 6803. Bail bond business; cities in excess of one hundred seventy-five thousand. (a) An insurance corporation or charitable bail organization engaged in the bail business in a city containing a population of more than one hundred seventy-five thousand inhabitants, according to the last preceding federal census or state enumeration, shall file with the district attorney of each county contained in such city or in which such a city is contained, the clerks of the supreme and county courts and the clerk of the criminal court of the city of New York, certified statements of the names of all persons authorized to execute bail bonds or effectuating such deposit on its behalf or to solicit such business as agent, together with a certificate duly executed by the superintendent, certifying with respect to each such person, that such person has been licensed by the superintendent pursuant to section six thousand eight hundred two of this article.

(b) The court or other public officer concerned in the matter may examine under oath any insurer or charitable bail organization doing a bail business or a depositor of security for bail, or the officer or agent of any such insurer, charitable bail organization or depositor proposing to execute a bail bond, or to make such deposit, as to the indemnity, if any, deposited or otherwise provided directly or indirectly against loss by reason of the deposit or bail bond and as to the fee charged, if any, for the giving of such bond. The court or other public officer concerned in the matter may refuse to accept such bond or deposit if satisfied that any portion of such security has been feloniously obtained by the defendant, or that the provisions of this or any other section of law have been violated, or that the person or persons indemnifying such insurer or depositor shall have within a period of one month prior thereto given indemnification or security for like purpose in more than two cases not arising out of the same

transaction and that such person is not duly licensed by the superintendent in accordance with the provisions of this chapter.

§ 6804. Premium or compensation. (a) The premium or compensation for giving bail bond or depositing money or property as bail shall not exceed ten per centum of the amount of such bond or deposit in cases where such bonds or deposits do not exceed the sum of three thousand dollars. Where such bonds or deposits exceed the sum of three thousand dollars, the premium shall not exceed ten per centum of the first three thousand dollars and eight per centum of the excess amount over three thousand dollars up to ten thousand dollars and six per centum of the excess amount over ten thousand dollars. In cases where the amount of the bond or deposit is less than two hundred dollars a minimum premium of ten dollars may be charged.

(b) No person or corporation shall:

(1) charge or receive, directly or indirectly, any greater compensation for making a deposit for bail or giving bail, or act in such business as aforesaid without obtaining a license, or

(2) accept any fee or compensation for obtaining a license or for obtaining a bondsman or bail bond. Such person or corporation shall be guilty of a misdemeanor and in addition shall in any action brought to recover any such overcharge be liable for treble damages.

(c) Any member of the bar having any financial interest by which he is to profit from the giving of bail shall be guilty of a misdemeanor.

§ 6805. Charitable bail organization. (a)(1) The superintendent may issue a certificate to a charitable bail organization to deposit money as bail for another in accordance with the provisions of this section only if such entity is a non-profit organization organized pursuant to the United States internal revenue code as described by section 501(c)(3) of title 26 of the United States code, is registered as a charity pursuant to article seven-A of the executive law and is current on such registration.

(2) The application for a charitable bail organization certificate shall be in such form or forms, and shall contain relevant information,

as the superintendent shall prescribe.

(3) The superintendent may refuse to issue a charitable bail organization certificate if, in the superintendent's judgment, an applicant, or an officer or director of the applicant, has: (A) demonstrated untrustworthiness or incompetence; (B) given cause for the revocation or suspension of the certificate; or (C) failed to comply with any prerequisite for the issuance of the certificate.

(4) A charitable bail organization certificate shall be valid for a term of five years from issuance. At the time of application for every such certificate, and for every renewal thereof, an applicant shall pay to the superintendent a sum of one thousand dollars payable each term or fraction of a term, provided, however, that in his or her discretion, the superintendent may waive such fee.

(5) If an application for a renewal certificate shall have been filed with the superintendent before the expiration of such certificate, then the certificate sought to be renewed shall continue in full force and effect either until the issuance by the superintendent or the renewal certificate applied for or until five days after the superintendent shall have refused to issue such renewal certificate.

(6) The superintendent may refuse to renew or may revoke or suspend a charitable bail organization certificate for a reasonable period determined by the superintendent if, after notice and hearing, the superintendent determines that an applicant or licensee, or an officer or director of the applicant or licensee, has: (A) demonstrated untrustworthiness or incompetence; (B) violated this section or authorized regulations promulgated thereunder; or (C) failed to stay current with their registration as a charity pursuant to article seven-A of the executive law. Any hearing conducted under this section shall comply with the requirements of section three hundred five of the financial services law.

(b) A charitable bail organization shall:

(1) only deposit money as bail in the amount of two thousand dollars or less for a defendant charged with one or more misdemeanors, provided, however, that such organization shall not execute as surety any bond for any defendant;

(2) only deposit money as bail on behalf of a person who is financially unable to post bail, which may constitute a portion or the

whole amount of such bail;

(3) only deposit money as bail in one county in this state. Provided, however, that a charitable bail organization whose principal place of business is located within a city of a million or more may deposit money as bail in the five counties comprising such city; and

(4) not charge a premium or receive compensation for acting as a charitable bail organization.

(c) The superintendent may promulgate regulations implementing this section.

ARTICLE 69

FINANCIAL GUARANTY INSURANCE CORPORATIONS

Section 6901. Definitions.
6902. Organization; financial requirements.
6903. Contingency, loss and unearned premium reserves.
6904. Limitations.
6905. Policy forms and rates.
6906. Reinsurance.
6907. Transition provisions.
6908. Applicability of other laws.
6909. Relationship to security fund.

§ 6901. Definitions. As used in this article: (a) (1) "Financial guaranty insurance" means a surety bond, an insurance policy or, when issued by an insurer or any person doing an insurance business as defined in paragraph one of subsection (b) of section one thousand one hundred one of this chapter, an indemnity contract, and any guaranty similar to the foregoing types, under which loss is payable, upon proof of occurrence of financial loss, to an insured claimant, obligee or indemnitee as a result of any of the following events:

(A) failure of any obligor on or issuer of any debt instrument or other monetary obligation (including equity securities guarantied under a surety bond, insurance policy or indemnity contract) to pay when due to be paid by the obligor or scheduled at the time insured to be received by the holder of the obligation, principal, interest, premium,

dividend or purchase price of or on, or other amounts due or payable with respect to, such instrument or obligation, when such failure is the result of a financial default or insolvency or, provided that such payment source is investment grade, any other failure to make payment, regardless of whether such obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted;

(B) changes in the levels of interest rates, whether short or long term or the differential in interest rates between various markets or products;

(C) changes in the rate of exchange of currency;

(D) changes in the value of specific assets or commodities, financial or commodity indices, or price levels in general; or

(E) other events which the superintendent determines are substantially similar to any of the foregoing.

(2) Notwithstanding paragraph one of this subsection, "financial guaranty insurance" shall not include:

(A) insurance of any loss resulting from any event described in paragraph one of this subsection if the loss is payable only upon the occurrence of any of the following, as specified in a surety bond, insurance policy or indemnity contract:

(i) a fortuitous physical event;

(ii) failure of or deficiency in the operation of equipment; or

(iii) an inability to extract or recover a natural resource;

(B) fidelity and surety insurance as defined in paragraph sixteen of subsection (a) of section one thousand one hundred thirteen of this chapter;

(C) credit insurance as defined in paragraph seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter;

(D) credit unemployment insurance as defined in paragraph twenty-four of subsection (a) of section one thousand one hundred thirteen of this chapter;

(E) residual value insurance as defined in paragraph twenty-two of subsection (a) of section one thousand one hundred thirteen of this chapter;

(F) mortgage guaranty insurance as defined in paragraph twenty-three of subsection (a) of section one thousand one hundred thirteen of this chapter and as permitted to be written by a mortgage guaranty insurer

under article sixty-five of this chapter;

(G) guaranteed investment contracts issued by life insurance companies which provide that the life insurer itself will make specified payments in exchange for specific premiums or contributions;

(H) indemnity contracts or similar guaranties, to the extent that they are not otherwise limited or proscribed by this chapter:

(i) in which a life insurer or an insurer subject to article forty-three of this chapter guaranties its obligations or indebtedness or the obligations or indebtedness of a subsidiary (as defined in paragraph forty of subsection (a) of section one hundred seven of this chapter), other than a financial guaranty insurance corporation, provided that:

(I) to the extent that any such obligations or indebtedness are backed by specific assets, such assets must at all times be owned by the insurer or the subsidiary; and

(II) in the case of the guaranty of the obligations or indebtedness of the subsidiary that are not backed by specific assets of such insurer, such guaranty terminates once the subsidiary ceases to be a subsidiary; or

(ii) in which a life insurer guaranties obligations or indebtedness (including the obligation to substitute assets where appropriate) with respect to specific assets acquired by such life insurer in the course of its normal investment activities and not for the purpose of resale with credit enhancement, or guaranties obligations or indebtedness acquired by its subsidiary, provided that the assets acquired pursuant to this item (ii) have been:

(I) acquired by a special purpose entity, whose sole purpose is to acquire specific assets of such life insurer or its subsidiary and issue securities or participation certificates backed by such assets; or

(II) sold to an independent third party; or

(iii) in which a life insurer guaranties obligations or indebtedness of an employee or insurance agent of such life insurer; or

(I) guarantees of higher education loans, unless written by a financial guaranty insurance corporation;

(J) guarantees of insurance contracts, except for:

(i) guarantees authorized pursuant to section one thousand one hundred fourteen of this chapter;

(ii) financial guaranty insurance policies insuring guaranteed investment contracts issued by life insurers, provided that:

(I) the obligations under such contracts are not dependent on the continuance of human life;

(II) the financial guaranty insurance policies do not guaranty death benefits provided by such contracts;

(III) the obligations insured by the financial guaranty insurance policies are investment grade based on the rating of the life insurers or, in the case of separate account guaranteed investment contracts, based on the ratings of such separate accounts;

(IV) the financial guaranty insurance policies shall not condition or delay payment of a claim with respect to such contracts upon the insured or beneficiary making a claim on the contracts with any insurance guaranty fund under this chapter or of any other jurisdiction; and

(V) the financial guaranty insurance policies provide that if, prior to payment by the insurer under the financial guaranty insurance policies, the guaranty fund has paid a claim under such contracts for an amount that, when added to the amount payable under the financial guaranty insurance policies, would exceed the amount owed under such contracts, then the financial guaranty insurer shall pay the portion of the amount payable in excess of the contract amounts to the guaranty fund instead of to the beneficiary under such contracts; or

(K) any other form of insurance covering risks which the superintendent determines to be substantially similar to any of the foregoing.

(b) "Financial guaranty insurance corporation" or "corporation" means an insurer licensed to transact the business of financial guaranty insurance in this state.

(c) "Affiliate" means a person which, directly or indirectly, owns at least ten percent but less than fifty percent of the financial guaranty insurance corporation or which is at least ten percent but less than fifty percent, directly or indirectly, owned by a financial guaranty insurance corporation.

(d) "Aggregate net liability" means the aggregate amount of insured unpaid principal, interest and other monetary payments, if any, of guarantied obligations insured or assumed, less reinsurance ceded and less collateral.

(e) "Asset-backed securities" mean:

(1) securities or other financial obligations of an issuer provided that:

(A) the issuer is a special purpose corporation, trust or other entity, or (provided that the securities or other financial obligations constitute an insurable risk) is a bank, trust company or other financial institution, deposits in which are insured by the Bank Insurance Fund or the Savings Insurance Fund (or any successor thereto); and

(B) a pool of assets:

(i) has been conveyed, pledged or otherwise transferred to or is otherwise owned or acquired by the issuer;

(ii) such pool of assets backs the securities or other financial obligations issued; and

(iii) no asset in such pool, other than an asset directly payable by, guaranteed by or backed by the full faith and credit of the United States government or that otherwise qualifies as collateral under paragraph one or two of subsection (g) of this section, has a value exceeding twenty percent of the pool's aggregate value; or

(2) a pool of credit default swaps or credit default swaps referencing a pool of obligations, provided that:

(A) the swap counterparty whose obligations are insured under the credit default swap is a special purpose corporation, special purpose trust or other special purpose legal entity;

(B) no reference obligation in such pool, other than an obligation directly payable by, guaranteed by or backed by the full faith and credit of the United States government or that otherwise qualifies as collateral under paragraph two of subsection (g) of this section, has a notional amount exceeding ten percent of the pool's aggregate notional amount; and

(C) the insurer has the benefit of a deductible or other first loss credit protection against claims under its insurance policy.

(f) "Average annual debt service" means the amount of insured unpaid principal and interest on an obligation, multiplied by the number of such insured obligations (assuming each obligation represents one thousand dollars par value), divided by the amount equal to the aggregate life of all such obligations (assuming each obligation

represents one thousand dollars par value). This definition, expressed as a formula in regard to bonds, is as follows:

$$\text{Average Annual Debt Service} = \frac{\text{Total Debt Service} \times \text{No. of Bonds}}{\text{Bond Years}}$$

$$\text{Total Debt Service} = \text{Insured Unpaid Principal} + \text{Interest}$$

$$\text{Number of Bonds} = \frac{\text{Total Insured Principal}}{\$1{,}000}$$

$$\text{Bond Years} = \text{Number of Bonds} \times \text{Term in Years}$$

Term in Years = Term to maturity based on scheduled amortization or, in the absence of a scheduled amortization in the case of asset-backed securities or other obligations lacking a scheduled amortization, expected amortization, in each case determined as of the date of issuance of the insurance policy based upon the amortization assumptions employed in pricing the insured obligations or otherwise used by the insurer to determine aggregate net liability.

(g) "Collateral" means:

(1) cash;

(2) the cash flow from specific obligations which are not callable and scheduled to be received based on expected prepayment speed on or prior to the date of scheduled debt service (including scheduled redemptions or prepayments) on the insured obligation provided that (i) such specific obligations are directly payable by, guaranteed by or backed by the full faith and credit of the United States government, (ii) in the case of insured obligations denominated or payable in foreign currency as permitted under paragraph four of subsection (b) of section six thousand nine hundred four of this article, such specific obligations are directly payable by, guaranteed by or backed by the full faith and credit of such foreign government or the central bank thereof, or (iii) such specific obligations are insured by the same insurer that insures the obligations being collateralized, and the cash flows from such specific obligations are sufficient to cover the insured scheduled payments on the obligations being collateralized;

(3) the market value of investment grade obligations, other than obligations evidencing an interest in the project or projects financed with the proceeds of the insured obligations;

(4) the face amount of each letter of credit that:

(A) is irrevocable;

(B) provides for payment under the letter of credit in lieu of or as reimbursement to the insurer for payment required under a financial guaranty insurance policy;

(C) is issued, presentable and payable either:

(i) at an office of the letter of credit issuer in the United States; or

(ii) at an office of the letter of credit issuer located in the jurisdiction in which the trustee or paying agent for the insured obligation is located;

(D) contains a statement that either:

(i) identifies the insurer and any successor by operation of law, including any liquidator, rehabilitator, receiver or conservator, as the beneficiary; or

(ii) identifies the trustee or the paying agent for the insured obligation as the beneficiary;

(E) contains a statement to the effect that the obligation of the letter of credit issuer under the letter of credit is an individual obligation of such issuer and is in no way contingent upon reimbursement with respect thereto;

(F) contains an issue date and a date of expiration;

(G) either:

(i) has a term at least as long as the shorter of the term of the insured obligation or the term of the financial guaranty policy; or

(ii) provides that the letter of credit shall not expire without thirty days prior written notice to the beneficiary and allows for drawing under the letter of credit in the event that, prior to expiration, the letter of credit is not renewed or extended or a substitute letter of credit or alternate collateral meeting the requirements of this subsection is not provided;

(H) states that it is governed by the laws of the state of New York or by the 1983 or 1993 Revision of the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400 or 500) or any successor Revision if approved by the superintendent, and contains a provision for an extension of time, of not less than thirty days after resumption of business, to draw against

the letter of credit in the event that one or more of the occurrences described in Article 19 of Publication 400 or 500 occurs; and

(I) is issued by a bank, trust company, or savings and loan association that:

(i) is organized and existing under the laws of the United States or any state thereof or, in the case of a non-domestic financial institution, has a branch or agency office licensed under the laws of the United States or any state thereof and is domiciled in a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a nationally recognized statistical rating organization acceptable to the superintendent;

(ii) has (or is the principal operating subsidiary of a financial institution holding company that has) a long-term debt rating of at least investment grade; and

(iii) is not a parent, subsidiary or affiliate of the trustee or paying agent, if any, with respect to the insured obligation if such trustee or paying agent is the named beneficiary of the letter of credit; or

(5) the amount of credit protection available to the insurer (or its nominee) under each credit default swap that:

(A) may not be amended without the consent of the insurer and may only be terminated: (i) at the option of the insurer; (ii) at the option of the counterparty to the insurer (or its nominee), if the credit default swap provides for the payment of a termination amount equal to the replacement cost of the terminated credit default swap determined with reference to standard documentation of the International Swap and Derivatives Association, Inc. or otherwise acceptable to the superintendent; or (iii) at the discretion of the superintendent acting as a rehabilitator, liquidator or receiver of the insurer upon payment by or on behalf of the insurer of any termination amount due from the insurer;

(B) provides for payment under all instances in which payment under a financial guaranty insurance policy is required, except that payment under the credit default swap may be on a first loss, excess of loss or other non-pro-rata basis and may apply on an aggregate basis to more than one policy;

(C) is provided by:

(i) a counterparty whose obligations under the credit default swap are insured by a financial guaranty insurance corporation licensed under this article or guaranteed by a financial institution referred to in items (ii) and (iii) of this subparagraph;

(ii) a financial institution satisfying the requirements of items (i) through (iii) of subparagraph (I) of paragraph four of this subsection; provided that (A) obligations of such financial institution on parity with its obligations under the credit default swap are investment grade and (B) if such financial institution is not organized under, or acting through a branch or agency office licensed under, the laws of the United States or any state thereof, then such financial institution is required to collateralize the replacement cost of the credit default swap in the event that it shall fail to maintain such rating; or

(iii) any other financial institution that the superintendent determines to be substantially similar to any of the foregoing.

Collateral must be deposited with the insurer; held in trust by a trustee or custodian acceptable to the superintendent for the benefit of the insurer; or held in trust pursuant to the bond indenture or other trust arrangement, for the benefit of security holders in the form of funds for the payment of insured obligations, sinking funds or other reserves which may be used for the payment of insured obligations and trustee and other administrative fees on a first priority basis established and continually maintained pursuant to the bond indenture or other trust arrangement by a trustee acceptable to the superintendent. The superintendent may promulgate regulations to limit the amount of collateral provided by obligations, letters of credit or credit default swaps or to limit the amount of collateral provided by any single issuer, bank or counterparty as provided for in this subsection.

(h) "Commercial real estate" means income producing real property other than residential property consisting of less than five units.

(i) (1) "Consumer debt obligations" guaranties means financial guaranty insurance that indemnifies a purchaser or lender against loss or damage resulting from defaults on a pool of debts owed for extensions of credit (including in respect of installment purchase agreements and leases) to individuals, provided in the normal course of the purchaser's

or lender's business, provided that (A) such pool meets the requirements of paragraph two of subsection (e) of this section and (B) such pool has been determined to be investment grade.

(2) Consumer debt obligations guaranty policies shall contain a provision that all coverage under the policies terminates upon sale or transfer of the underlying consumer debt obligation to any transferee not insured by the same insurer under a similar policy.

(j) "Contingency reserve" means an additional liability reserve established to protect policyholders against the effects of adverse economic developments or cycles or other unforeseen circumstances.

(j-1) "Credit default swap" means an agreement referencing the credit derivative definitions published from time to time by the International Swap and Derivatives Association, Inc. or otherwise acceptable to the superintendent, pursuant to which a party agrees to compensate another party in the event of a payment default by, insolvency of, or other adverse credit event in respect of, an issuer of a specified security or other obligation; provided that such agreement does not constitute an insurance contract and the making of such credit default swap does not constitute the doing of an insurance business.

(k) "Governmental unit" means the United States of America, Canada, a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top three generic lettered rating classifications by a nationally recognized statistical rating organization acceptable to the superintendent, a state, territory or possession of the United States of America, the District of Columbia, a province of Canada, a municipality, or a political subdivision of any of the foregoing, or any public agency or instrumentality thereof.

(k-1) "Excess spread" means, with respect to any insured issue of asset-backed securities, the excess of (A) the scheduled cash flow on the underlying assets that is reasonably projected to be available, over the term of the insured securities after payment of the expenses associated with the insured issue, to make debt service payments on the insured securities over (B) the scheduled debt service requirements on the insured securities, provided that such excess is held in the same manner as collateral is required to be held under subsection (g) of this section.

(l) "Industrial development bond" means any security or other

instrument, other than a utility first mortgage obligation, under which a payment obligation is created, issued by or on behalf of a governmental unit, to finance a project serving a private industrial, commercial or manufacturing purpose, and not payable or guarantied by a governmental unit.

(m) "Insurable risk" means, with respect to asset-backed securities, as defined in subsection (e) of this section, that such obligation on an uninsured basis has been determined to be not less than investment grade based solely on the pool of assets backing the insured obligation or securing the insurer, without consideration of the creditworthiness of the issuer.

(n) "Investment grade" means that:

(1) the obligation or parity obligation of the same issuer has been determined to be in one of the top four generic lettered rating classifications by a nationally recognized statistical rating organization acceptable to the superintendent;

(2) the obligation or parity obligation of the same issuer has been identified in writing by such nationally recognized statistical rating organization to be of investment grade quality; or

(3) if the obligation or parity obligation of the same issuer has not been submitted to any such nationally recognized statistical rating organization, the obligation is determined to be investment grade (as indicated by a rating in category 1 or 2) by the Securities Valuation Office of the National Association of Insurance Commissioners.

(o) "Municipal bonds" means municipal obligation bonds and special revenue bonds.

(p) "Municipal obligation bond" means any security or other instrument, including a lease payable or guaranteed by the United States or another national government that qualifies as a governmental unit or any agency, department or instrumentality thereof, or by a state or an equivalent political subdivision of another national government that qualifies as a governmental unit, but not a lease of any other governmental unit, under which a payment obligation is created, issued by or on behalf of or payable or guaranteed by a governmental unit or issued by a special purpose corporation, special purpose trust or other special purpose legal entity to finance a project serving a substantial public purpose, and which is:

(1) (A) payable from tax revenues, but not tax allocations, within the jurisdiction of such governmental unit;

(B) payable or guaranteed by the United States or another national government that qualifies as a governmental unit, or any agency, department or instrumentality thereof, or by a housing agency of a state or an equivalent subdivision of another national government that qualifies as a governmental unit;

(C) payable from rates or charges (but not tolls) levied or collected in respect of a non-nuclear utility project, public transportation facility (other than an airport), or public higher education facility; or

(D) with respect to lease obligations, payable from future appropriations; and

(2) provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity, (A) such obligations are investment grade at the time of issuance; (B) such obligations are payable from sources enumerated in subparagraph (A), (B), (C) or (D) of paragraph one of this subsection; and (C) the project being financed or the tolls, tariffs, usage fees or other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

(q) "Reinsurance" means cessions qualifying for credit under section six thousand nine hundred six of this article.

(r) "Special revenue bond" means any security or other instrument, under which a payment obligation is created, issued by or on behalf of or payable or guaranteed by a governmental unit to finance a project serving a substantial public purpose, and not payable from any of the sources enumerated in subsection (p) of this section; or securities which are the functional equivalent of the foregoing issued by a not-for-profit corporation or a special purpose corporation, special purpose trust or other special purpose legal entity; provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity, (1) such obligations are investment grade at the time of issuance; (2) such obligations are not payable from the sources enumerated in subparagraph (A), (B), (C) or (D) of paragraph one of subsection (p) of this section; and (3) the project being financed or the tolls, tariffs, usage fees or

other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

(s) "Utility first mortgage obligation" means any obligation of an issuer secured by a first priority mortgage on utility property owned by or leased to an investor-owned or cooperative-owned utility company and located in the United States, Canada or a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a nationally recognized statistical rating organization acceptable to the superintendent; provided that the utility or utility property or the usage fees or other similar utility rates or charges are subject to regulation or oversight by a governmental unit.

§ 6902. Organization; financial requirements. (a) A financial guaranty insurance corporation may be organized and licensed in the manner prescribed in section one thousand two hundred one of this chapter and a foreign insurer may be licensed in the manner prescribed in section one thousand one hundred six of this chapter, except as modified by the following provisions:

(1) a corporation organized for the purpose of transacting financial guaranty insurance may, subject to all the applicable provisions of this chapter, be licensed to transact only the following additional kinds of insurance:

(A) residual value insurance, as defined in paragraph twenty-two of subsection (a) of section one thousand one hundred thirteen of this chapter;

(B) surety insurance, as defined in subparagraphs (C), (D), (E), (F), (G), (H) and (I) of paragraph sixteen of subsection (a) of section one thousand one hundred thirteen of this chapter; and

(C) credit insurance, as defined in subparagraph (A) of paragraph seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter;

(2) a financial guaranty insurance corporation may only assume those kinds of insurance for which it is licensed to write direct business;

(3) prior to the issuance of a license, unless a plan of operation has been previously approved by the superintendent, a corporation shall

submit for the approval of the superintendent a plan of operation, detailing the types and projected diversification of guaranties that will be issued, the underwriting procedures that will be followed, managerial oversight methods, investment policies, and such other matters as may be prescribed by the superintendent; and

(4) a financial guaranty insurance corporation's investments in any one entity insured by that corporation shall not exceed four percent of its admitted assets at last year-end, except that this limit shall not apply to investments payable or guaranteed by a United States governmental unit or New York state if such investments payable or guaranteed by the United States governmental unit or New York state shall be rated in one of the top two generic lettered rating classifications by a nationally recognized statistical rating organization acceptable to the superintendent.

(5) in addition to any transaction that an insurer meeting the requirements of subsection (c) of section one thousand four hundred three of this chapter may effect and maintain under any other provision of this chapter, a financial guaranty insurance corporation may effect and maintain transactions in (A) contracts for the future delivery or receipt of the currency of a foreign country, (B) interest rate options, (C) credit default swaps under which the insurer is acquiring credit protection and (D) other products included in the plan referred to in clause (vii) of this subparagraph, in each case meeting the following requirements:

(i) the transaction is used for the purpose of limiting risk of loss under financial guaranty insurance policies or reinsurance contracts covering such policies due to fluctuations in interest rates or currency exchange rates or, in the case of credit default swaps, financial default, insolvency or other credit events;

(ii) the transaction shall not exceed a duration of twelve months beyond the term of such policies or reinsurance contracts;

(iii) the amount of foreign currencies to be purchased under the transaction shall not exceed the amount guaranteed under such policies or reinsurance contracts that is denominated in foreign currency;

(iv) the amount that is subject to interest rate hedging transactions does not exceed the amount guaranteed under such policies or reinsurance contracts that is subject to the risk of interest rate fluctuations;

(v) the counterparty to such transaction has (or is the principal operating subsidiary of a holding company that has) a long term unsecured debt rating or claims-paying ability rating that is at least investment grade;

(vi) the transaction is not conducted for arbitrage purposes; and

(vii) the transaction is entered into pursuant to a plan that has been approved by the board of directors of the financial guaranty insurance corporation and filed with and approved by the superintendent.

(b) (1) A financial guaranty insurance corporation shall not transact business unless it has paid-in capital of at least two million five hundred thousand dollars and paid-in surplus of at least seventy-two million five hundred thousand dollars, and shall at all times thereafter maintain a minimum surplus to policyholders of at least sixty-five million dollars.

(2) An insurer transacting only financial guaranty insurance prior to the effective date of this article which has a paid-in capital of at least two million five hundred thousand dollars and maintains surplus to policyholders of at least forty-five million dollars shall have thirty-six months from the effective date of this article to fully comply with the surplus requirements set forth in paragraph one of this subsection.

(3) A financial guaranty insurance company shall be deemed to be in compliance with paragraphs one and two of subsection (b) of section one thousand four hundred two of this chapter if not less than sixty percent of the amount of the required minimum capital or minimum surplus to policyholder investments shall consist of the types specified in paragraphs one and two of subsection (b) of section one thousand four hundred two of this chapter and direct government obligations of any state of the United States or of any county, district or municipality thereof, provided such government obligations have been given the highest quality designation of the Securities Valuation Office of the National Association of Insurance Commissioners. Before investing any part of the required minimum capital or surplus in direct government obligations of any other state of the United States or of any county, district or municipality thereof, such financial guaranty insurance company shall have invested at least ten percent of such required minimum in government obligations of New York state or of any county,

district or municipality thereof. Only for purposes of meeting the required investment in government obligations of New York state, the insurer may count investments in any government obligation of New York state, whether direct or otherwise.

§ 6903. Contingency, loss and unearned premium reserves. (a) Contingency reserves. (1) A corporation shall establish and maintain contingency reserves for the protection of insureds and claimants against the effects of excessive losses occurring during adverse economic cycles.

(2) With respect to all financial guaranties written prior to and in force as of the first day of the next calendar quarter commencing after the date that the act enacting this article shall become law:

(A) the insurer shall establish and maintain a contingency reserve consistent with the requirements applicable for municipal bond guaranties in effect prior to the effective date of this article equal to fifty percent of earned premiums on such policies; and

(B) to the extent that the insurer's contingency reserves maintained as of the first day of the next calendar quarter commencing after the date that the act enacting this article shall become law are less than those required for municipal bond guaranties, the insurer shall have three years from such date to bring its contingency reserves into compliance.

(3) With respect to financial guaranties of municipal obligation bonds, special revenue bonds, industrial development bonds and utility first mortgage obligations written on and after the first day of the next calendar quarter commencing after the date that the act enacting this article shall become law:

(A) the insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each category listed in subparagraph (B) of this paragraph;

(B) the total contingency reserve required shall be the greater of fifty percent of premiums written for each such category or the following amount prescribed for each such category:

(i) municipal obligation bonds, 0.55 percent of principal guarantied;

(ii) special revenue bonds, and obligations demonstrated to the

satisfaction of the superintendent to be the functional equivalent thereof, 0.85 percent of principal guarantied;

(iii) investment grade industrial development bonds, secured by collateral or having a term of seven years or less, and utility first mortgage obligations, 1.0 percent of principal guarantied;

(iv) other investment grade industrial development bonds, 1.5 percent of principal guarantied; and

(v) all other industrial development bonds, 2.5 percent of principal guarantied; and

(C) Contributions to the contingency reserve required by this paragraph, equal to one-eightieth of the total reserve required, shall be made each quarter for twenty years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in items (i) through (v) of subparagraph (B) of this paragraph exceeds the percentages contained in such items (i) through (v) when applied against unpaid principal.

(4) With respect to all other financial guaranties written on or after the first day of the next calendar quarter commencing after the date that the act enacting this article shall become law:

(A) the insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each such category listed in subparagraph (B) of this paragraph;

(B) the total contingency reserve required shall be the greater of fifty percent of premiums written for each such category or the following amount prescribed for each such category:

(i) investment grade obligations, secured by collateral or having a term of seven years or less, 1.0 percent of principal guarantied;

(ii) other investment grade obligations, 1.5 percent of principal guarantied;

(iii) non-investment grade consumer debt obligations, 2.0 percent of principal guarantied;

(iv) non-investment grade asset-backed securities, 2.0 percent of principal guarantied;

(v) other non-investment grade obligations, 2.5 percent of principal guarantied; and

(C) Contributions to the contingency reserve required by this paragraph, equal to one-sixtieth of the total reserve required, shall be

made each quarter for fifteen years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in items (i) through (v) of subparagraph (B) of this paragraph exceeds the percentages contained in such items (i) through (v) when applied against unpaid principal.

(5) Contingency reserves required in paragraphs two, three and four of this subsection may be established and maintained net of collateral and reinsurance, provided that, in the case of reinsurance, the reinsurance agreement requires that the reinsurer shall, on or after the effective date of the reinsurance, establish and maintain a reserve in an amount equal to the amount by which the insurer reduces its contingency reserve, and contingency reserves required in paragraphs three and four of this subsection may be maintained (A) net of refundings and refinancings to the extent the refunded or refinanced issue is paid off or secured by obligations which are directly payable or guarantied by the United States government and (B) net of insured securities in a unit investment trust or mutual fund that have been sold from the trust or fund without insurance.

(6) The contingency reserves may be released thereafter in the same manner in which they were established and withdrawals therefrom, to the extent of any excess, may be made from the earliest contributions to such reserves remaining therein:

(A) with the prior written approval of the superintendent:

(i) if the actual incurred losses for the year, in the case of the categories of guaranties subject to paragraph three of this subsection exceeds thirty-five percent of earned premiums, or in the case of the categories of guaranties subject to paragraph four of this subsection exceed sixty-five percent of earned premiums; or

(ii) if the contingency reserve applicable to the categories of guaranties subject to paragraph three of this subsection has been in existence for less than forty quarters, or for less than thirty quarters for the categories of guaranties subject to paragraph four of this subsection, upon a demonstration satisfactory to the superintendent that the amount carried is excessive in relation to the insurer's outstanding obligations under its financial guaranties.

(B) upon thirty days prior written notice to the superintendent, provided that the contingency reserve applicable to the categories of

guaranties subject to paragraph three of this subsection has been in existence for forty quarters, or thirty quarters for categories of guaranties subject to paragraph four of this subsection, upon a demonstration satisfactory to the superintendent that the amount carried is excessive in relation to the insurer's outstanding obligations under its financial guaranties.

(7) An insurer providing financial guaranty insurance may invest the contingency reserve in tax and loss bonds (or similar securities) purchased pursuant to section 832(e) of the Internal Revenue Code (or any successor provision), only to the extent of the tax savings resulting from the deduction for federal income tax purposes of a sum equal to the annual contributions to the contingency reserve. The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in paragraphs one through three of subsection (b) of section one thousand four hundred two of this chapter and paragraphs one through three of subsection (a) of section one thousand four hundred four of this chapter.

(b) Loss reserves. (1) The case basis method or such other method as may be prescribed by the superintendent shall be used to establish and maintain loss reserves, net of collateral, for claims reported and unpaid, in a manner consistent with section four thousand one hundred seventeen of this chapter. A deduction from loss reserves shall be allowed for the time value of money by application of a discount rate equal to the average rate of return on the admitted assets of the insurer as of the date of the computation of any such reserves. The discount rate shall be adjusted at the end of each calendar year.

(2) If the insured principal and interest on a defaulted issue of obligations due and payable during any three years following the date of default exceeds ten percent of the insurer's surplus to policyholders and contingency reserves, its reserve so established shall be supported by a report from an independent source acceptable to the superintendent.

(c) Unearned premium reserve. An unearned premium reserve shall be established and maintained net of reinsurance and collateral with respect to all financial guaranty premiums. Where financial guaranty insurance premiums are paid on an installment basis, an unearned premium reserve shall be established and maintained, net of reinsurance and collateral, computed on a daily or monthly pro rata basis. All other

financial guaranty insurance premiums written shall be earned in proportion with the expiration of exposure, or by such other method as may be prescribed by the superintendent.

§ 6904. Limitations. (a) Financial guaranty insurance may be transacted in this state only by a corporation licensed for such purpose pursuant to section six thousand nine hundred two of this article.

(b) Permissible guarantees. (1) The superintendent shall not permit the writing of financial guaranty insurance except as defined in subparagraph (A) of paragraph one of subsection (a) of section six thousand nine hundred one of this article, and a corporation may insure the timely payment of United States dollar debt instruments, or other monetary obligations, only in the following categories:

(A) municipal obligation bonds;

(B) special revenue bonds;

(C) industrial development bonds;

(D) obligations of corporations, trusts or other similar entities established under applicable law;

(E) partnership obligations;

(F) asset-backed securities, trust certificates and trust obligations other than mortgage-backed securities secured by first mortgages on real property which are insurable by a mortgage guaranty insurer authorized under paragraph twenty-three of subsection (a) of section one thousand one hundred thirteen of this chapter, unless:

(i) such mortgages with loan-to-value ratios in excess of eighty percent are:

(I) in the case of mortgages on property located in the state of New York, insured by mortgage guaranty insurers authorized under paragraph twenty-three of subsection (a) of section one thousand one hundred thirteen of this chapter;

(II) in the case of mortgages on property located in a state other than the state of New York, insured by mortgage guaranty insurers authorized to do business in such other state; or

(III) in an aggregate principal amount less than the single risk limits prescribed in paragraph five of subsection (d) of this section; or

(ii) additional mortgages with principal balances, other collateral with a market value, or (provided the insured risk is investment grade) excess spread in an amount, in each instance at least equal to the coverage that would otherwise be provided by such mortgage guaranty insurers in accordance with item (i) of this subparagraph are pledged as additional security for the asset-backed securities;

(G) installment purchase agreements executed as a condition of sale;

(H) consumer debt obligations;

(I) utility first mortgage obligations; and

(J) any other debt instrument or financial obligation that the superintendent determines to be substantially similar to any of the foregoing or shall otherwise be approved by the superintendent.

(2) An insurer may insure obligations enumerated in subparagraphs (A), (B), and (C) of paragraph one of this subsection that are not investment grade so long as at least ninety-five percent of the insurer's aggregate net liability on the kinds of obligations enumerated in subparagraphs (A), (B) and (C) of paragraph one of this subsection shall be investment grade.

(3) A corporation may insure the timely payment of monetary obligations in any category designated in this subsection notwithstanding that such obligation may be insured by a financial guaranty insurance policy issued by another insurer. In the event that any obligation is insured by more than one financial guaranty insurance policy, then each such insurance policy may by its terms specify its priority of payment in the event of a default under the obligation insured or any other insurance policy; provided that an insurer shall be entitled to take into account payment under another policy insuring such obligation for purposes of establishing and maintaining loss reserves only to the extent that the policy issued by such insurer provides for payment only in the event of payment default under both such obligation and the other policy.

(4) A corporation may also write financial guaranty insurance as defined in subparagraph (A) of paragraph one of subsection (a) of section six thousand nine hundred one of this article to insure the timely payment of non-United States dollar debt instruments or other monetary obligations denominated or payable in foreign currency, only for the categories listed in subparagraphs (A) through (J) of paragraph

one of this subsection, provided that:

(A) such currency is that of an Organisation for Economic Co-operation and Development country or such other country (i) whose sovereign rating is investment grade or (ii) as shall not otherwise be disapproved by the superintendent within thirty days following receipt of written notification. The superintendent shall not disapprove such notification upon demonstration that there is no undue risk associated with insuring the timely payment of such instruments or obligations. In making such a determination the superintendent shall take into consideration the corporation's outstanding liabilities on non-investment grade instruments and obligations in relation to its outstanding liabilities on all instruments and obligations and in relation to the amount of its surplus to policyholders;

(B) reserves required pursuant to section six thousand nine hundred three of this article in regard to such obligations shall be established and adjusted quarterly based upon the then current foreign exchange rates;

(C) such obligations shall not exceed twenty-five percent of an insurer's aggregate net liability; and

(D) the aggregate and single risk limitations prescribed by subsections (c) and (d) of this section shall be determined by applying the then current foreign exchange rates.

(c) Aggregate risk limits. The corporation must at all times maintain surplus to policyholders and contingency reserves in the aggregate no less than the sum of:

(1)(A) 0.3333 percent or 1/300th of the aggregate net liability under guaranties of municipal bonds including obligations demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof and investment grade utility first mortgage obligations; plus

(B) 0.6666 percent or 1/150th of the aggregate net liability under guaranties of investment grade asset-backed securities; plus

(C) 1.0 percent or 1/100th of the aggregate net liability under guaranties, secured by collateral or having a term of seven years or less, of:

(i) investment grade industrial development bonds,

(ii) other investment grade obligations; plus

(D) 1.5 percent or 1/66.67th of the aggregate net liability under

guaranties of other investment grade obligations; plus

(E) 2.0 percent or 1/50th of the aggregate net liability under guaranties of:

(i) non-investment grade consumer debt obligations, and

(ii) non-investment grade asset-backed securities; plus

(F) 2.5 percent or 1/40th of the aggregate net liability under guaranties of non-investment grade obligations secured by first mortgages on commercial real estate and having loan-to-value ratios of eighty percent or less; plus

(G) 4.0 percent or 1/25th of the aggregate net liability under guaranties of other non-investment grade obligations; and

(H) if the amount of collateral required by subparagraph (C) of this paragraph is no longer maintained, that proportion of the obligation insured which is not so collateralized shall be subject to the aggregate limits specified in subparagraph (D) of this paragraph; and

(2) surplus to policyholders determined by the superintendent to be adequate to support the writing of residual value insurance, surety insurance and credit insurance, if the corporation has elected to transact such kinds of insurance pursuant to subsection (a) of section six thousand nine hundred two of this article.

(d) Single risk limits. A financial guaranty insurance corporation shall limit its exposure to loss on any one risk insured by policies providing financial guaranty insurance, net of collateral and reinsurance, as follows:

(1) for municipal obligation bonds, special revenue bonds, and obligations demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof:

(A) the insured average annual debt service with respect to a single entity and backed by a single revenue source shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve; and

(B) the insured unpaid principal issued by a single entity and backed by a single revenue source shall not exceed the following percent of the aggregate of the insurer's surplus to policyholders and contingency reserve based on the highest sovereign rating, by a nationally recognized statistical rating organization acceptable to the superintendent, of the country of the applicable governmental unit:

(i) seventy-five percent: any rating in one of the top two generic lettered rating classifications;

(ii) fifty-nine percent: an A+, A1, or equivalent rating at the highest grade of the third generic lettered rating classification;

(iii) forty-three percent: an A, A2, or equivalent rating at the middle grade of the third generic lettered rating classification; and

(iv) twenty-six percent: an A-, A3, or equivalent rating at the lowest grade of the third generic lettered rating classification;

(2) for each issue of asset-backed securities issued by a single entity and for each pool of consumer debt obligations, the lesser of:

(A) insured average annual debt service; or

(B) insured unpaid principal (reduced by the extent to which the unpaid principal of the supporting assets and, provided the insured risk is investment grade, excess spread exceed the insured unpaid principal) divided by nine;

shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve, provided that no asset in the pool supporting the asset-backed securities exceeds the single risk limits prescribed in paragraph five of this subsection, if directly guaranteed; and provided further that, if the issuer of such insured asset-backed securities is a special purpose corporation, trust or other entity and such issuer shall have indebtedness outstanding with respect to any other pool of assets, either such other indebtedness shall be entitled to the benefits of a financial guaranty policy of the same insurer, or such other indebtedness shall: (i) be fully subordinated to the insured obligation, with respect to, or be non-recourse with respect to, the pool of assets that supports the insured obligation, (ii) be non-recourse to the issuer other than with respect to the asset pool securing such other indebtedness and proceeds in excess of the proceeds necessary to pay the insured obligation ("excess proceeds") and (iii) not constitute a claim against the issuer to the extent that the asset pool securing such other indebtedness or excess proceeds are insufficient to pay such other indebtedness;

(3) for obligations issued by a single entity and secured by commercial real estate, and not meeting the definition of asset-backed securities, the insured unpaid principal less fifty percent of the appraised value of the underlying real estate shall not exceed ten

percent of the aggregate of the insurer's surplus to policyholders and contingency reserve;

(4) for utility first mortgage obligations, the insured average annual debt service shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve; and

(5) for all other policies providing financial guaranty insurance with respect to obligations issued by a single entity and backed by a single revenue source, the insured unpaid principal shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve.

(e) Except as provided in subsection (f) of this section, if an insurer at any time exceeds any limitation prescribed by subsection (c) or (d) of this section or paragraph two of subsection (b) of this section, the insurer shall within thirty days after the limitations are breached, submit a written plan to the superintendent detailing the steps that it will take or has taken to reduce its exposure to loss to no more than the permitted amounts, and if after notice and hearing the superintendent determines that an insurer has exceeded any limitation prescribed by this section, he may order such insurer to cease transacting any new financial guaranty insurance business until its exposure to loss no longer exceeds said limitations or with respect to the limitations prescribed in paragraph two of subsection (b) of this section, may order such insurer to limit its writing of the types of guaranties permitted under subparagraphs (A), (B) and (C) of paragraph one of subsection (b) of this section to investment grade obligations until such time as it shall be in compliance with such limitations.

(f) An insurer shall not be deemed in violation of any limitation prescribed by subsection (d) of this section with respect to any financial guaranty insurance outstanding prior to the effective date of this article, if the insurer was in compliance with the applicable single risk limit in effect in this state at the time that the financial guaranty insurance policy was issued. If the insurer was not so in compliance, such financial guaranty insurance shall comply with the limitations prescribed by subsection (d) of this section no later than three years after the effective date of this article.

(g) No insurer authorized to transact the business of financial guaranty insurance shall pay any commission or make any gift of money,

property or other valuable thing to any employee, agent or representative of any potential purchaser of a financial guaranty insurance policy, as an inducement to the purchase of such a policy, and no such employee, agent or representative of such potential purchaser shall receive any such payment or gift. Violation of the provisions of this section shall not, however, have the effect of rendering void the insurance policy issued by the insurer.

§ 6905. Policy forms and rates. (a) Policy forms and any amendments thereto shall be filed with the superintendent within thirty days of their use by the insurer if not otherwise filed prior to the effective date of this article. Every such policy shall provide that, in the event of a payment default by or insolvency of the obligor, there shall be no acceleration of the payment required to be made under such policy unless such acceleration is at the sole option of the corporation; provided that (1) policies may insure amounts payable under a credit default swap or interest rate, currency or other swap upon a credit event or termination event if the expected amount payable on an accelerated basis in respect of any individual obligation referenced by a credit default swap or in the aggregate under an interest rate, currency or other swap does not exceed the single risk limits prescribed in paragraph five of subsection (d) of section six thousand nine hundred four of this article and (2) policies insuring credit default swaps referencing an obligation shall be treated as if the insurer had directly insured the referenced obligation for all other purposes of this article, except that the currency of amounts owed under the credit default swap, rather than the currency of the obligations referenced by the credit default swap, shall apply for purposes of determining whether the obligation is a permissible guaranty under subsection (b) of section six thousand nine hundred four of this article. The superintendent may prescribe minimum policy provisions determined by the superintendent to be necessary or appropriate to protect policyholders, claimants, obligees or indemnitees.

(b) Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition, detrimental to the solvency of the insurer, or otherwise unreasonable. In determining whether rates comply with the

foregoing standards, the superintendent shall include all income earned by such insurer. Criteria and guidelines utilized by insurers in establishing rating categories and ranges of rates to be utilized shall be filed with the superintendent for information prior to their use by the insurer if not otherwise filed prior to the effective date of this article.

(c) All such filings shall be available for public inspection at the department of financial services.

§ 6906. Reinsurance. (a) For financial guaranty insurance that takes effect on or after the effective date of this article, an insurer authorized to transact financial guaranty insurance shall receive credit for reinsurance, in accordance with the provisions of this chapter applicable to property/casualty insurers, as an asset or as a reduction from liabilities provided that such reinsurance is subject to an agreement that, for its stated term and with respect to any such reinsured financial guaranty insurance in force, the reinsurance agreement (facultative or treaty) may only be terminated or amended (i) at the option of the reinsurer or the ceding insurer, if the reinsurance agreement provides that the liability of the reinsurer with respect to policies in effect at the date of termination shall continue until the expiration or cancellation of each such policy, or (ii) with the consent of the ceding company, if the reinsurance agreement provides for a cutoff of the reinsurance in force at the date of termination, or (iii) at the discretion of the superintendent acting as rehabilitator, liquidator or receiver of the ceding or assuming insurer; and provided that such reinsurance is:

(1) placed with a financial guaranty insurance corporation licensed under this article or an insurer writing only financial guaranty insurance as is or would be permitted by this article; or

(2) placed with a property/casualty insurer or an accredited reinsurer licensed or accredited to reinsure risks of every kind or description (including municipal obligation bonds), as set forth in subsection (c) of section four thousand one hundred two of this chapter, if the reinsurance agreement with such insurer requires that such insurer:

(A) have and maintain surplus to policyholders of at least thirty-five

million dollars;

(B) establish and maintain the reserves required in section six thousand nine hundred three of this article, except that if the reinsurance agreement is not pro rata the contribution to the contingency reserve shall be equal to fifty percent of the quarterly earned reinsurance premium. However, the assuming insurer need not establish and maintain such reserve to the extent that the ceding insurer has established and continues to maintain such reserve;

(C) comply with the provisions of subsection (c) of section six thousand nine hundred four of this article, except that the maximum total exposures reinsured net of retrocessions and collateral shall be one-half of that permitted for a financial guaranty insurance corporation;

(D) if a parent of the insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer, then the aggregate of all risks assumed by such reinsurers shall not exceed ten percent of the insurer's exposures, net of retrocessions and collateral. Direct or indirect ownership interests of fifty percent or more shall be deemed a parent/subsidiary relationship;

(E) if an affiliate of the insurer, such affiliate shall not assume a percentage of the insurer's total exposures insured net of retrocessions and collateral in excess of its percentage of equity interest in the insurer; and

(F) assumes from the financial guaranty insurer and any affiliate, parent of the insurer, another subsidiary of the parent of the insurer, or subsidiary of the insurer that is a financial guaranty insurance corporation or an insurer writing only financial guaranty insurance as is or would be permitted by this article and such other kinds of insurance that a financial guaranty insurance corporation may write in this state, together with all other reinsurers subject to this paragraph, less than fifty percent of the total exposures insured by the financial guaranty insurer and such affiliates, parents or subsidiaries of the insurer, net of collateral, remaining after deducting any reinsurance placed with another financial guaranty insurance corporation that is not an affiliate, a parent of the financial guaranty insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer or a financial guaranty insurer writing only financial guaranty

insurance as is or would be permitted by this article that is not an affiliate, a parent of the financial guaranty insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer; or

(3) if placed with an unauthorized or unaccredited reinsurer which otherwise meets the requirements of either the opening paragraph of this subsection and paragraph one of this subsection, or the opening paragraph of this subsection and subparagraphs (A), (D), (E) and (F) of paragraph two of this subsection, in an amount not exceeding the liabilities carried by the ceding insurer for amounts withheld under a reinsurance treaty with such reinsurer or amounts deposited by such reinsurer as security for the payment of obligations under the treaty if such funds or deposit are held subject to withdrawal by, and under the control of, the ceding insurer.

(b) In determining whether the insurer meets the aggregate risk limitations, in addition to credit for other types of qualifying reinsurance, the insurer's aggregate risk may be reduced to the extent of the limit for aggregate excess reinsurance, but in no event in an amount greater than the amount of the aggregate risks which will become due during the unexpired term of such reinsurance agreement in excess of the insurer's retention pursuant to such reinsurance agreement.

§ 6907. Transition provisions. A licensed insurer writing financial guaranty insurance prior to the effective date of this article, but which is not authorized to write financial guaranty insurance in this state, shall be subject to all the provisions of this article, except section six thousand nine hundred two of this article, and:

(a) may, unless the superintendent determines after notice and an opportunity to be heard that such activity poses a hazard to the insurer, its policyholders or to the public, continue to write financial guaranties (except guaranties of municipal bonds) of the types authorized by subsection (b) of section six thousand nine hundred four of this article applicable to financial guaranty insurance corporations, subject to the following conditions:

(1) For a transition period not to exceed sixty months from the effective date of this article, if the insurer has and maintains surplus

to policyholders of at least seventy-five million dollars (for the purpose of this paragraph, if the insurer is a foreign insurer, its surplus to policyholders shall be computed as if it were a domestic insurer); provided that:

(A) during the sixty month transition period, the amount of surplus to policyholders needed to meet the single and aggregate risk limitations imposed by this article must be less than four percent of the insurer's surplus to policyholders;

(B) within nine months of the effective date of this article, the insurer shall file a reasonable plan of operation, acceptable to the superintendent, which shall contain:

(i) a reasonable timetable and appropriate procedures to implement that timetable to make a determination as to whether or not the insurer will make application to organize a financial guaranty insurance corporation during the aforesaid sixty month period;

(ii) the types and projected diversification of guaranties that will be issued during the transition period;

(iii) the underwriting procedures that will be followed;

(iv) oversight methods;

(v) investment policies; and

(vi) such other matters as may be prescribed by the superintendent. The plan of operation shall be deemed acceptable unless, within sixty days of its filing, the superintendent notifies the insurer of any specific objections to such plan. The plan shall be updated in the event of a material change with respect to the foregoing and at least annually;

(C) if the insurer has determined that it will not organize a financial guaranty insurance corporation, within thirty days after that determination it shall notify the superintendent, cease writing policies of financial guaranty insurance and comply with the provisions of paragraph four of this subsection; and

(D) the insurer shall file such additional statements or reports as may be required by the superintendent.

(2) For a transition period not to exceed ninety-six months from the effective date of this article, if the insurer has and maintains surplus to policyholders of at least one hundred fifty million dollars (for the purpose of this section, surplus to policyholders means the aggregate

surplus to policyholders of said insurer and other member companies of an inter-company pool, and if the insurer is a foreign insurer its surplus to policyholders shall be computed as if it were a domestic insurer) and the aggregate financial guaranty written premium of said insurer and other member companies of an inter-company pool shall have been at least one million dollars in any one of the five years ending December thirty-first, nineteen hundred eighty-eight, provided that:

(A) during the first sixty months of the transition period, the amount of surplus to policyholders needed to meet the aggregate risk limitations imposed by this article must be less than four percent of the insurer's surplus to policyholders. After such sixty month period, provided the insurer complies with subparagraph (D) of this paragraph, the amount of surplus to policyholders needed to meet such aggregate risk limitations must be less than five percent of the insurer's surplus to policyholders for the succeeding twelve month period and less than six percent for the next succeeding twenty-four month period;

(B) during the transition period, the amount of surplus to policyholders needed to meet the single risk limitations imposed by paragraphs two through five of subsection (d) of section six thousand nine hundred four of this article must be less than twenty percent of the insurer's surplus to policyholders, except that the single risk limitation with respect to investment grade obligations under such paragraph five shall be the lesser of eighty million dollars or seven percent of the insurer's surplus to policyholders;

(C) during the transition period, notwithstanding the last sentence of paragraph one of subsection (b) of section six thousand nine hundred four, industrial development bonds shall not be included in the investment grade requirements set forth in such sentence.

(D) during the transition period, reinsurance in the form of intercompany pooling agreements, shall not be subject to subparagraphs (C), (D), (E) and (F) of paragraph two of subsection (a) of section six thousand nine hundred six of this article, if such intercompany pooling agreements were in effect on January first, nineteen hundred eighty-nine, and reinsurance placed with insurers which are subject to the provisions of paragraph two of subsection (a) of section six thousand nine hundred six and are not members of the ceding company's intercompany pooling agreement may not exceed sixty percent of the total

exposures insured net of collateral remaining after deducting any reinsurance placed with another financial guaranty insurance corporation or an insurer writing only financial guaranty insurance as is or would be permitted by this article;

(E) within sixty months of the effective date of this article, the insurer shall file a reasonable plan of operation, acceptable to the superintendent, which shall contain:

(i) a reasonable timetable and appropriate procedures to implement that timetable to make a determination as to whether or not the insurer will make application to organize a financial guaranty insurance corporation during the aforesaid ninety-six month period;

(ii) the types and projected diversification of guaranties that will be issued during the transition period;

(iii) the underwriting procedures that will be followed;

(iv) oversight methods;

(v) investment policies; and

(vi) such other matters as may be prescribed by the superintendent. The plan of operation shall be deemed acceptable unless, within sixty days of its filing, the superintendent notifies the insurer of any specific objections to such plan. The plan shall be updated in the event of a material change with respect to the foregoing and at least annually;

(F) if the insurer has determined that it will not organize a financial guaranty insurance corporation, within thirty days after that determination it shall notify the superintendent, cease writing policies of financial guaranty insurance and comply with the provisions of paragraph four of this subsection; and

(G) the insurer shall file such additional statements or reports as may be required by the superintendent.

(3) For a transition period not to exceed twelve months from the effective date of this article, in the case of an insurer transacting only financial guaranty insurance prior to the effective date of this article and which qualifies for licensing as a financial guaranty insurance corporation under section six thousand nine hundred two of this article, provided that it makes application to amend its current license to that of a financial guaranty insurance corporation licensed to transact only those kinds of insurance permitted pursuant to section

six thousand nine hundred two of this article within sixty days of the effective date of this article, and provided that, for purposes of this paragraph, an insurer shall be deemed to be transacting only financial guaranty insurance prior to the effective date of this article if, with the approval of the superintendent, it has reinsured all of any other insurance liabilities with one or more authorized insurers or has otherwise made provision for such liabilities.

(4) For a transition period not to exceed nine months, in the case of an insurer that does not qualify under either paragraph one, two or three of this subsection or does not file a plan of operation pursuant to paragraph one or two of this subsection, such insurer shall cease writing any new financial guaranty insurance business and may:

(A) reinsure its net in force business with a licensed financial guaranty insurance corporation; or

(B) subject to the prior approval of its domiciliary commissioner, reinsure all or part of its net in force business in accordance with the requirements of paragraph two of subsection (a) of section six thousand nine hundred six of this article, except that subparagraphs (D), (E) and (F) of paragraph two of such subsection shall not be applicable. The assuming insurer shall maintain reserves of such reinsured business in the manner applicable to the ceding insurer under this paragraph; or

(C) thereafter continue the risks then in force and, with thirty days prior written notice to its domiciliary commissioner, issue new financial guaranty policies, provided that the issuing of such policies is reasonably prudent to mitigate either the amount of or possibility of loss in connection with business transacted prior to the effective date of this article. Provided, however, an insurer must receive the prior approval of its domiciliary commissioner before issuing any new financial guaranty insurance policies that would have the effect of increasing its risk of loss;

(b) shall, for all guaranties in force prior to the effective date of this article, including those which fall under the definition of financial guaranty insurance contained in subsection (a) of section six thousand nine hundred one of this article, be subject to the reserve requirements applicable for municipal bond guaranties in effect prior to the effective date of this article. To the extent that the insurer's contingency reserves maintained as of the effective date of this article

are less than those required for municipal bond guaranties, the insurer shall have three years to bring its reserves into compliance, except that a part of the reserve may be released proportional to the reduction in aggregate net liability resulting from reinsurance, provided that the reinsurer shall, on the effective date of the reinsurance, establish a reserve in an amount equal to the amount released and, in addition, a part of the reserve may be released with the approval of the superintendent upon demonstration that the amount carried is excessive in relation to the corporation's outstanding obligations; and

(c) shall be subject to the reserve requirements specified in section six thousand nine hundred three of this article for all policies of financial guaranty insurance issued on or after the effective date of this article.

§ 6908. Applicability of other laws. An insurer issuing policies of financial guaranty insurance shall be subject to all of the provisions of this chapter applicable to property/casualty insurers to the extent that such provisions are not inconsistent with the provisions of this article.

§ 6909. Relationship to security fund. No insurer or agent of an insurer may deliver a policy of financial guaranty insurance unless such policy and any prospectus delivered on or after the effective date of this article with respect to the insured obligations clearly discloses that the policy is not covered by the property/casualty insurance security fund specified in article seventy-six of this chapter.

ARTICLE 70

CAPTIVE INSURANCE COMPANIES

Section 7001. Purpose and applicability.
7002. Definitions.
7003. License; power; filing; fees.
7004. Required capital and surplus as regards policyholders.
7005. Organization and corporate procedure.

7006. Annual report.
7007. Examinations.
7008. Suspension or revocation of license.
7009. Investments.
7010. Reinsurance.
7011. Exemption from compulsory associations.
7012. Franchise taxes.

§ 7001. Purpose and applicability. (a) The purpose of this article is to facilitate the formation and operation of captive insurance companies within the state of New York.

(b) In addition to the provisions of this article and this chapter specifically referred to in this article, the following provisions of this chapter shall apply to captive insurance companies:

(1) article one of this chapter, pertaining to general provisions;

(2) sections three hundred one, three hundred six, three hundred eight, three hundred ten, three hundred eleven, three hundred twelve and three hundred twenty-nine of this chapter and sections two hundred six, three hundred three, three hundred four, three hundred five, three hundred six, three hundred eight, and three hundred nine of the financial services law, pertaining to certain administrative and procedural provisions; and

(3) article seventy-four of this chapter, pertaining to rehabilitation, liquidation, conservation and dissolution of insurers.

§ 7002. Definitions. In this article: (a) "Affiliated companies" means companies in the same corporate system as an industrial insured by virtue of common ownership, control, operation, or management. Such term shall also include any statutory subsidiary, affiliate, contractor, subcontractor and consultant of any tier of a city with a population of one million or more for liability related to or arising out of activities in or near the World Trade Center site in response to the attacks of September eleventh, two thousand one.

(b) "Captive insurance business" means the business authorized pursuant to subsection (a) of section seven thousand three of this

article.

(c) "Captive insurance company" means any pure captive insurance company or any group captive insurance company licensed to do a captive insurance business under the provisions of this article.

(d) "Captive manager" means any person or firm contracted by a captive insurance company to manage its affairs.

(e) "Industrial insured" means an insured:

(1) whose net worth exceeds one hundred million dollars;

(2) who is a member of a holding company system whose net worth exceeds one hundred million dollars;

(3) who is the metropolitan transportation authority and its statutory subsidiaries. When filing an application to form a pure captive insurance company the metropolitan transportation authority shall submit written notice of such filing to the governor, the temporary president of the senate and the speaker of the assembly;

(4) who is the power authority of the state of New York and any statutory subsidiary thereof. When filing an application to form a pure captive insurance company the power authority shall submit written notice of such filing to the governor, the temporary president of the senate and the speaker of the assembly;

(5) who is the New York convention center operating corporation, or any statutory subsidiary thereof formed pursuant to section twenty-five hundred sixty-four of the public authorities law. When filing an application to form a pure captive insurance company, the corporation shall submit written notice of such filing to the governor, the temporary president of the senate and the speaker of the assembly; or

(6) who is a city with a population of one million or more. When filing an application to form a pure captive insurance company, a city with a population of one million or more shall submit written notice of such filing to the governor, the temporary president of the senate and the speaker of the assembly.

(f) "Group captive insurance company" means any domestic insurance company licensed under the provisions of this article for the primary purpose of providing insurance or reinsurance covering the risks of the industrial insureds that comprise the industrial insured group.

(g) "Industrial insured group" means any group of unaffiliated industrial insureds that are engaged in similar or related businesses or

activities, however, the metropolitan transportation authority, the power authority of the state of New York, the New York convention center operating corporation and any statutory subsidiary thereof and cities with a population of one million or more shall not be a member of an industrial insured group, and that collectively:

(1) own, control or hold with power to vote all of the outstanding voting shares of stock of a group captive insurance company incorporated as a stock insurer; or

(2) represent one hundred percent of the voting members of a group captive insurance company organized as a mutual insurer.

(h) "Pure captive insurance company" means any company that:

(1) is a subsidiary of an industrial insured which is one hundred percent owned by or is a statutory subsidiary of the industrial insured; and

(2) is licensed under the provisions of this article for the primary purpose of providing insurance or reinsurance covering the risks of its parent and affiliated companies.

§ 7003. License; power; filing; fees. (a) Any captive insurance company, when permitted by its articles of association or charter, shall apply to the superintendent for a license to do a captive insurance business under this article. A captive insurance business consists of the kinds of insurance set forth in section one thousand one hundred thirteen and section one thousand one hundred fourteen of this chapter, provided that:

(1) a pure captive insurance company shall insure, on a primary basis, only risks of its parent and affiliated companies;

(2) a group captive insurance company shall insure, on a primary basis, only risks of the industrial insureds that comprise the industrial insured group;

(3) a pure captive insurance company or a group captive insurance company shall not be authorized to provide, on a primary basis or as reinsurance, the kinds of insurance specified in paragraphs one, two, three, eighteen, twenty-three and twenty-five of subsection (a) of section one thousand one hundred thirteen of this chapter;

(4) a pure captive insurance company or a group captive insurance

company shall not be authorized to provide, on a primary basis:

(A) workers' compensation and employers' liability insurance; or

(B) any other kind of insurance, including motor vehicle liability insurance, that is required, under the laws of this state or any political subdivision of this state, as a demonstration of financial responsibility for obtaining a license or permit to undertake specific activities when such requirement must be satisfied by obtaining insurance coverage from an insurer authorized in this state, up to the minimum amount of insurance so required under such laws; and

(C) except that subparagraphs (A) and (B) of this paragraph shall not prohibit a pure captive insurance company from providing primary indemnity coverage to its parent and affiliated companies for any insurance or self-insurance program specified in such subparagraphs (A) or (B), provided the insurance or self-insurance program has qualified under the applicable state or federal law requiring the program; and

(5) a pure captive insurance company or a group captive insurance company shall reinsure only risks as set forth in section seven thousand ten of this article.

Notwithstanding any inconsistent provisions of paragraphs one through five of this subsection, a pure captive insurance company formed by a city with a population of one million or more may insure or provide reinsurance for its parent, statutory subsidiaries and affiliated companies only for liability related to or arising out of activities in or near the World Trade Center site in response to the attacks of September eleventh, two thousand one.

(b) No captive insurance company shall do any captive insurance business in this state unless:

(1) it first obtains from the superintendent a license authorizing it to do captive insurance business in this state;

(2) its board of directors holds at least one meeting each year in this state;

(3) it maintains its principal office and its records in this state;

(4) it utilizes a captive manager resident in this state who is:

(A) licensed as an agent or a broker under the provisions of article twenty-one of this chapter; or

(B) any other person approved by the superintendent provided that the

approval may be withdrawn by the superintendent, upon notice and hearing, if the person has:

(i) been guilty of fraudulent or dishonest practices; or

(ii) demonstrated incompetency or untrustworthiness to act in such a capacity; and

(5) it submits a power of attorney, in accordance with the provisions of section one thousand two hundred twelve of this chapter, designating the superintendent as its agent for the purpose of receiving service of process in any proceeding against it.

(c)(1) Before receiving a license to do a captive insurance business, a captive insurance company shall file an application for license with the superintendent for review and approval. Such application shall include a certified copy of its charter and bylaws, a financial statement certified by two principal officers, a plan of operation, which shall include an actuarial report prepared by a qualified independent actuary, and any other statements or documents required by the superintendent.

(2) In evaluating the plan of operation, the superintendent shall consider the following factors:

(A) the amount and liquidity of its assets relative to the risks to be assumed;

(B) the adequacy of the expertise, experience, and character of the person or persons who will manage it;

(C) the overall soundness of the plan and the projections contained therein;

(D) the adequacy of the loss prevention programs of its parent, member organizations, or industrial insureds as applicable; and

(E) such other factors deemed relevant by the superintendent in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(3) Any material filed with the superintendent pursuant to this subsection shall be given confidential treatment and shall not be subject to public inspection under article six of the public officers law, or to discovery under article thirty-one of the civil practice law and rules, except to the extent the superintendent finds release of information necessary to protect the public or necessary to initiate any proceeding or action as provided by this article or except where a court

of competent jurisdiction in an action involving a private litigant and a captive insurer finds that discovery of same should be allowed upon a showing that such information is essential to the establishment of the claim or defense brought or asserted and the party seeking discovery has demonstrated to the satisfaction of the court that such party is unable to otherwise obtain the substantial equivalent of the material.

(4) In order to provide for the review of the application submitted pursuant to this subsection in a timely manner, the superintendent may engage such other qualified persons and services as may be necessary. Prior to retaining any such persons and services, the superintendent shall notify the applicant and provide an estimate of the cost of such services. The superintendent shall recover such costs in the manner prescribed in subsection (f) of section two hundred six of the financial services law.

(5) In the case of a pure captive insurance company formed by a city with a population of one million or more to insure such city and its affiliated companies for liability related to or arising out of activities in or near the World Trade Center site in response to the attacks of September eleventh, two thousand one, the superintendent, in addition to the provisions set forth in paragraph two of this subsection, shall consider such factors as the unique risk insured by such captive and the source and limits of the premium payments along with any limitations on the acceptance of claims and the payment of accepted claims so long as such limitations provide an equitable basis for the allocation of the assets of such company to pay claims.

(d) Any proposed amendments or revisions to the charter and bylaws of a captive insurance company shall be filed with the superintendent for review and approval.

(e) If the superintendent is satisfied that the documents and statements filed by the captive insurance company comply with the provisions of this article, a license authorizing it to do a captive insurance business in this state shall be issued for a term expiring on June thirtieth. Thereafter, the superintendent may issue a renewal license for successive one year terms expiring on June thirtieth.

§ 7004. Required capital and surplus as regards policyholders. (a)

No pure captive insurance company or group captive insurance company shall be issued a license unless it shall possess and thereafter maintain unimpaired paid-in capital and surplus as regards policyholders of:

(1) in the case of a pure captive insurance company incorporated as a stock insurer, not less than two hundred fifty thousand dollars of total surplus as regards policyholders, of which one hundred thousand dollars shall represent paid-in capital;

(2) in the case of a pure captive insurance company incorporated as a mutual insurer, not less than two hundred fifty thousand dollars of total surplus as regards to policyholders;

(3) in the case of a group captive insurance company incorporated as a stock insurer, not less than five hundred thousand dollars of total surplus as regards policyholders, of which two hundred thousand dollars shall represent paid-in capital; and

(4) in the case of a group captive insurance company incorporated as a mutual insurer, not less than five hundred thousand dollars of total surplus as regards policyholders.

(b) The minimum capital and surplus to policyholders required in subsection (a) of this section shall be in the form of:

(1) cash;

(2) minimum capital or surplus to policyholders investments of the type specified in paragraphs one and two of subsection (b) of section one thousand four hundred two of this chapter; or

(3) an irrevocable letter of credit, in a form approved by the superintendent, naming the superintendent as beneficiary for the security of the captive insurance company's policyholders and issued by a bank acceptable to the superintendent.

(c) The superintendent may prescribe additional capital and surplus to policyholders based upon the type, volume and nature of insurance business transacted. Any additional capital and surplus to policyholders so required shall be in the form as set forth in subsection (b) of this section.

§ 7005. Organization and corporate procedure. (a) A pure captive insurance company may be incorporated (1) as a stock insurer with its

capital divided into shares and held by the stockholders; or (2) as a mutual insurer without capital stock, the governing body of which is appointed by the parent industrial insured; or (3) in the case of a public benefit corporation, public authority or other public entity, as the applicable state law may require. In the case of a city with a population of one million or more, a pure captive insurance company also may be formed as a public benefit corporation or not-for-profit corporation at the discretion of the mayor of such city, for the purpose of providing insurance that is retroactive to September eleventh, two thousand one, for risks incurred by such city and its affiliated companies related to or arising out of activities in or near the World Trade Center site in response to the attacks of September eleventh, two thousand one. Such pure captive insurance company formed by a city with a population of one million or more shall be exempt from all state and local taxes. The members or directors, as the case may be, of such pure captive insurance company shall be appointed by the mayor of such city or by such other city official as the mayor may designate. Neither the mayor of such city, nor any of the captive's members, directors, officers, employees or agents appointed by or with the approval of such city, nor any officials, officers, employees or agents of the city, while acting within the scope of their authority, shall be subject to any personal liability resulting from the exercise or carrying out of any of the city's or captive's purposes or powers under this article.

(b) A group captive insurance company may be incorporated:

(1) as a stock insurer with its capital divided into shares and held by the stockholders, or

(2) as a mutual insurer without capital stock, the governing body of which is elected by the member organizations of the industrial insured group.

(c) The proposed incorporators shall submit to the superintendent the company's proposed charter, which shall contain:

(1) the corporation's name, which shall not be the same as, deceptively similar to, or likely to be confused with or mistaken for any other existing business name registered in this state;

(2) the kind of insurance business to be transacted;

(3) the place where the principal office is to be located;

(4) the number of directors;

(5) the amount of its capital, if a stock corporation; and

(6) any other particulars necessary to explain the corporation's objectives, management and control.

(d) The charter and any organization fee shall be transmitted to the attorney general, who shall record the charter.

(e) The recorded charter shall be filed in the superintendent's office and a certified copy shall be issued to the incorporators.

(f) The capital stock of a captive insurance company incorporated as a stock insurer shall be issued at not less than par value.

(g) The board of directors of a captive insurance company incorporated in this state shall have at least three members, with at least two of the members required to be residents of this state.

(h) The provisions of article seventy-one of this chapter shall apply in determining the procedures to be followed by captive insurance companies in carrying out any of the transactions described therein, except the superintendent may waive or modify the requirements in accordance with rules or regulations which the superintendent shall adopt addressing such categories of transactions.

(i) The articles of incorporation or bylaws of a captive insurance company shall authorize a quorum of a board of directors to consist of no fewer than one-third of the fixed number of directors.

§ 7006. Annual report. Every captive insurance company licensed to do a captive insurance business in this state shall file with the superintendent:

(a) annually on or before March first, a statement of its financial condition and any amendment to the plan of operation at last year-end, verified by the oath of at least two of its executive officers. The statement shall be in the form prescribed by the superintendent; and

(b) annually on or before July first, a report of its financial condition at last year-end with an opinion of an independent certified public accountant; and

(c) annually on or before July first, evidence in a form prescribed by the superintendent, that the industrial insured or member of the industrial insured group owning the captive insurance company continues to meet the financial standards set forth in subsection (e) of section

seven thousand two of this article.

§ 7007. Examinations. The superintendent may make an examination into the affairs of any captive insurance company licensed to do a captive insurance business in this state whenever it is deemed necessary for the protection of the interests of the people of this state but the superintendent shall conduct at least one examination every five years. Such examinations shall be conducted in accordance with the provisions of sections three hundred ten, three hundred eleven, three hundred twelve of this chapter and subsection (f) of section two hundred six of the financial services law.

§ 7008. Suspension or revocation of license. (a) The license of a captive insurance company to do a captive insurance business in this state may be suspended or revoked by the superintendent for any of the following reasons:

(1) insolvency or impairment of required capital or surplus to policyholders;

(2) refusal or failure to submit an annual report, as required by section seven thousand six of this article, or any other report or statement required by law or by lawful order of the superintendent;

(3) failure to comply with the provisions of its own charter or bylaws;

(4) failure to submit to examination or any legal obligation relative thereto, as required by section seven thousand seven of this article;

(5) refusal or failure to pay the cost of examination as required by section seven thousand seven of this article;

(6) refusal or failure to pay the taxes as required by section seven thousand twelve of this article and section fifteen hundred two-b of the tax law;

(7) removal of home office or records from this state;

(8) use of practices that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders; or

(9) failure to otherwise comply with laws of this state.

(b) If the superintendent finds, upon examination, hearing, or other investigation, that any captive insurance company has committed any of the acts specified in subsection (a) of this section, the license to do a captive business may be suspended or revoked. In addition, the license to do a captive business may be suspended or revoked if it is deemed to be in the best interests of the public and the policyholders of such captive insurance company, notwithstanding any other provision of this article.

§ 7009. Investments. (a) No captive insurance company shall be subject to any restrictions on allowable investments, except as set forth in subsections (b) and (c) of this section.

(b) A group captive insurance company shall not make loans to the industrial insureds that comprise its industrial insured group. A pure captive insurance company may make loans to its parent company or affiliates with the prior approval of the superintendent. Such loan must be evidenced by a note in a form approved by the superintendent. Loans of minimum capital and surplus funds required by section seven thousand four of this article are prohibited.

(c) The superintendent may prohibit or limit any investment that threatens the solvency or liquidity of any captive insurance company.

§ 7010. Reinsurance. (a) Any captive insurance company may assume reinsurance on risks ceded by any other insurer when the risks ceded under the reinsurance agreement are solely those of the industrial insured or members of industrial insured group owning the captive insurance company.

(b) With the approval of the superintendent, any captive insurance company may assume risks of any other insurer, provided the reinsurance premiums assumed do not exceed fifty percent of the assuming captive insurance company's gross premiums written in any calendar year.

(c) Any captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers complying with the provisions of paragraph nine of subsection (a) of section one thousand three hundred one and section one thousand three hundred eight of this

chapter. Prior approval of the superintendent shall be required for ceding or taking credit for reserves on risks or portions of risks ceded to reinsurers not complying with these sections.

§ 7011. Exemption from compulsory associations. No captive insurance company shall be permitted to join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this state, nor shall any captive insurance company, or its insured, or its parent or any affiliated company, or any member organization of its association, receive any benefit from any such plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

§ 7012. Franchise taxes. Captive insurance companies licensed to do a captive insurance business shall be liable for the payment of franchise taxes in accordance with section fifteen hundred two-b of the tax law.

ARTICLE 71
MERGER, CONSOLIDATION, REDOMESTICATION, ACQUISITION OF ASSETS AND ACQUISITION OF CERTAIN SHARES OF INSURERS

Section 7101. Definitions.
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7106. Merger or consolidation between domestic and foreign companies; certificate of approval.
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7119. Appraisal of shares of dissenting shareholder on merger or consolidation of domestic company or on acquisition of minority interests in a subsidiary insurer.
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7121. Effects upon guaranty corporations of certain events.

§ 7101. Definitions. In this article:

(a) "Merger" means the merger of two or more companies in a single company which is one of the constituent companies.

(b) "Consolidation" means the consolidation of two or more companies into a single new company.

(c) "Constituent company" means an existing company that is participating in the merger or consolidation with one or more other companies.

(d) "Surviving company" means the constituent company into which one or more other constituent companies are merged.

(e) "Consolidated company" means the new company into which two or more constituent companies are consolidated.

(f) "Company" means an insurance company.

(g) "Acquisition of assets" and "acquire the assets of", means the acquisition through the purchase or otherwise of all or substantially all of the assets of a domestic company or of any company by a domestic company.

§ 7102. Merger, consolidation and acquisition of assets; when permitted. (a) Upon complying with this article and subject to section seven thousand one hundred nine of this article, any domestic company is hereby authorized and empowered to:

(1) consolidate, merge with or acquire the assets of any other domestic company, and

(2) consolidate or merge with any foreign company which is authorized to do an insurance business in this state or acquire the assets of any foreign company if such merger, consolidation or acquisition of assets is authorized by the laws of the state in which such foreign company is organized.

(b) A stock company may merge or consolidate with another stock company or a reciprocal insurer, but shall not merge or consolidate with a mutual company; provided, however, a domestic mutual life insurance company may merge with a wholly-owned subsidiary stock life insurance company of the said domestic mutual life insurance company in circumstances in which the said domestic mutual life insurance company shall be the surviving company. A reciprocal insurer may merge with a stock company.

(c) A proposed consolidation shall not be approved unless the consolidated company has the capital, surplus, or surplus to policyholders which a similar company would be required to maintain if initially licensed to write the same kinds of insurance on the date of the consolidation.

§ 7103. Content of merger or consolidation agreement, and of charter of surviving or consolidated company. (a) Any agreement for merger or consolidation shall contain the proposed charter of the surviving or consolidated company and such other particulars as may be necessary to explain and make manifest the objects and purposes of the surviving or consolidated company and the manner in which it is to be conducted. Such company may be given the name of one or more of the constituent companies, which name shall, however, comply with subsection (g) of section one thousand one hundred two of this chapter. The approval of such agreement by the superintendent shall constitute an approval of such proposed charter.

(b) The proposed charter shall conform to all requirements of paragraph five of subsection (a) of section one thousand two hundred one of this chapter.

(c) If the surviving or consolidated company shall be a stock company, its charter shall provide that its capital shall be no larger than the sum of the capital of the constituent companies.

§ 7104. Company approval of merger or consolidation agreement. (a) When any domestic company shall propose to enter into an agreement of merger or consolidation, the board of directors, trustees or other governing body shall, except as provided by section seven thousand one hundred seven of this article, submit the question of such agreement to the shareholders or members as the case may be at a meeting thereof, by causing a copy of such proposed agreement or a summary thereof approved by the superintendent, together with notice, stating the time, place and purpose of such meeting, to be delivered personally, or deposited in the post office, postage prepaid at least thirty days, unless a shorter time not less than ten days, be approved by the superintendent, prior to the time fixed for such meeting, addressed to each shareholder or member, as the case may be, at his address of record. However, a domestic mutual company may give notice by publication in a newspaper of general circulation in the county in which the company has its principal office and in either of the two largest cities in each state in which the company shall be licensed to do business, provided, however, that a full, true and correct copy of such proposed agreement, or a summary thereof approved by the superintendent, shall be included in such notice.

(b) At any such meeting, the shareholders or members may vote in person or by proxy, each shareholder to be entitled to one vote for each share held by him and each member shall be entitled to such number of votes as may be provided for in the by-laws of the company; and votes representing two-thirds of all the shares in the case of purely stock companies, or votes representing two-thirds of all the shares, if any, and votes representing two-thirds of all the votes cast by members represented at the meeting in person or by proxy in the case of other companies, shall be necessary for the adoption of such proposed

agreement.

(c) In effecting a merger of a reciprocal insurer with a stock company subscribers of reciprocals shall be deemed shareholders in proportion to their respective interests in the reciprocal insurer's surplus to policyholders.

(d) Notwithstanding any other law, in circumstances in which a domestic mutual life insurance company is merging with a wholly-owned subsidiary stock life insurance company as provided in subsection (b) of section seven thousand one hundred two of this article, in lieu of the provisions set forth in subsection (a) of this section, the directors or trustees of such domestic mutual life insurance company and such wholly-owned subsidiary stock life insurance company may authorize the officers of such companies to adopt a merger agreement between them by a majority vote of their respective boards at meetings held not less than thirty days after notice of the proposed agreement has been given to such directors or trustees.

§ 7105. Approval by superintendent. (a) Upon the adoption of an agreement of merger or consolidation, or an agreement for the acquisition of assets, the proposed agreement shall be executed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of each of the constituent or contracting companies. A certified copy of such agreement, together with a certificate of its adoption as provided for herein, subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of their respective companies, shall be submitted to the superintendent for his approval. The superintendent shall thereupon consider such agreement, and if satisfied that it complies with this article, is fair and equitable, does not tend to substantially lessen competition in any line of insurance or tend to create a monopoly therein, and is not inconsistent with law, he shall approve such agreement. If the superintendent shall refuse to approve such agreement, notification of such refusal, assigning the reasons therefor, shall within thirty days from the date of submission to him of such agreement be given in writing by the superintendent to each of the constituent or contracting companies. No agreement shall take effect unless the

approval of the superintendent has been obtained.

(b) In the event any domestic life insurance company submits to the superintendent for his approval an agreement of merger or consolidation pursuant to this section, the superintendent may extend the five year interval for examination prescribed by section three hundred nine of this chapter for an additional one year interval.

§ 7106. Merger or consolidation between domestic and foreign companies; certificate of approval. (a) In case of a merger or consolidation between a domestic and a foreign company, the agreement of merger or consolidation shall be executed by the proper officers of said foreign company when they are duly authorized thereto by such action on the part of the directors, shareholders or members of said foreign company as may be required by the laws of the state where the same is incorporated; and if required by such laws, said agreement of merger or consolidation shall be submitted to the superintendent or other insurance supervisory official of the state in which such foreign company is incorporated and no such merger or consolidation shall take effect until it shall have been approved by the superintendent of this state, and, if required as aforesaid, by such insurance official of the state where said foreign company is incorporated, as evidenced by a certificate of his approval, filed in the office of the superintendent of this state.

(b) No such merger or consolidation between a domestic and foreign company shall take effect, unless and until the surviving or consolidated company, if such company is a foreign company, shall file with the superintendent of this state a power of attorney in compliance with section one thousand two hundred twelve of this chapter.

§ 7107. Expedited approval; mutual property/casualty insurance companies. If in the judgment of the superintendent the interests of the policyholders require it, a domestic mutual property/casualty insurance company may, after obtaining the tentative approval of the superintendent and subject to his final approval, enter into an agreement of merger or consolidation with an authorized assuming mutual

property/casualty insurance company, upon the adoption of such agreement by the boards of directors of such companies at special meetings called for the purpose upon at least ten days notice. Upon the execution of such agreement, notice thereof, in a form approved by the superintendent, shall immediately be mailed to the policyholders of both companies. If within thirty days after such notice five percent or more of the policyholders of either company, determined as of the date of mailing such notice, shall file with the superintendent their objections to such agreement, the superintendent shall call a hearing thereon upon such notice as the superintendent shall deem advisable. If upon such hearing the superintendent shall find that the terms of such agreement are not fair and reasonable to the policyholders and creditors affected thereby, the superintendent may withdraw his tentative approval of such agreement which shall thereupon become null and void. If the superintendent finally approves such agreement, the other provisions of this article, except sections seven thousand one hundred four, seven thousand one hundred five and seven thousand one hundred nineteen of this article, shall be applicable to such merger or consolidation.

§ 7108. Filing of agreement of merger or consolidation. A duplicate or certified copy of the agreement of merger or consolidation with the approval of the superintendent endorsed thereon shall be filed in the office of the clerk of the county where the principal office of each domestic constituent company is located and upon such filing, if all other requirements have been fulfilled, such merger or consolidation shall become effective.

§ 7109. Limitation on enlargement of powers. This article shall not enlarge the charter powers of any company except in conformity with the provisions of the proposed charter of the surviving or consolidated company as provided in section seven thousand one hundred three of this article, nor authorize any company to do any kind of insurance business not authorized by its charter, nor authorize any foreign or alien company to do any kind of insurance business in this state not authorized by its license or certificate of authority to do business in

this state.

§ 7110. Fees; certification; prohibitions; penalty. (a) Whenever an agreement of consolidation or merger or for the acquisition of assets, or a plan for acquisition of minority interests in a subsidiary insurer as provided in section seven thousand one hundred eighteen of this article, shall be filed with the superintendent, there shall also be filed with him a certificate executed by the president and attested by the secretary, or by officers corresponding to either of them, under the corporate seal of each of the constituent or contracting companies, or of the parent corporation and subsidiary insurer, and subscribed by such officers and affirmed by them as true under the penalties of perjury, setting forth all fees, commissions or other compensations or valuable considerations paid or to be paid, directly or indirectly, to any person, firm or corporation, for in any manner securing, aiding, promoting or assisting in any such consolidation, merger or acquisition of assets or minority interests.

(b) No director, officer or member of any such company or of any parent corporation or subsidiary insurer, except as fully expressed in the agreement of consolidation or merger or for the acquisition of assets or in the plan for acquisition of minority interests in a subsidiary insurer, shall receive any fee, commission, other compensation or valuable consideration, directly or indirectly, for in any manner aiding, promoting or assisting in such consolidation, merger, or acquisition of assets or minority interests.

(c) Any person violating the provisions of subsection (a) hereof or knowingly making any false certificate or statement pursuant thereto, shall be guilty of a felony.

§ 7111. Proof of proceedings of meeting and action of company. A certified copy of the proceedings of any meeting made by the secretary thereof or of the action of any company made by the secretary of such company, subscribed and affirmed by him as true under the penalties of perjury, shall be presumptive evidence of the holding of the meeting and the action of such meeting and the action of such company.

§ 7112. Vesting of property in surviving or consolidated company; assumption of liabilities. Upon the merger or consolidation of any companies in the manner herein provided, all the rights, franchises and interests of the constituent companies, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed as transferred to and vested in the surviving or consolidated company, without any other deed or transfer; and simultaneously therewith such surviving or consolidated company shall be deemed to have assumed all of the liabilities of the constituent companies.

§ 7113. Transfer of deposits to surviving or consolidated company. If any constituent company in a merger or consolidation under the provisions of this article shall have on deposit with the superintendent securities held for the benefit and protection of all of its policyholders or policyholders and creditors within the United States, the superintendent is authorized, upon the completion of such merger or consolidation, to transfer residuary interest in such deposit of such constituent company to the surviving or consolidated company, and to release such deposit or any part thereof if no longer required of such surviving or consolidated company under the provisions of this chapter.

§ 7114. Pending actions. No action or proceeding, pending at the time of the merger or consolidation to which either of the constituent companies may be a party, shall be abated or discontinued by reason of such merger or consolidation, but the same may be prosecuted to final judgment in the same manner as if the merger or consolidation had not taken place; or the continuing or consolidated company, may be substituted in the place of such constituent company by order of the court in which the action or proceeding may be pending.

§ 7115. Shareholders' liability. The shareholders of a stock company

merging or consolidating shall continue subject to all the liabilities, claims and demands existing against them as such at or before such merger or consolidation.

§ 7116. Liability of members of assessment company to continue. In case of a merger or consolidation of assessment companies the liability of members thereof to assessments shall continue and be transferred to the surviving or consolidated company.

§ 7117. Return of shares of constituent company. A surviving or consolidated company may require the return of the original certificates of stock held by each shareholder in each constituent company, and issue in lieu thereof new certificates for such number of its own shares as such shareholder may be entitled to receive.

§ 7118. Plan for acquisition of minority interests in a subsidiary insurer. (a) Definitions. In this section:

(1) "Parent" means a corporation directly or indirectly owning at least ninety-five percent of the aggregate issued and outstanding shares of all classes of voting shares of a subsidiary.

(2) "Subsidiary" means a domestic company whose voting shares are so owned.

(b) Any parent or subsidiary may, pursuant to a plan for acquisition of minority interests in such subsidiary, adopted by the board of directors, trustees or other governing body of the parent or subsidiary, acquire all of the subsidiary's remaining issued and outstanding voting shares, by exchange of shares, other securities, cash, other consideration or any combination thereof.

(c) Such plan shall set forth:

(1) the name of the subsidiary;

(2) the total number of issued and outstanding voting shares of each class of the subsidiary, the number of its shares owned by the parent and, if either of the foregoing is subject to change prior to the effective date of acquisition, the manner in which any change may occur;

(3) the terms and conditions of the plan, including the manner and basis of exchanging the shares to be acquired for shares or other securities of the parent, for cash, other consideration, or any combination of the foregoing, the proposed effective date of acquisition and a statement clearly describing the rights of dissenting shareholders to demand appraisal;

(4) if the parent has adopted the plan and is neither a domestic corporation nor an authorized insurer, its agreement to be bound by section seven thousand one hundred nineteen of this article with respect to the plan, its consent to the enforcement against it in this state of the rights of shareholders pursuant to the plan, and a designation of the superintendent as the agent upon whom process may be served against the parent in the manner set forth in section one thousand two hundred twelve of this chapter in any action or proceeding to enforce any such rights; and

(5) such other provisions with respect to the plan as the board of directors, trustees or other governing body deems necessary or desirable, or which the superintendent may prescribe.

(d) Upon adoption of the plan, it shall be executed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of the parent or subsidiary which has adopted the plan, as the case may be. Thereupon, a certified copy of the plan, together with a certificate of its adoption subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of the parent or the subsidiary, as the case may be, shall be submitted to the superintendent for his approval. The superintendent shall thereupon consider the plan and, if satisfied that it complies with this article, is fair and equitable and not inconsistent with law, he shall approve the plan. If the superintendent disapproves the plan, notification of his disapproval, assigning the reasons therefor, shall be given in writing by him to the parent or subsidiary that submitted the plan. No plan shall take effect unless the approval of the superintendent has been obtained.

(e) If the superintendent approves the plan, the parent or the subsidiary which has adopted the plan shall deliver to each person who, as of the date of delivery, is a holder of record of shares to be acquired, a copy of the plan, or a summary thereof approved by the

superintendent, in person or by depositing the same in the post office, postage prepaid, addressed to the shareholder at his address of record. On or before the date of acquisition proposed in the plan, the parent or the subsidiary which has adopted the plan shall file with the superintendent a certificate, executed by its president and attested by its secretary, or by officers corresponding to either of them, and subscribed by such officers and affirmed by them as true under the penalties of perjury, and under the seal of the parent or the subsidiary, as the case may be, attesting to compliance with this subsection.

(f) Upon compliance with this section, ownership of the shares to be acquired pursuant to the plan shall vest in the parent or the subsidiary which has adopted the plan on the date of acquisition proposed in the plan whether or not the certificates for such shares have been surrendered for exchange. If the plan was adopted by the parent it shall be entitled to have new certificates registered in its name. If the plan was adopted by the subsidiary the shares shall be retired and the capital of the subsidiary reduced by the par value of the retired shares. Shareholders whose shares have been so acquired shall thereafter retain only the right either to receive the consideration to be paid in exchange for their shares pursuant to the plan or to demand appraisal pursuant to section seven thousand one hundred nineteen of this article.

(g) Neither the right granted by this section nor the exercise thereof by a parent or subsidiary shall preclude the exercise by it of any other rights it may have under this article.

§ 7119. Appraisal of shares of dissenting shareholder on merger or consolidation of domestic company or on acquisition of minority interests in a subsidiary insurer. (a) A shareholder of a domestic company, by complying with section six hundred twenty-three of the business corporation law except as otherwise provided in subsections (b) and (c) hereof, shall have the right to receive payment for the fair value of his shares, and such other rights and benefits as are provided by such section of the business corporation law, in the following cases:

(1) a shareholder entitled to vote who does not assent to the taking of any action specified in section seven thousand one hundred two of

this article; or

(2) a shareholder whose shares are acquired pursuant to section seven thousand one hundred eighteen of this article.

(b) A shareholder who elects to dissent from an acquisition proposed under section seven thousand one hundred eighteen of this article shall, in lieu of the procedures set forth in paragraphs (a), (b) and (c) of section six hundred twenty-three of the business corporation law, file a written notice of his election to dissent with the parent within twenty days after the delivery to him of either a copy of the plan or a summary thereof pursuant to subsection (e) of section seven thousand one hundred eighteen of this article.

(c) For purposes of this section, the provisions of section six hundred twenty-three of the business corporation law, other than paragraphs (i) and (m) thereof, are applicable except that:

(1) the references to "this chapter" in paragraph (a) of such section of the business corporation law are deemed to refer to this article;

(2) in the case of shares acquired pursuant to section seven thousand one hundred eighteen of this article, the references to "shareholders' authorization date" in paragraph (g) of such section of the business corporation law are deemed to refer to the date of delivery of the plan or a summary thereof as provided in subsection (e) of section seven thousand one hundred eighteen of this article; and

(3) upon payment of the value of the shares of a shareholder who has dissented from a merger or consolidation, as provided in paragraph (g) or (h) of such section of the business corporation law, the shares shall be cancelled.

§ 7120. Redomestication of foreign insurance companies. (a) Definitions. In this section:

(1) "Redomestication" means the transfer to this state of the corporate domicile of an authorized foreign company, as provided for in this section.

(2) "Transferring company" means any authorized foreign company seeking redomestication.

(b) A transferring company shall:

(1) file with the superintendent a certificate in such form as

prescribed by the superintendent signed by the insurance supervisory official of the state where such transferring company is domiciled approving the proposed redomestication and confirming that upon redomestication the transferring company shall no longer be subject as a domestic company to the requirements of its current state of domicile;

(2) comply with the applicable requirements of this chapter regarding the organization and licensing of a domestic company of the same type;

(3) demonstrate to the satisfaction of the superintendent that upon redomestication, the transferring company will be in compliance with the requirements of this chapter and any regulations promulgated thereunder applicable to a domestic company of the same type;

(4) submit to the superintendent all documents and filings necessary to comply with paragraphs two and three of this subsection; and

(5) submit new policy forms to the superintendent for use after redomestication, if so ordered by the superintendent, or use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the superintendent.

(c) After the transferring company has complied with the provisions of this section, the superintendent may, in accordance with section one thousand one hundred two of this chapter issue a new license to the transferring company to reflect the change in its state of corporate domicile. The duration of its license shall be governed by section one thousand one hundred three of this chapter. Upon issuance of such new license the redomestication shall become effective and the transferring company shall be a domestic company.

(d) Simultaneous with the redomestication taking effect:

(1) all materials and documents that were submitted to the superintendent by the transferring company pursuant to the requirements of this section shall be filed in the office of the superintendent; and

(2) the superintendent shall, in accordance with section one thousand two hundred one or other applicable provisions of this chapter issue to the company a certified copy of its new declaration and charter and a certificate of incorporation. The new charter of the company may provide for the continuation of the corporate existence of the transferring company and in such case the original date of incorporation of the transferring company shall be the date of incorporation of the new domestic company.

(e) All outstanding insurance policies and contracts shall remain in full force and effect with no change and need not be endorsed as to the new name of the company, if any, or its new location unless ordered by the superintendent.

(f) All agents' appointments and licenses, rates, and other items that the superintendent allows, existing at the time of redomestication, shall continue in full force and effect in accordance with applicable provisions of this chapter.

§ 7121. Effects upon guaranty corporations of certain events. (a) No domestic life insurance company which became a domestic insurer in accordance with section seven thousand one hundred twenty of this article shall, except as provided in paragraph two of subsection (c) of this section, at any time be deemed to be a member company of The Life Insurance Guaranty Corporation provided for in article seventy-five of this chapter.

(b) No benefits for any person shall arise or be increased or decreased under article seventy-five or article seventy-seven of this chapter as a result of the redomestication of a foreign life insurer pursuant to section seven thousand one hundred twenty of this article.

(c)(1) No merger or consolidation between a domestic life insurance company which is a member company of The Life Insurance Guaranty Corporation and a domestic life insurance company which is not a member company of The Life Insurance Guaranty Corporation shall result in any increase or decrease of the protection provided under article seventy-five of this chapter to the policies or contracts of the member company. No policy or contract issued by a non-member company prior to such merger or consolidation shall receive the protection provided under article seventy-five of this chapter as a result of such merger or consolidation.

(2) If the surviving or consolidated company of any such merger or consolidation is not a member company of The Life Insurance Guaranty Corporation, the surviving or consolidated company shall be deemed to be a member company of The Life Insurance Guaranty Corporation and shall be subject to any assessment levied against member companies pursuant to section seven thousand five hundred four of this chapter in proportion

to the surviving or consolidated company's total admitted assets as shown in its annual statement for the year next preceding the date of such assessment; provided, however, in the event that an assessment is levied against the surviving or consolidated company the year such merger or consolidation is consummated, the surviving or consolidated company shall be assessed in proportion to the admitted assets of its constituent member company as shown in such member company's annual statement for the year next preceding the date of such assessment.

ARTICLE 72
DOMESTICATION OF THE UNITED STATES BRANCH OF AN ALIEN INSURER

Section 7201. Definitions.
7202. Domestication of the United States branch of an alien insurer permitted.
7203. Authorization and execution of domestication agreement.
7204. Approval by superintendent.
7205. Consummation of domestication agreement; transfer of deposits; withdrawal of trusteed assets.

§ 7201. Definitions. In this article:

(a) "Domestication" means the reorganization pursuant to the provisions of this article of the United States branch of an alien insurer whereby a domestic or foreign insurer succeeds to all business and assets and assumes all liabilities of such branch.

(b) "United States branch" means the business unit through which business is transacted within the United States by an alien insurer and the assets and liabilities of such insurer within the United States pertaining to such business.

(c) "Domestic insurer" means a stock insurance company incorporated under the laws of this state.

(d) "Foreign insurer" means a stock insurance company incorporated under the laws of any other state.

§ 7202. Domestication of the United States branch of an alien insurer permitted. (a) (1) Upon compliance with the provisions of this article any licensed alien insurer having its United States branch entered through this state and owning beneficially, directly or indirectly, all outstanding shares of a domestic insurer or of a foreign insurer qualified and licensed in this state to write all the kinds of insurance for which the United States branch is qualified and licensed may domesticate its United States branch by agreeing in writing with such domestic or foreign insurer to the acquisition of the business and assets, and the assumption of all liabilities, of the United States branch, by the domestic or foreign insurer for no consideration except such assumption.

(2) The agreement may, however, provide for additional consideration payable by the issuance of shares by the acquiring insurer.

(3) The domestication shall be subject to prior written approval by the superintendent if the acquiring insurer is domestic, or by the insurance supervisory official of the state of incorporation if it is foreign.

(4) The domestication shall be subject to final approval by the superintendent and if the acquiring insurer is foreign by the supervisory official of such state.

(b) Any shares of the acquiring insurer or voting trust certificates therefor held among the trusteed assets of the United States branch or held in a trust created by the alien insurer of which the alien insurer is a beneficiary shall be deemed to be shares held beneficially, but indirectly, by such alien insurer.

(c) Any acquisition of assets and assumption of liabilities pursuant to subsection (a) hereof shall be effected by filing with the superintendent an instrument of transfer and assumption, executed by the alien insurer and the acquiring insurer, in form satisfactory to the superintendent as to a domestic insurer or to both the superintendent and the insurance supervisory official of the state of incorporation as to a foreign insurer.

(d) The acquiring insurer may be licensed to engage in the insurance business in this state either before entering into such domestication agreement or, if the superintendent approves, effective with consummation of the agreement in accordance with the provisions of

section seven thousand two hundred five of this article.

(e) This article shall not be construed to (i) authorize any insurance company to do any kind of insurance business not authorized by its charter or (ii) authorize any foreign or alien insurance company to do any kind of insurance business in this state not authorized by its license or certificate of authority to do business in this state.

§ 7203. Authorization and execution of domestication agreement. (a) Such domestication agreement shall be authorized, adopted, approved, signed and acknowledged by the alien insurer pursuant to the laws of the country where organized.

(b) Such agreement shall also be approved, adopted and authorized by the acquiring insurer's board of directors and executed by its president or any vice president and attested by its secretary or assistant secretary under its corporate seal, or, in the case of a foreign insurer, as otherwise provided in the laws of the state of its domicile.

§ 7204. Approval by superintendent. (a) An executed counterpart of the domestication agreement, together with certified copies of the corporate proceedings of the acquiring insurer and the alien insurer approving, adopting and authorizing the execution of such domestication agreement, and, in the case of a foreign insurer, the written approval of the insurance supervisory official of the state in which the wholly owned foreign insurer is incorporated, shall be submitted to the superintendent for his approval.

(b) If satisfied that the agreement is in accordance with the provisions of this article and that the interests of policyholders and creditors of the United States branch are not materially adversely affected the superintendent may approve such domestication agreement and authorize its consummation in compliance with the provisions of section seven thousand two hundred five of this article.

§ 7205. Consummation of domestication agreement; transfer of deposits; withdrawal of trusteed assets. (a) (1) Upon the filing with the

superintendent of a certified copy of the instrument of transfer and assumption, the domestication of the United States branch shall be effective.

(2) Thereupon all rights, franchises and interests of such United States branch in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed transferred to and vested in the acquiring insurer and it shall be deemed to have assumed all liabilities of such United States branch.

(3) Simultaneously all deposits of the United States branch held by superintendents, state officers or other state regulatory agencies pursuant to state laws shall be deemed held as security for the full performance by the acquiring insurer of its assumption as direct liabilities of all the liabilities to policyholders and creditors within the United States of such United States branch, and such desposits shall be deemed admitted assets of the acquiring insurer and reported as such in its annual financial statements and other reports required to be filed by it in this state.

(4) Upon the ultimate release by any such state officer or agency of any such deposits, the securities and cash released shall be delivered and paid over to such acquiring insurer as the lawful successor in interest to such United States branch.

(b) Contemporaneously with the consummation of the domestication of the United States branch, notwithstanding the provisions of sections one thousand three hundred fifteen and one thousand three hundred seventeen of this chapter, the superintendent shall transfer to the acquiring insurer's account the securities deposited by such United States branch in compliance with the provisions of this chapter, and the superintendent shall consent that the trustee of the trusteed assets deposited by such United States branch in compliance with the provisions of this chapter shall withdraw from the trust and transfer and deliver to the acquiring insurer all assets held by such trustee. However, if a United States branch is domesticated into a foreign insurer, the superintendent, unless otherwise satisfied that the interests of policyholders of in force business and of creditors on outstanding claims are protected, may defer consent to the withdrawal of so much of the trusteed assets as in his judgment is reasonably required to protect such interests as of the date of domestication; and he shall consent to

their withdrawal from time to time as such interests expire.

ARTICLE 73

CONVERSION TO DIFFERENT TYPE OF INSURER

Section 7301. Prohibited conversion.

7302. Conversion of stock life insurance companies into mutual companies.

7303. Conversion of retirement systems into mutual life insurance companies.

7304. Conversion of fraternal benefit societies into mutual life insurance companies.

7305. Conversion of assessment corporations into advance premium corporations.

7306. Conversion of advance premium corporations or assessment corporations into mutual property/casualty insurance companies.

7306-a. Reconversion of domestic mutual property/casualty insurance company into advance premium corporation or assessment corporation.

7307. Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers not in rehabilitation.

7308. Conversion of domestic reciprocal insurers into stock property/casualty insurance companies.

7309. Conversion of domestic reciprocal insurers into mutual property/casualty insurance companies.

7310. Reorganization of domestic guarantee capital life insurance companies into domestic stock life insurance companies.

7311. Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers in rehabilitation.

7312. Reorganization of a domestic mutual life insurer into a domestic stock life insurer.

7313. Reorganization of domestic mutual accident and health insurance companies.
7315. Reorganization of domestic life insurance companies.
7316. Conversion of savings banks life insurance into a mutual life insurance company.
7317. Conversion of certain article 43 corporations.

§ 7301. Prohibited conversion. No insurer organized or licensed under this chapter shall convert to a different type of insurer except as provided in this article.

§ 7302. Conversion of stock life insurance companies into mutual companies. (a) A domestic stock life insurance company may become a mutual life insurance company, whether or not its policyholders have become entitled to vote for directors pursuant to section four thousand two hundred twelve of this chapter or the former insurance law, and to that end may formulate and carry out a plan for the acquisition of its outstanding shares, as follows:

(1) Such plan shall have been adopted by a vote of a majority of the directors of the company.

(2) Such plan shall have been approved by a vote of shareholders representing a majority of the outstanding shares at a meeting called for that purpose.

(3) Such plan shall have been approved by the vote of a majority of the policyholders eligible to vote who vote at a meeting called for that purpose. Any policyholder who holds life insurance in such company in an amount at least equal to one thousand dollars or an equivalent thereto as hereinafter provided and whose insurance is then in force and has been in force for at least one year prior to such shareholders' meeting, shall be eligible to vote thereat, either in person or by proxy or by mail. The aforementioned reference to life insurance in an amount at least equal to one thousand dollars shall be deemed to include, as equivalent thereto, an annuity contract which at normal date of maturity requires the payment of one hundred dollars or more annually, a pure endowment contract for the principal sum of one thousand dollars or

more, and a policy of accident or health insurance requiring the payment of a premium of not less than twenty-five dollars annually. In the case of every policy or contract of group insurance or group annuity contract, issued by such company, the employer, or other person, firm, corporation or association to whom or in whose name the master policy shall have been issued and held, shall be deemed one policyholder within the meaning of this paragraph. Notice of such meeting shall be given by mailing such notice from the home office of such company at least thirty days prior to such meeting, in a sealed envelope, postage prepaid, addressed to each policyholder at his last known post office address. Such meeting shall be conducted in such manner as may be provided for in such plan, with the approval of the superintendent. The superintendent shall supervise and direct the methods and procedure of such meeting and, to conduct the voting, shall appoint an adequate number of inspectors who shall have power to determine all questions concerning the validity and verification of the ballots, the qualifications of the voters and the canvass of the vote. Such inspectors, or any one thereof designated by the superintendent, shall certify to the superintendent and to such company the result of such vote, under such rules as shall be prescribed by the superintendent. All necessary expenses incurred by the superintendent or incurred with his approval by the inspectors appointed by him shall be paid by such company upon the certificate of the superintendent.

(4) Such plan may specify the purchase price to be paid by such company for its shares, and in such case the price so specified shall be adhered to. If such plan does not specify the price to be paid for such shares, the company shall first obtain the approval of the superintendent for every payment made for the acquisition of any shares.

(5) The plan shall name three trustees authorized to receive shares of the company and hold them in trust for all policyholders until the conversion process has been completed. The plan shall provide a method for filling vacancies among the trustees.

(6) The plan shall have been submitted to the superintendent and approved as conforming to the requirements of this chapter and as not prejudicial to the policyholders of the company or to the insuring public. Before approving any such plan or any such payment, the superintendent shall be satisfied, by such investigation as he may make

or by such evidence as he may require, that such company, after deducting the aggregate sum appropriated by such plan for the acquisition of any or all of its shares, and in the case of any payment not fixed by such plan, after deducting also the amount of such payment, will be possessed of admitted assets in an amount equal to the sum of:

(A) its entire liabilities, including the net values of its outstanding contracts computed in accordance with the provisions of this chapter,

(B) the minimum surplus prescribed by this chapter for mutual life insurance companies organized to do the same kinds of business, and

(C) an additional contingent surplus deemed by the superintendent necessary to protect the company's policyholders and the insuring public, in view of the past experience of such company, the character of its assets, its present management, and its probable future earnings.

(7) No change shall be made in any such plan, adopted and approved as aforesaid, except upon the formulation, adoption and approval of a new plan in accordance with the foregoing requirements.

(8) In pursuance of any such plan to convert a domestic stock life insurance company into a mutual life insurance company, such company shall have power, and shall be privileged, to acquire any of its shares by gift, bequest, or purchase. Until all of its outstanding shares are acquired, any shares so acquired shall be taken and held in trust for all the policyholders of such company, by the trustees named in such plan. Before undertaking any of the duties of the appointment each trustee shall file with the company an acceptance of the appointment and a declaration that he will faithfully discharge his duties as trustee, subscribed and affirmed by him as true under the penalties of perjury. All shares held by the trustees shall be deemed admitted assets of the company at their par value. The trustees shall have power to vote any shares so acquired at all corporate meetings at which shareholders have the right to vote. All dividends and other sums received by such trustees on the shares acquired by them, after paying the necessary expenses of the trust, shall be immediately repaid to such company for the benefit of all who are or may become policyholders of such company and entitled to participate in the profits thereof, and shall be added to and become a part of the surplus earned by such company, apportionable as a part of such surplus among such policyholders. The

provisions of section six hundred twenty-one of the business corporation law and of section 9-1.1 of the estates, powers and trusts law shall not apply to the trust hereinbefore authorized.

(b) (1) Whenever:

(A) a plan adopted and approved in accordance with subsection (a) of this section shall have been in effect for more than ten years,

(B) the company shall have acquired and transferred to the trustees under the plan at least ninety percent of its outstanding shares,

(C) the plan itself contains no provision for the compulsory completion of the mutualization of the company inconsistent with the terms of subsection (a) hereof, the directors by a vote of a majority may offer to acquire by purchase all of the shares of the company not theretofore acquired under the plan, at a specified price, uniform as to class and series of shares, which the company considers to be their fair value as of the date of making such offer. Before such offer shall be made, it shall be submitted to the superintendent for approval. Before approving any such offer the superintendent shall be satisfied, by such investigation as he may make or by such evidence as he may require, that the offer complies with the requirements of this chapter, that such acquisition of such shares pursuant to such offer will not be prejudicial to the policyholders of the company and that such company, after deducting the sum required to acquire such shares at the price stated in such offer, or any lesser price agreeable to shareholders, will be possessed of admitted assets in an amount equal to the sum of:

(i) its entire liabilities, including the net values of all outstanding contracts computed in accordance with the provisions of this chapter;

(ii) the minimum surplus prescribed by this chapter for mutual life insurance companies organized to do the same kind or kinds of business; and

(iii) such additional contingent surplus based upon the past experience of such company, its assets, its present management and its probable future earnings as the superintendent deems necessary to protect its policyholders.

(2) If the offer is approved by the superintendent, the company may make a written offer, by registered mail, to each shareholder whose shares have not theretofore been acquired by the company under the plan

or otherwise, to acquire all his shares at the specified price if accepted in writing within thirty days after the mailing of such offer. Such offer shall be accompanied by a copy of this subsection and by the most current available balance sheet of the company, which shall be as of a date not earlier than twelve months before the mailing of such offer, and a profit and loss statement or statements for not less than a twelve month period ended on the date of such balance sheet. Any shareholder accepting such offer within the thirty day period shall, within sixty days after his acceptance, transfer his shares and surrender the certificates representing such shares, to the company and shall thereupon be paid the offered price. All such shares shall be assigned to the trustees referred to in paragraph five of subsection (a) hereof and held by them as shares acquired pursuant to the plan.

(3) Each shareholder who does not accept such offer to acquire his shares within such thirty day period shall within thirty days after the expiration of such period apply to the supreme court, at any special term thereof held in the district in which is situated the county in which the company making the offer has its principal place of business, upon at least eight days' notice to such company, for the appointment of three disinterested persons to appraise the value of his shares as of the date of making such offer, and the court shall appoint such appraisers and designate the time and place of their first meeting, with such directions in respect to their proceedings as shall be deemed proper. The court may fill any vacancies in the board of appraisers occurring by refusal to hold such office or neglect to act. The appraisers shall meet at the time and place designated and, after being duly sworn, shall hear the parties, faithfully and fairly discharge their duties, estimate and certify in writing the fair value of such shares as of the date of the offer, and deliver one copy of such certificate to such company and another to each such shareholder. Within twenty days after such delivery any party to the appraisal proceedings may apply to the supreme court, at any such special term thereof upon at least eight days' notice to all the parties to such appraisal proceedings and to the superintendent, for approval of the report of the board of appraisers. The court, after hearing the parties and the superintendent, may approve the report and the value of the shares as stated therein, or may itself, upon the evidence and proceedings before

the appraisers, determine the fair value of the shares as of the date of such offer, or may refer the matter back to the same appraisers or other appraisers to be so appointed by the court, to proceed in the same manner. Whenever the court shall approve or determine the fair value of such shares, it may also determine the terms of payment thereof by the company. The charges and expenses of the appraisers, after approval by the court, shall be paid by the company. Upon any such order approving or determining the value of the shares and the method of the payment thereof becoming final and from which no appeal is pending, or when the time to appeal therefrom has expired, each shareholder party to the proceeding shall transfer his shares and surrender the certificates representing such shares to the company and the company shall make payment therefor as provided in such order. Any shares so acquired by the company shall be assigned and transferred to the trustees and held by them as shares acquired pursuant to the plan.

(4) Any shareholder who does not make application to the court in the manner and within the time prescribed in paragraph three hereof shall be deemed to have accepted the offer referred to in paragraph two hereof, effective, however, upon the expiration of the time prescribed in paragraph three hereof for making such an application and such shareholder's time for accepting such offer shall, for that purpose only, be deemed to have been extended accordingly.

(5) Any offer to acquire shares made pursuant to this subsection shall, except as otherwise provided in paragraphs two and four hereof limiting the time for acceptance at the offered price, be irrevocable until all proceedings upon such offer provided by this subsection have been completed or all shares have otherwise been earlier acquired by the company.

(6) Upon application by the company or by any aggrieved shareholder, and upon at least eight days' notice to all persons to be affected thereby and to the superintendent, the supreme court, at any special term thereof held in the district in which is situated the county in which the company has its principal place of business, may make any order appropriate in the circumstances to implement or enforce the provisions of this subsection. If any proceeding in respect of any of the shares shall have been commenced pursuant to paragraph three hereof, all subsequent applications pursuant to this subsection shall be made or

transferred to, and be heard and determined by, the court in which such proceeding has been commenced.

(c) When all of the outstanding shares of the company have been acquired, they shall be retired and cancelled, and thereupon the company shall become a mutual life insurance company without shares.

§ 7303. Conversion of retirement systems into mutual life insurance companies. Any retirement system licensed pursuant to article forty-six of this chapter may be converted into and licensed as a mutual life insurance company, to do the kinds of business specified in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter, provided that at the time of such conversion it has a surplus of at least three million dollars and provided further that its plan of conversion has been approved by the superintendent. Such plan shall be submitted to the superintendent in writing and shall set forth in full the terms and conditions thereof. The board of trustees of the retirement system shall, after adopting such plan, submit it to the members of such retirement system, as defined by its constitution, by-laws or declaration of trust, at any regular or special meeting of such members, by giving a full, true and correct copy of such plan with notice of such meeting. Such notice shall be given as provided in the constitution or by-laws or declaration of trust of such retirement system for the convocation of such regular or special meeting. The affirmative votes of two-thirds of the members of the retirement system eligible to vote who vote in person or by proxy at such regular or special meeting shall be necessary for the approval of the plan. The superintendent may grant such approval if, after a hearing upon the fairness of the plan after written notice of the hearing is given to each member of the retirement system for distribution to participants in its employ and publication in at least two newspapers of general circulation, at which hearing such members and participating employees will have a right to appear, the superintendent finds that the proposed conversion conforms to the requirements of law and is fair to the members and participating employees of such retirement system.

§ 7304. Conversion of fraternal benefit societies into mutual life insurance companies. Any domestic fraternal benefit society, as defined in subsection (a) of section four thousand five hundred one of this chapter, may be converted into and licensed as a mutual life insurance company, to furnish the kinds of benefits authorized by such section, by compliance with all the requirements of section four thousand two hundred eight of this chapter if such plan of conversion has been approved by the superintendent. Such plan shall be submitted to the superintendent in writing and shall set forth in full the terms and conditions thereof. The board of directors or other executive body charged with responsibility for management of the society's affairs shall, after adopting the plan, submit it to the supreme governing body of such society at any regular or special meeting thereof, by giving a full, true and correct copy of such plan with notice of such meeting. Such notice shall be given as provided in the laws of the society for the convocation of such supreme governing body in regular or special session, as the case may be. The affirmative votes of two-thirds of all members of such supreme governing body shall be necessary for the approval of such plan. The superintendent may give his approval if he finds that the proposed conversion conforms to the requirements of law and is not prejudicial to the certificate holders of the society.

§ 7305. Conversion of assessment corporations into advance premium corporations. Any assessment corporation, as defined in section six thousand six hundred two of this chapter, licensed under section six thousand six hundred three of this chapter to do the business of fire insurance may be converted into and licensed as an advance premium corporation, as defined in section six thousand six hundred two of this chapter, in the manner prescribed in this section and subject to any other requirements of law. The successive steps shall be as follows:

(a) A majority of the board of such assessment corporation shall adopt a resolution approving the proposed conversion and appointing a committee of not less than three directors to prepare a draft of a proposed declaration and charter and proposed by-laws.

(b) Such committee's proposed declaration, charter and by-laws shall be submitted with an appropriate resolution to the board of directors

for approval.

(c) A majority of the board at any regular or special meeting thereof shall approve by resolution a proposed declaration and charter and proposed by-laws, which shall conform to the requirements of this chapter relative to the contents of charters and by-laws of advance premium corporations hereafter organized, with such modifications as the superintendent, by regulation, shall prescribe to make such requirements applicable to the nature and character of such conversion proceeding. Such resolution shall also direct that notice that the proposed conversion will be submitted for approval at the next annual meeting of members or at a special meeting to be called for that purpose be given to all members pursuant to section six hundred five of the business corporation law, together with copies of the resolutions referred to in subsections (a) and (b) hereof and in this subsection, and of the proposed declaration, charter and by-laws.

(d) At least two-thirds of the votes of the members voting at such meeting either in person or by proxy, if the corporation's by-laws provide for a vote by proxy, shall be cast in favor of the proposed conversion and of the adoption of the proposed declaration and charter and proposed by-laws. A resolution shall similarly be adopted instructing the president and secretary to execute or certify and file all necessary papers and instruments incident to the proposed conversion.

(e) The proposed declaration and charter executed by the president and secretary, together with copies of all other necessary papers and instruments incident to the proposed conversion, subscribed and affirmed by each as true under the penalties of perjury, shall be submitted to the superintendent.

(f) If the superintendent finds, by such investigation or examination as he deems appropriate to make, that the corporation meets the minimum surplus requirements of section six thousand six hundred four of this chapter, he shall file in his office the declaration, charter, by-laws and other documents submitted as required by subsection (e) hereof, and coincident with such filing such assessment corporation shall become an advance premium corporation. For an assessment corporation initially licensed to do business in this state prior to July first, nineteen hundred eighty-two such minimum surplus requirements and minimum capital

investment requirements shall be those applicable to an advance premium corporation initially licensed to do business in this state prior to such date.

(g) Upon compliance by the corporation with the foregoing and with any other lawful prerequisites for the issuance of an insurer's license, the superintendent may, in accordance with subsection (d) of section one thousand one hundred two of this chapter, grant a license to such advance premium corporation to do the kinds of insurance business specified in its charter. The territory in which such corporation shall be licensed shall be that for which it was licensed when an assessment corporation immediately prior to its conversion as herein provided, but if it has a surplus of at least one hundred fifty thousand dollars it may be licensed by the superintendent to do business throughout the state, subject to the requirements of section six thousand six hundred ten of this chapter and to all the provisions and requirements of this article relative to advance premium corporations.

§ 7306. Conversion of advance premium corporations or assessment corporations into mutual property/casualty insurance companies. Any advance premium corporation or assessment corporation, as defined in section six thousand six hundred two of this chapter, which has in force contracts of insurance of the kinds which domestic mutual property/casualty insurance companies, as defined in subsection (a) of section one hundred seven of this chapter, may be authorized to do, covering not less than three hundred separate risks and on which the premiums in force or the most recent annual assessment aggregates not less than one hundred thousand dollars, may be converted into and licensed as a domestic mutual property/casualty insurance company in the manner prescribed in this section and subject to any other requirements of law. The successive steps shall be as follows:

(a) A majority of the board of directors of the corporation shall adopt a resolution approving the proposed conversion and appointing a committee of not less than three directors to prepare a draft of a proposed declaration, charter and by-laws.

(b) The proposed declaration, charter and by-laws shall be submitted with an appropriate resolution to the board for its approval.

(c) A majority of the board at any regular or special meeting thereof shall approve by resolution the proposed declaration, charter and by-laws, which shall conform to the requirements of this chapter relative to the contents of charters and by-laws of domestic mutual property/casualty insurance companies hereafter organized, with such additions as the superintendent shall approve to accommodate insurance contracts then in force. Such resolution shall also direct that notice that the proposed conversion will be submitted for approval at the next annual meeting of members or at a special meeting to be called for that purpose be mailed, with postage prepaid, to all members at their last known post office addresses respectively, at least thirty days prior to the date of the meeting, together with copies of the resolutions provided for in subsections (a) and (b) hereof and this subsection and of the proposed declaration, charter and by-laws.

(d) At least two-thirds of the votes of members voting at such meeting either in person or by proxy, if the corporation's by-laws provide for a vote by proxy, shall be cast in favor of the proposed conversion and of the adoption of the proposed declaration and charter and proposed by-laws. A resolution shall similarly be adopted instructing the president and secretary to execute or certify and file all necessary papers and instruments incident to the proposed conversion.

(e) The proposed declaration and charter executed by the president and secretary together with proof of mailing of notice of members' meeting and copies of all other necessary papers and instruments incident to the proposed conversion, together with a certificate of their adoption as provided for herein, subscribed and affirmed by such officers as true under the penalties of perjury, shall be submitted to the superintendent.

(f) If the superintendent finds, by such investigation or examination as he deems appropriate to make, that the corporation meets the initial surplus and reserve requirements for domestic mutual fire insurance companies organized and licensed immediately before July first, nineteen hundred eighty-two, to do the kinds of insurance business for which the corporation is to be licensed, and complies with all other provisions of this section, he shall approve the declaration and charter and by-laws and file the same together with the other documents submitted as required by subsection (e) hereof in his office, and coincident with

such filing such advance premium corporation or assessment corporation shall become a domestic mutual property/casualty insurance company.

(g) Upon compliance by the corporation with the foregoing and with any other lawful prerequisites for the issuance of an insurer's license, the superintendent may, in accordance with subsection (d) of section one thousand one hundred two of this chapter, grant a license to such mutual property/casualty insurance company. Such corporation shall thereafter be subject to all the provisions and requirements of this chapter relative to mutual property/casualty insurance companies.

§ 7306-a. Reconversion of domestic mutual property/casualty insurance company into advance premium corporation or assessment corporation. Any domestic mutual property/casualty insurance company, organized under article twelve of this chapter and licensed under article forty-one of this chapter which was previously organized as an advance premium corporation or assessment corporation and which has in force contracts of insurance of the kinds which advance premium corporations or assessment corporations, as defined in section six thousand six hundred two of this chapter, may be authorized to do, covering not less than three hundred separate risks and on which the premiums in force aggregates not less than one hundred thousand dollars, may be reconverted into and licensed as an advance premium corporation or assessment corporation in the manner prescribed in this section and subject to any other requirements of law. The successive steps shall be as follows:

(a) A majority of the board of directors of the domestic mutual property/casualty insurer shall adopt a resolution approving the proposed reconversion and appointing a committee of not less than three directors to prepare a draft of a proposed declaration, charter and by-laws.

(b) The proposed declaration, charter and by-laws shall be submitted with an appropriate resolution to the board for its approval.

(c) A majority of the board at any regular or special meeting thereof shall approve by resolution the proposed declaration, charter and by-laws, which shall conform to the requirements of this chapter relative to the contents of charters and by-laws of advance premium

corporations or assessment corporations, as the case may be, hereafter organized, with such additions as the superintendent shall approve to accommodate insurance contracts then in force. Such resolution shall also direct that notice that the proposed reconversion will be submitted for approval at a special meeting of policyholders to be called for that purpose be mailed, with postage prepaid, to all policyholders at their last known post office addresses respectively, at least thirty days prior to the date of the meeting, together with copies of the resolutions provided for in subsections (a) and (b) of this section and this subsection and of the proposed declaration, charter and by-laws.

(d) At least two-thirds of the votes of policyholders voting at such meeting either in person or by proxy, if the domestic mutual property/casualty insurer's by-laws provide for a vote by proxy, shall be cast in favor of the proposed reconversion and of the adoption of the proposed declaration and charter and proposed by-laws. A resolution shall similarly be adopted instructing the president and secretary to execute or certify and file all necessary papers and instruments incident to the proposed conversion.

(e) The proposed declaration and charter executed by the president and secretary together with proof of mailing of notice of policyholders' meeting and copies of all other necessary papers and instruments incident to the proposed reconversion, together with a certificate of their adoption as provided for herein, subscribed and affirmed by such officers as true under the penalties of perjury, shall be submitted to the superintendent.

(f) If the superintendent finds, by such investigation or examination as he deems appropriate to make, that the corporation meets the initial surplus and reserve requirements for advance premium corporations or assessment corporations, as the case may be, to do the kinds of insurance business for which the corporation is to be licensed, and complies with all other provisions of this section, he shall approve the declaration and charter and by-laws and file the same together with the other documents submitted as required by subsection (e) of this section in his office, and coincident with such filing such domestic mutual property/casualty insurance company shall become an advance premium corporation or assessment corporation, as the case may be.

(g) Upon compliance by the domestic mutual property/casualty insurer

with the foregoing and with any other lawful prerequisites for the issuance of an insurer's license, the superintendent may, in accordance with subsection (d) of section one thousand one hundred two of this chapter, grant a license to such advance premium corporation or assessment corporation, as the case may be. Such corporation shall thereafter be subject to all the provisions and requirements of this chapter relative to advance premium corporations or assessment corporations, as the case may be.

§ 7307. Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers not in rehabilitation. (a) In this article:

(1) "Affiliate" of a mutual insurer means any person who controls, is controlled by or is under common control with, the mutual insurer being converted. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of persons manage the two corporations.

(2) "Control" has the meaning assigned to it in paragraph two of subsection (a) of section one thousand five hundred one of this chapter.

(3) A "domestic mutual insurer" or "mutual insurer" means a domestic mutual property/casualty insurance company organized under article twelve of this chapter and licensed under article forty-one of this chapter, or a domestic advance premium corporation organized and licensed under article sixty-six of this chapter, in either case authorized to issue non-assessable policies only and not operating under an order of rehabilitation.

(4) A "holder of a section 1307 agreement" means the holder of an agreement executed pursuant to section one thousand three hundred seven of this chapter.

(b) A domestic mutual insurer may apply to the superintendent for permission to convert into a domestic stock property/casualty insurer complying with the relevant organization and licensing provisions of articles twelve and forty-one of this chapter. The application to the superintendent shall be pursuant to a resolution, adopted by no less than a majority of the entire board of directors, specifying the reasons

for and the purposes of the proposed conversion, and the manner in which the conversion is expected to benefit policyholders and the public. A copy of the resolution, together with a statement of its adoption, both certified by the president and secretary, or officers corresponding to either of them, and affirmed by them as true under the penalties of perjury and under the seal of the mutual insurer, shall accompany the application. The superintendent may thereafter request any additional documents and information which he may reasonably require. Unless the superintendent finds that:

(1) the resolution is defective upon its face;

(2) the proposed conversion is contrary to law or is not in the best interests of the policyholders or the public; or

(3) the mutual insurer does not have a surplus to policyholders at least equal to the minimum capital and surplus required to be maintained for a newly organized stock insurer doing the same kinds of insurance, in which cases the proposed conversion shall terminate, the superintendent shall order an examination of the mutual insurer pursuant to section three hundred ten of this chapter as of the last day of the period covered in its latest filed statement. The superintendent may also examine any affiliate of the mutual insurer.

(c) The superintendent shall also appoint one or more qualified disinterested persons to appraise and report to the superintendent the fair market value of the mutual insurer and, to the extent necessary, its affiliates, on the basis of its latest filed annual or quarterly statement, and of any significant subsequent developments. Such persons shall consider the assets and liabilities of the mutual insurer and any factors bearing on the value of the mutual insurer or its affiliates. The appraisers shall receive reasonable compensation and be reimbursed for reasonable expenses incurred in discharging their duties. They may, as necessary, employ consultants to advise them on any technical matters.

(d) The superintendent shall make copies of such examination report and appraisal report available to the board of directors within fifteen days of his receipt of the reports. After receiving such reports the superintendent may grant or deny permission to the board of directors to submit to him a plan of conversion. If permission is granted, the plan shall include the provisions, and be submitted in the manner and under

the conditions, required by subsection (e) hereof. If permission is denied, the superintendent shall make a written statement of his findings and the board shall have the right to a hearing before the superintendent within thirty days of the date of denial.

(e) Such plan shall be adopted by a majority of the entire board. It shall be signed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of the insurer. A copy of the plan and resolution, both certified by such officers as true under the penalties of perjury and under the seal of the insurer, shall be submitted to the superintendent not later than forty-five days after permission was granted under subsection (d) hereof. The plan shall include:

(1) The proposed charter and by-laws of the insurer as a stock corporation set out in accordance with paragraph five of subsection (a) of section one thousand two hundred one of this chapter.

(2) The manner of treating a holder of a section 1307 agreement, if any; such holder, if otherwise qualified, may, at its option, exchange such agreement for an equitable share of the securities or other consideration, or both, of the corporation into which the insurer is to be converted.

(3) The manner and basis of exchanging the equitable share of each eligible mutual policyholder for securities or other consideration, or both, of the stock corporation into which the mutual insurer is to be converted and the disposition of any unclaimed shares. The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution described in subsection (b) hereof shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both. The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) hereof bears to the total net premiums received by the mutual insurer from such eligible policyholders. In computing a

policyholder's equitable share, no credit shall be given for any net premiums which result from an endorsement which is effective on or after the date of adoption of the resolution; except that credit shall be given for any net premiums resulting from an audit or retrospective premium adjustment which is billed within one hundred eighty days after such date, provided such premium is paid timely. If the equitable share of the eligible policyholder entitles such policyholder to the purchase of a fractional share of stock, the policyholder shall have the option to receive the value of the fractional share in cash or purchase a full share by paying the balance in cash.

(4) The number of voting common shares proposed to be authorized for the stock corporation, their par value and the price at which they shall be offered, which price may not exceed one-half of the median equitable share of all policyholders under paragraph three hereof.

(5) Any other features requested by the superintendent.

(f) Prompt notice shall be given by the mutual insurer to all persons who become policyholders or holders of section 1307 agreements on or after the date of the adoption of the resolution described in subsection (b) hereof, of the pendency of a proposed conversion and of the effect thereof on them.

(g) The superintendent shall hold a public hearing, adequate notice of which shall be mailed by the mutual insurer to each person who was a policyholder on the day preceding the date of adoption of the resolution described in subsection (b) hereof, accompanied by a copy of the plan of conversion and any comment the superintendent considers necessary for the adequate information of the policyholders. In addition, the insurer shall give notice of the hearing by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state in which the insurer has underwritten insurance within the five years preceding the date of the adoption of the resolution described in subsection (b) hereof; such notice shall be accompanied by a summary approved by the superintendent of the plan and any comment the superintendent considers necessary for the adequate information of former policyholders and the public.

(h) (1) After the hearing the superintendent shall approve the plan as submitted, refuse to approve the plan, or request modification of the plan before granting approval. If the superintendent finds that the plan

does not violate this chapter, is not inconsistent with law, is fair and equitable and is in the best interests of the policyholders and the public, he shall approve such plan. If the superintendent finds that the plan does not meet the foregoing standards for approval he shall either refuse to approve the plan and the plan shall become null and void or return the plan to the mutual insurer for modification to meet his stated objections.

(2) If within ninety days after receipt of the superintendent's request for modifications the insurer submits an amended plan which meets the superintendent's objections and complies with the standards for approval he shall approve such amended plan.

(i) After approval by the superintendent the plan shall be submitted to a vote of the persons who were policyholders of the mutual insurer on the day preceding the date of adoption of the resolution described in subsection (b) hereof. The plan shall provide for proxy voting in a manner to be prescribed by the superintendent. The board shall submit the question of the plan to such policyholders at a meeting thereof, by causing a full, true and correct copy or a summary thereof approved by the superintendent, together with notice, stating the time, place and purpose of such meeting, to be delivered personally, or deposited in the post office, postage prepaid, at least thirty days (unless a shorter time, not less than ten days, be approved by the superintendent) prior to the time fixed for such meeting, addressed to each such policyholder at his last post office address appearing on the records of the insurer.

(j) Each such policyholder eligible to vote pursuant to subsection (i) hereof shall be entitled to such number of votes as may be provided for in the by-laws of the mutual insurer. The votes of two-thirds of all the votes cast by policyholders represented at the meeting in person or by proxy, shall be necessary for the adoption of the plan. Upon the conclusion of the vote the insurer shall submit to the superintendent a certified copy of the plan voted on together with a certificate setting forth the results of the vote, both of which shall be subscribed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of the insurer, and affirmed by them as true under the penalties of perjury.

(k) No domestic mutual insurer which is affiliated with other mutual companies may be converted to a stock company unless all such affiliated

companies are converted to stock companies at the same time, except to the extent the superintendent may determine that the interests of the policyholders of any of the other mutual companies can be permanently protected by limitations on the corporate powers of the stock corporation or on its authority to do business.

(l) If at any stage in the process of a conversion under this section the superintendent finds that the mutual insurer is impaired or that the further transaction of business will be hazardous to its policyholders, its creditors, or the public, the proposed conversion shall terminate.

(m) If the conversion plan is adopted pursuant to subsection (j) hereof, the superintendent, upon being satisfied that the insurer will have at least the minimum capital and surplus required to be maintained for a newly organized domestic stock insurer doing the same kinds of insurance, shall issue a new certificate of authority to the insurer, thereby converting the mutual insurer into a stock insurer. At the same time, the superintendent may issue such license as may be required pursuant to section one thousand two hundred four of this chapter.

(n) Upon such conversion, the stock insurer shall give notice thereof by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state in which the insurer shall be licensed to do business. The notice shall include a correct copy of the plan, or a summary thereof approved by the superintendent.

(o) Upon the conversion of the mutual insurer in the manner herein provided, all the rights, franchises and interests of the former mutual insurer, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed as transferred to and vested in the stock insurer, without any other deed or transfer; and simultaneously therewith such company shall be deemed to have assumed all of the obligations and liabilities of the former mutual insurer.

(p) No action or proceeding, pending at the time of the conversion to which the mutual insurer may be a party shall be abated or discontinued by reason of such conversion, but the same may be prosecuted to final judgment in the same manner as if the conversion had not taken place, or the stock corporation may be substituted in place of such mutual insurer by order of the court in which the action or proceeding may be pending.

(q) The directors and officers of the mutual insurer shall serve until new directors and officers have been duly elected and qualified pursuant to the charter and by-laws of the stock insurer.

(r) The insurer, whether before or after conversion, shall pay no compensation of any kind to any person other than regular salaries to existing personnel, in connection with the proposed conversion, other than for clerical and mailing expenses, except that, with the superintendent's approval, payment may be made at reasonable rates for printing costs, and for legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the department of financial services, shall be borne by the insurer.

(s) No voting common shares shall be subscribed by or issued to persons other than eligible policyholders or holders of section 1307 agreements until all subscriptions by such policyholders or agreement holders have been filled or other consideration has been provided in accordance with the plan. Thereafter, any new issue of common shares within three years after the conversion shall first be offered to the persons who have become voting common shareholders, pursuant to subsection (e) hereof in proportion to their holdings of such shares.

(t) No insurer becoming a domestic stock insurer under the provisions of this section shall: for a period of ten years after conversion, redomesticate directly or indirectly or remove its principal offices from within the state; or for a period of five years after conversion:

(1) enter into any agreement by the terms of which any person, partnership or corporation agrees to pay all or a portion of the expenses of management of the insurer in consideration of the insurer's agreement to pay him or it either commissions on premiums due the insurer or any other compensation for his or its services, or

(2) enter into any agreement with an officer or director of the insurer or with any firm or corporation in which any officer or director of the insurer is pecuniarily interested, directly or indirectly, under which agreement the insurer agrees to pay, for the acquisition of business, any commissions or other compensation which by the terms of such agreement varies with the amount of such business or with the earnings of the insurer on such business.

(u) Any action taken pursuant to the provisions of this section shall

in no way impede or impair the exercise by the superintendent of his authority under any other provision of this chapter.

§ 7308. Conversion of domestic reciprocal insurers into stock property/casualty insurance companies. (a) Any domestic reciprocal insurer doing business under the provisions of this article may, by the affirmative vote of its subscribers holding two-thirds of its operating reserve accumulations at the date of the meeting at which the proposal to convert is voted upon, be converted into and licensed as a stock property/casualty insurance company, in the manner prescribed by this section and subject to any other requirements of law. The advisory committee of any such reciprocal insurer proposing so to convert shall cause the attorney-in-fact of such reciprocal insurer to give to each subscriber of record at the close of business on the last day of the quarter year next preceding the issue of such notice not less than thirty days notice by mail of the meeting at which the proposed conversion is to be voted upon and of a hearing of the subscribers before the superintendent. At such hearing or any adjournment thereof, the superintendent shall pass upon the fairness of the terms and conditions of the proposed conversion and of the issuance of shares of the corporation and he shall approve or disapprove the same. The provisions of this chapter relative to a similar domestic insurance company organized to do the same kinds of insurance business shall apply to the organization and licensing of such corporation.

(b) If converted into a stock insurance corporation, subscriptions to the capital shares may be made, in whole or in part, by the subscribers of the reciprocal insurer, and their subscriptions may be paid in to the extent of their operating reserve accumulations by a transfer thereof or any portion thereof to such corporation. The contingent surplus of the reciprocal insurer accumulated pursuant to subsection (a) of section six thousand one hundred five of this chapter shall be included in the capital and surplus of the corporation and shares representing the same shall be issued to existing subscribers, at the rate determined as provided in the next sentence for each dollar of par value of the shares of such new corporation, in proportion to their shares in the aggregate operating reserves at the time when the proposal to convert is adopted.

The rate of payment for each dollar of par value of the stock of such new corporation shall be determined by agreement between the advisory committee of the reciprocal insurer and the board of directors of the stock insurance company. Every such subscriber shall be entitled in the subscription to the capital shares of such corporation to a priority in subscribing thereto for thirty days after the opening of the books of subscription in proportion to his interest in such reciprocal insurer at such date but at the rate of payment fixed by the board of directors. At the expiration of such thirty days the board of directors may sell and dispose of the capital shares which have not been taken or subscribed, as aforesaid, but at not less than the same rate of payment.

(c) If after examination, the superintendent finds that the proceedings for the conversion to a corporation of any such insurer have been regularly taken in conformity with law, and that the corporation meets with the requirements of this chapter, he may issue a license to such insurer to do business under the provisions of this chapter. Thereupon, the remaining assets shall be forthwith transferred to it, and the predecessor reciprocal insurer or insurers shall cease to have authority to do business as such and shall be deemed extinguished. Every such new corporation formed by conversion shall assume and succeed to all of the obligations and liabilities of the converting reciprocal insurer and be held liable to pay and discharge all such debts and liabilities in the same manner as if they had been incurred or contracted by the corporation, but the subscribers of the reciprocal insurer shall continue subject to all the liabilities, claims and demands which shall then exist, or which may thereafter accrue against them, or any of them, by reason of any obligations incurred by them or in their behalf as such subscribers before the date of conversion. Upon the conversion of any reciprocal insurer, dissenting subscribers, meaning thereby subscribers who shall not within thirty days after the opening of the books of subscription have subscribed to shares of the corporation and applied their accumulated operating reserves to payment therefor as provided in subsection (b) hereof, shall be entitled to the conditional withdrawal of their accumulated operating reserves on deposit with the reciprocal insurer as of the date of conversion but a sufficient amount thereof shall be retained by the corporation as a deposit until all of the obligations incurred on its behalf have been

extinguished. When all of such obligations have been paid, discharged or terminated, and the superintendent after an examination shall have so certified, the said subscribers' deposits or the balances thereof remaining to their credit shall be returned and released, whereupon the powers of the attorney-in-fact relating thereto shall cease and terminate.

§ 7309. Conversion of domestic reciprocal insurers into mutual property/casualty insurance companies. Any domestic reciprocal insurer doing business under the provisions of this article which has in force contracts of insurance, of the kinds which domestic mutual property/casualty insurance companies may be authorized to make, covering not less than three hundred separate risks and on which the premiums in force aggregate not less than one hundred fifty thousand dollars, may be converted into and licensed as a domestic mutual property/casualty insurance company, in the manner prescribed in this section and subject to any other requirements of law. The successive steps shall be as follows:

(a) Not less than a majority of the advisory committee of any such reciprocal insurer proposing so to convert shall adopt a resolution approving the proposed conversion and appointing a committee of not less than three from its membership to prepare a draft of a proposed declaration, charter and by-laws.

(b) Such committee shall prepare a proposed declaration, charter and by-laws, which shall be submitted with an appropriate resolution to the advisory committee for approval.

(c) Not less than a majority of the advisory committee, at any regular or special meeting thereof, shall approve by resolution a proposed declaration, charter and by-laws, which shall conform to the requirements of this chapter relative to the contents of charters and by-laws of domestic mutual property/casualty insurance companies hereafter organized to do the kinds of business transacted by such reciprocal insurer, with such additions thereto as the superintendent shall approve, in order to make provision on account of insurance contracts then in force. Such resolution shall also instruct the attorney-in-fact of such reciprocal insurer to give notice of the

meeting at which the proposed conversion is to be voted upon and of a hearing of the subscribers before the superintendent. A copy of such resolution, together with copies of those required in subsections (a) and (b) of this section, a copy of the proposed declaration, charter and by-laws and a suitable proxy form approved by the superintendent, shall accompany such notice, which notice shall be mailed, with postage prepaid, to all subscribers at their post office addresses shown on the records of the reciprocal insurer, at least thirty days prior to the date of the meeting. At the hearing, the superintendent shall pass upon the fairness of the terms and conditions of the proposed conversion and of the issuance of certificates of interest in the surplus of the corporation and he shall approve or disapprove the proposed conversion.

(d) At least two-thirds of the votes of subscribers at any reciprocal insurer, voting at such meeting, either in person or by proxy on the form furnished the subscriber, if the subscriber's agreement at such reciprocal insurer provides for a vote by proxy, shall be cast in favor of the proposed conversion and of the adoption of the proposed declaration, charter and by-laws. A resolution shall be similarly adopted authorizing thirteen persons, who shall be either members of an advisory committee of a reciprocal insurer proposing to convert, the attorney-in-fact, if an individual, officers of the attorney-in-fact if a corporation, or subscribers at a reciprocal insurer proposing to convert, to execute the declaration and authorizing the attorney-in-fact, if an individual, or the president or a vice-president and one other officer of the attorney-in-fact, if a corporation, to execute or certify and file all necessary papers and instruments incident to the proposed conversion.

(e) The proposed declaration executed as aforesaid and proposed charter with proof of mailing of notice of the subscribers' meeting and copies of all other papers and instruments referred to in this section, together with a certificate of their adoption, subscribed and affirmed as true under the penalties of perjury, as provided for in subsection (d) of this section, shall be submitted to the superintendent.

(f) If, after examination, the superintendent finds that the proceedings for the change to a mutual insurance corporation have been regularly taken in conformity with law and the declaration and charter conform to all requirements of paragraph five of subsection (a) of

section one thousand two hundred one of this chapter, he shall file the declaration and charter in his office and issue a certified copy thereof to the proposed incorporators. If requested by such proposed incorporators, the superintendent shall also issue to them a certificate of incorporation executed by him in the name of the people of the state. Upon the issuance of such certified copy, such incorporators shall become a body corporate, and shall then have power to receive payment of subscriptions to its surplus as set forth in subsection (g) of this section, but such corporation shall not be authorized to do the business of insurance until it shall have obtained a license therefor.

(g) Those subscribers who have voted in person or by proxy for the conversion and any other subscribers who thereafter agree to subscribe to the surplus of the corporation shall be deemed to have subscribed to the surplus of the corporation to an amount equal to their operating reserve accumulations at the reciprocal insurer, and such subscriptions shall be paid by a transfer of their operating reserve accumulations to the corporation. Certificates of interest in said surplus shall be issued to such subscribers in amounts equal to their respective operating reserve accumulations at the time when the proposal to convert is adopted by the subscribers. Such certificates of interest shall be issued upon the agreement set forth in section one thousand three hundred seven of this chapter.

(h) If, after examination, the superintendent finds that the new corporation meets the requirements of this chapter, including the requirements as to initial surplus and reserves applicable under section four thousand one hundred seven of this chapter, he may issue a license to the insurer to do business under the provisions of this chapter. Thereupon, the remaining assets of the reciprocal insurer shall be transferred to the corporation and the reciprocal insurer shall cease to have authority to do business as such and shall be deemed extinguished. Every such corporation resulting from conversion shall assume and succeed to all of the obligations and liabilities of the reciprocal insurer and shall be held liable to pay and discharge all such debts and liabilities in the same manner as if they had been incurred or contracted by the corporation, but the subscribers of the reciprocal insurer shall continue subject to all the liabilities, claims and demands which shall then exist, or which may thereafter accrue against

them, or any of them, by reason of any obligations incurred by them or on their behalf as such subscribers before the date of conversion and such subscribers who become subscribers to the surplus shall be entitled to recoup from the corporation any payment made by reason of such liabilities, claims or demands.

(i) No action or proceeding, pending at the time of the conversion to which the reciprocal insurer may be a party, shall be abated or discontinued by reason of such conversion, but the same may be prosecuted to final judgment in the same manner as if the conversion had not taken place, or the corporation may be substituted in place of such reciprocal insurer by order of the court in which the action or proceeding may be pending.

(j) Upon such conversion the accumulated operating reserves of subscribers who shall not have subscribed to the surplus of the corporation, held on deposit with the reciprocal insurer as of the date of the conversion shall be held by the corporation for the benefit of such subscribers until all the obligations incurred on their behalf have been extinguished. When all of such obligations have been discharged or terminated, and the superintendent shall have so certified, the said subscribers' deposits or the balances thereof remaining to their credit shall be released and returned, whereupon the powers of the attorney-in-fact relating thereto shall cease and terminate.

§ 7310. Reorganization of domestic guarantee capital life insurance companies into domestic stock life insurance companies. (a) As used in this section, the following terms shall have the following meanings:

(1) "Guarantee capital insurer" means a domestic life insurer with a guarantee capital represented by shares.

(2) "Shareholder" means a record holder of shares of guarantee capital of a guarantee capital insurer.

(3) "Policyholder" means a holder, as determined by the records of a guarantee capital insurer, of an insurance contract issued by such insurer which is of a type described in paragraph one, two, or three of subsection (a) of section one thousand one hundred thirteen of this chapter and which entitles the holder thereof, under the charter of the guarantee capital insurer, to the policyholder equity interest defined

in this section. A person who, for purposes of subsection (a) of section four thousand two hundred ten of this chapter would be deemed the "policyholder" of any insurance contract is deemed to be the holder of such contract for purposes of this section.

(4) "Policyholders' equity interest" means and includes all rights of the policyholders as provided in or arising under the charter of the guarantee capital insurer. The term "policyholders' equity interest" includes the policyholders' right under the charter to vote and to participate in distributions of profits and any right arising under the charter to participate in any distribution of surplus whether such distribution is made incident to a liquidation of the guarantee capital insurer or otherwise. Anything in the foregoing sentence to the contrary notwithstanding, the term "policyholders' equity interest" does not include any right expressly conferred upon the policyholders by their insurance contracts which is in addition to those rights provided in or arising under the charter of the guarantee capital insurer.

(5) "Plan of reorganization" means a plan of conversion, a plan of merger or a plan for amendment of charter adopted in accordance with this section.

(6) "Reorganized insurer" means either (i) the domestic stock life insurer into which a guarantee capital insurer has been converted in accordance with this section, or (ii) the corporation surviving a merger between a guarantee capital life insurer and a domestic stock life insurer in accordance with this section, or (iii) the former guarantee capital insurer as constituted after an amendment to its charter in accordance with this section.

(b) Any other provision of this chapter to the contrary notwithstanding, upon compliance with the requirements and completion of the proceedings prescribed by this section, a guarantee capital insurer may either (i) convert into a domestic stock life insurer, or (ii) merge with a domestic stock life insurer, or (iii) amend its charter so as to eliminate its policyholders' equity interest. The provisions of paragraph four of subsection (a) of section one thousand two hundred six of this chapter shall not apply to an amendment to the charter of a guarantee capital insurer eliminating its policyholders' equity interest made under and in accordance with the provisions of this section. In case of a merger with a domestic stock insurer, the domestic stock

insurer shall comply with the provisions of this chapter applicable to its participation in a merger.

(c) (1) The guarantee capital insurer shall adopt a plan of reorganization by the vote of a majority of its entire board of directors. The plan of reorganization shall set forth (i) the reasons for and purposes of the proposed reorganization, (ii) the form of the reorganization which shall be one of the forms of reorganization set forth in subsection (b) of this section, (iii) the manner and basis by which the reorganization shall take place, and (iv) the consideration to be given to the shareholders in exchange for their shares of guarantee capital and to the policyholders in exchange for their policyholders' equity interest or the manner of converting the guarantee capital or the policyholders' equity interests into other securities or other consideration. If the reorganized insurer proposes to issue for delivery in this state participating insurance policies or contracts, the plan of reorganization shall so specify and shall be accompanied by such information or agreements relative thereto as the superintendent may require pursuant to section four thousand two hundred thirty-one of this chapter and, in such event, upon the superintendent's approval of the plan of reorganization pursuant to this section, the superintendent shall, in accordance with said section four thousand two hundred thirty-one, issue a revocable permit to the reorganized insurer authorizing it to issue participating policies and contracts in this state. The plan of reorganization may contain any other provisions which the board of directors of the guarantee capital insurer may deem necessary or advisable in connection with the proposed reorganization.

(2) The consideration to be given in exchange for the shares of guarantee capital and the policyholders' equity interest or into which such shares and equity interest are to be converted may consist of securities of the reorganized insurer or securities of another corporation or corporations or other consideration or any combination of such forms of consideration. The consideration to be given in exchange for shares of guarantee capital or into which such shares are to be converted need not be the same as the consideration given in exchange for the policyholders' equity interests or into which the policyholders' equity interests are to be converted. The consideration given to any class or category of policyholder need not be the same as the

consideration given to any other class or category of policyholder. In the case of a charter amendment in which the shares of guarantee capital remain outstanding and unchanged, the plan need not provide any consideration to the holders of such shares.

(3) The plan of reorganization shall include the proposed charter of the reorganized insurer set out in accordance with subsection (a) of section one thousand two hundred one of this chapter and its proposed by-laws, giving effect to any amendments to the charter or by-laws to be effected by the plan of reorganization.

(4) The plan of reorganization shall specify one or more record dates to be used for purposes of determining (i) the shareholders and policyholders who shall be entitled to notice of and to vote at the meeting called pursuant to this section to act upon a proposal to approve the plan of reorganization, (ii) the shareholders and policyholders who shall be entitled to receive notice of the public hearing required by this section, and (iii) the shareholders and policyholders who shall be entitled to receive the consideration provided for by the plan. Each shareholder of record on the record date specified pursuant to item (iii) of the immediately preceding sentence shall be entitled to the consideration provided in the plan on the basis of the number of shares held of record by him as of said record date. Each policyholder of record as of such record date shall be entitled to the consideration provided for him in the plan based on his policyholder's equity interest as of the effective date of conversion, merger or charter amendment pursuant to this section but only to the extent that such policyholder's equity interest arose from insurance contracts of which he was the holder as of such record date.

(5) Upon adoption of the plan of reorganization, it shall be duly executed by the chairman of the board, the president or a vice president and attested by the secretary or an assistant secretary of the guarantee capital insurer under such insurer's corporate seal and shall be submitted to the superintendent with a copy of the resolutions adopting such plan accompanied by a certificate of adoption of such resolutions subscribed by such officers and affirmed by them as true under penalties of perjury and under the seal of the guarantee capital insurer.

(d) The guarantee capital insurer may, by action of a majority of the entire board of directors, amend the plan of reorganization at any time

before the plan becomes effective as provided by this section. On adoption of an amendment it shall be duly executed by the chairman of the board, the president or a vice president and attested by the secretary or an assistant secretary of the guarantee capital insurer under such insurer's corporate seal and shall be submitted to the superintendent with a copy of the resolutions adopting such amendment subscribed by such officers and affirmed by them as true under penalties of perjury and under the seal of the guarantee capital insurer. In case of an amendment, all references in this section to the plan of reorganization shall be deemed to refer to the plan as amended. No amendment made after any public hearing required by this section or after approval by the shareholders or policyholders as provided in this section shall change the plan in a manner which the superintendent determines is materially disadvantageous to the shareholders or any of the policyholders unless a further public hearing is held on the plan as amended if the amendment is made after the public hearing, or the plan as amended is submitted for reconsideration by the shareholders or policyholders, whichever is disadvantaged by the amendment, if the amendment is made after the plan has been approved by the shareholders or policyholders under the conditions and procedures determined by the superintendent in accordance with this section.

(e) Upon submission to him of the plan of reorganization, the superintendent may request any additional documents or information and may examine the guarantee capital insurer or any of its affiliates, to the extent he may determine to be necessary to enable him to make the findings required by this section for the approval by him of the plan of reorganization.

(f) The superintendent shall appoint one or more qualified disinterested persons to appraise in writing the value of the policyholders' equity interest and the value of the consideration to be given to the policyholders in exchange for their equity interest or into which such equity interest shall be converted. Such valuation shall be made on a fair and equitable basis taking into account the latest filed annual or quarterly statement of the guarantee capital insurer, and any significant developments occurring subsequent to the date of such statement. The appraisers may request of the guarantee capital insurer access to its books and records and the furnishing by it of any other

information in its possession, to the extent they may reasonably deem necessary to make the valuations contemplated by this subsection. They shall report to the superintendent any instance in which the guarantee capital insurer fails to provide any information requested by them. The appraisers shall not, under judicial process or otherwise, be obligated or permitted to divulge to anyone except the superintendent any information not otherwise publicly available which is so obtained by them. The appraisers shall receive reasonable compensation and shall be reimbursed for reasonable expenses incurred in performing their duties. They may, as necessary, employ consultants to advise them on technical matters associated with the appraisal. The appraisal report shall be made to the superintendent. In making the determinations contemplated by this section, the superintendent shall not be bound by any findings, conclusions or recommendations made by the appraisers. All information obtained by the superintendent pursuant to this section, including without limitation information obtained through examinations by him, reports of appraisers and other information secured by appraisers and turned over to the superintendent, are hereby specifically exempted, as contemplated by paragraph (a) of subdivision two of section eighty-seven of the public officers law, from disclosure by the superintendent under said section eighty-seven. Such exemption shall not preclude or exempt the superintendent from disclosure of such information pursuant to judicial process under provisions of law other than said section eighty-seven.

(g) The superintendent shall hold a public hearing upon the fairness of the terms and conditions of the exchange of the policyholders' equity interest for the securities or other consideration provided for by the plan of reorganization and upon whether the reorganization is in the public interest. Notice stating the time, place and purpose of the hearing shall be mailed to each holder of guarantee capital and each policyholder entitled under the plan to receive such consideration at his address as shown on the records of the guarantee capital insurer at least thirty days before the date of the hearing. Such notice shall be preceded or accompanied by a true and complete copy of the plan or a summary thereof approved by the superintendent and by such other explanatory information as the superintendent shall approve or require. In addition, the guarantee capital insurer shall give notice of the

time, place and purpose of the hearing by publication in a newspaper of general circulation in the city in which the insurer has its principal office and in two other newspapers of general circulation in other cities within or without this state approved by the superintendent. Such newspaper publications shall be made not less than fifteen days nor more than sixty days before the hearing and shall be in form approved by the superintendent.

(h) (1) A proposal to approve the plan of reorganization shall be submitted to a meeting of shareholders and policyholders. Notice stating the time, place and purpose of such meeting shall be mailed to each such shareholder and policyholder of record as of the record date for the meeting, at his address as shown on the records of the guarantee capital insurer, at least thirty days before the date of the meeting. Such notice may be combined with notice of the public hearing required by this section. Such notice shall be preceded or accompanied by a true and complete copy of the plan or a summary thereof approved by the superintendent and by such other explanatory information as the superintendent shall approve or require.

(2) Each shareholder of record as of the record date for the meeting shall be entitled to cast one vote at such meeting, in person or by proxy, for each share held of record by him on such record date. Each policyholder of record as of the record date for the meeting shall be entitled to cast one vote at such meeting, in person or by proxy, irrespective of the number or amount of the policies he holds. Any proxy shall be revocable at any time except to the extent that, at the time of exercise, the power conferred thereby has been exercised. The presence in person or by proxy of (i) the holders of record of two-thirds of the outstanding shares of guarantee capital, and (ii) such number of policyholders as attend in person or proxy shall constitute a quorum for the meeting. All votes shall be by written ballot cast in person by shareholders or policyholders entitled to vote or by proxy agents duly appointed by shareholders or policyholders entitled to vote. The proposal to approve the plan of reorganization may be adopted by the affirmative vote of two-thirds of all guarantee capital shares issued and outstanding as of the record date and the affirmative vote of two-thirds of all votes cast by policyholders or record as of the record date.

(3) The superintendent shall have power to supervise and direct and prescribe rules governing the procedure for the conduct of the meeting to such extent, consistent with the provisions of this section, as he deems necessary to insure a fair and accurate vote. Such powers shall include but not be limited to power to supervise and regulate (i) the determination of the shareholders and policyholders entitled to notice of and to vote at the meeting, (ii) the giving of notice, (iii) the receipt, custody, safeguarding, verification and tabulation of proxy forms and ballots, and (iv) the resolution of disputes.

(4) The superintendent shall appoint as inspectors an adequate number of personnel of the department of financial services or other competent and disinterested persons and may appoint if necessary, expert accountants and other assistants and may authorize the procurement of stationery and supplies necessary for conducting the election and canvassing the votes. The inspectors shall have power to determine all questions concerning the verification of the ballots and proxies, the ascertainment of the validity thereof, the qualifications of the voters and the canvass of the vote, and with respect thereto shall act under such rules as shall be prescribed by the superintendent. Any disagreement among the inspectors shall be reported to and shall be resolved by the superintendent. Any determinations by the inspectors or the superintendent shall be subject to judicial review.

(5) Representatives of the shareholders and of the policyholders, including representatives of shareholders and policyholders favoring or opposing the approval of the plan, shall be entitled to be present during the filing, casting, verification and canvassing of the proxies and ballots and shall be entitled to examine and object to any such proxy or ballot. The superintendent or the inspectors may limit the number of persons representing any interested person or group and may specify fair and reasonable procedures for the examination of and presentation of objections to the proxies and ballots. Costs incurred in providing such representation shall not be a charge upon or paid from the funds of the guarantee capital insurer.

(6) Neither the guarantee capital insurer nor any officer, agent or employee thereof shall knowingly omit, from any list of policyholders entitled to notice of the meeting, the name of any policyholders required to be included therein, or shall knowingly omit to give the

correct name and address of any policyholder, or shall knowingly give a wrong address. No person shall conceal or withhold or aid or abet any other person in concealing or withholding any proxy or ballot from the authorized custodians thereof or from the inspectors. No policyholder or shareholder shall sell or offer to sell any vote or proxy for any sum of money or anything of value other than the consideration provided for in the plan of reorganization if said plan becomes effective.

(7) All ballots and proxies received by the inspectors shall immediately upon the completion of the canvass be placed in sealed packages and shall be preserved by the said inspectors for a period of one year, subject to the order of any court having jurisdiction of any proceedings relating thereto, and then shall be turned over to the guarantee capital insurer, or the reorganized insurer, if the reorganization has become effective.

(8) The meeting and the conduct thereof shall at all times, on petition of the superintendent or of any person or persons whose rights may be affected, be subject to the supervision and control of the supreme court in the judicial district in which the guarantee capital insurer has its home office.

(9) The inclusion by the guarantee capital insurer of the name of any person in any list of policyholders required by this section shall not be construed as an admission by such insurer of the validity of any policy or contract and no such list shall be competent evidence against such insurer in any action or proceeding in which the question of the validity of any policy or contract or of any claim under it is involved.

(10) The provisions of section four thousand two hundred ten of this chapter shall not apply to a meeting of shareholders and policyholders held pursuant to this section.

(11) Upon the conclusion of the vote, the guarantee capital insurer shall submit to the superintendent (i) a certified copy of the plan of reorganization, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or an assistant secretary of the guarantee capital insurer, (ii) a certificate, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or assistant secretary of the guarantee capital insurer, or subscribed by the person or persons, if any, designated by the superintendent to supervise the giving of notice

of the meeting, to the effect that notice of the meeting was given in accordance with this section to all persons entitled to such notice, and (iii) a certificate subscribed by the inspectors of the attendance at the meeting and of the results of the vote thereat, as evidenced by the valid proxies and ballots filed thereat. Each such certificate shall be affirmed as true under the penalties of perjury by the person or persons subscribing the same and, in the case of a certificate signed by officers of the guarantee capital insurer, shall be affirmed under the corporate seal of the guarantee capital insurer.

(i) The superintendent shall approve the plan of reorganization in writing if he finds that the proposed reorganization does not violate this chapter and is fair and equitable to the shareholders and the policyholders and the public, and that after giving effect to the reorganization, the reorganized insurer would have capital and surplus at least equal to the minimum capital and surplus required by the superintendent for a newly organized stock insurer doing the same kind or kinds of insurance business, or an amount of capital and surplus the superintendent deems to be reasonably necessary for the solvency of the reorganized insurer, whichever is the greater. If approval is denied, the denial shall be in writing setting forth a statement of the reasons therefor and the guarantee capital insurer shall have the right to a hearing before the superintendent within thirty days of the date of such denial. Unless otherwise agreed by the guarantee capital insurer, the superintendent shall approve or disapprove the plan in writing on or before a date which is the later of: (i) sixty days after submission to him of the report of the appraiser or appraisers appointed pursuant to subsection (f) of this section, (ii) sixty days after the conclusion of the public hearing required by subsection (g) of this section, or (iii) ten days after certification to him of the results of the vote at the meeting held pursuant to subsection (h) of this section.

(j) When the superintendent has given his approval of the plan of reorganization as provided in subsection (i) of this section and certification of approval of the plan has been made to the superintendent as provided in subsection (h) of this section, a copy of the plan of reorganization with the superintendent's approval endorsed thereon shall be filed in the office of the superintendent. In the case of a merger, a copy of such plan shall also be filed in the office of

the clerk of the county where the principal office of the guarantee capital insurer and the domestic stock insurer is located. The plan of reorganization shall take effect in accordance with its terms on the date when the filings required by this subsection have been made or on such later date, if any, as may have been specified in such plan or pursuant thereto.

(k) Upon the conversion of the guarantee capital insurer or merger in the manner herein provided, all the rights, franchises and interests of the former guarantee capital insurer, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed transferred to and vested in the reorganized insurer, without any other deed or transfer; and simultaneously therewith such company shall be deemed to have assumed all of the obligations and liabilities of the former guarantee capital insurer, other than obligations and liabilities with respect to the policyholders' equity interest eliminated by the plan of reorganization.

(l) No action or proceeding pending at the time of the conversion or merger to which the guarantee capital insurer may be a party shall be abated or discontinued by reason of such conversion or merger, but the same may be prosecuted to final judgment in the same manner as if the conversion or merger had not taken place, or the reorganized insurer may be substituted in place of such guarantee capital insurer by order of the court in which the action or proceeding may be pending.

(m) The directors and officers of the guarantee capital insurer shall serve as directors and officers of the reorganized insurer until new directors and officers have been duly elected and qualified pursuant to the charter and by-laws of the reorganized insurer.

(n) The guarantee capital insurer shall deliver to the superintendent at the time of submission of the plan of reorganization a written undertaking in form and substance satisfactory to the superintendent and signed by the guarantee capital insurer and by such other persons as the superintendent may require, specifying the manner in which all costs and expenses incurred in any manner in connection with the plan of reorganization shall be paid or reimbursed. Such undertaking shall provide for the payment or reimbursement of all expenses incurred by the superintendent or the department of financial services in connection with the plan of reorganization, other than normal operating expenses of

the department of financial services. Such undertaking shall provide to the effect that no payment of expenses by the guarantee capital insurer or the reorganized insurer shall, after giving effect to any reimbursement or contribution received by such insurer with respect thereto, have the effect of reducing the consideration to be paid to the policyholders pursuant to the plan of reorganization or of reducing the portion of the surplus of the reorganized insurer which is attributable to policyholders. The said undertaking shall apply to expenses incurred prior to the submission of the plan of reorganization as well as those incurred thereafter and shall be binding whether or not the plan of reorganization takes effect. The consideration to be paid to policyholders pursuant to the plan shall not be subject to this subsection nor to said undertaking.

(o) Notice of the pendency of the proposed reorganization and of the effect thereof shall be given by the guarantee capital insurer or the reorganized insurer in a manner satisfactory to the superintendent to all persons to whom the guarantee capital insurer or the reorganized insurer delivers insurance contracts which are issued after the record date specified for policyholders entitled to receive any of the consideration provided for in the plan of reorganization but are issued on or before the date sixty days after such record date. Such persons shall have the right to rescind such contracts, and to receive refund of any amounts paid with respect thereto by written notice to such insurer or its agent given within ten days of their receipt of the aforesaid notice given by such insurer.

(p) If the plan of reorganization takes effect, the rights of all policyholders thereafter shall be as specified in the charter of the reorganized insurer and in their insurance contracts and they shall have no rights under the charter of the guarantee capital insurer. The reorganized insurer shall thereafter be subject to all laws, rules and regulations applicable to domestic stock life insurers and shall not be subject to any laws, rules or regulations of this state applicable to domestic mutual insurers and not to domestic stock life insurers. If the reorganized insurer has outstanding shares of guarantee capital after the reorganization takes effect, the reorganization shall not affect the rights of such shares as provided in the charter of the reorganized insurer but for all other purposes of this chapter such shares shall be

deemed to constitute shares of stock.

(q) If the guarantee capital insurer complies substantially and in good faith with the requirements of this section with respect to the giving of any required notice to shareholders or policyholders, its failure in any case to give such notice to any person or persons entitled thereto shall not impair the validity of the actions and proceedings taken under this section or entitle such person to any injunctive or other equitable relief with respect thereto but this subsection shall not impair any claim for damage such person or persons would otherwise have due to such failure.

(r) A shareholder or policyholder whose shares or policyholder's equity interest would be exchanged for or converted into other consideration pursuant to a plan of reorganization adopted pursuant to this section shall, by complying with section six hundred twenty-three of the business corporation law, except as otherwise provided in this subsection, have the right to receive payment for the fair value of his shares or policyholder's equity interest. In the case of a policyholder, no act pursuant to such section six hundred twenty-three, and no receipt by him of any payment pursuant to such section with respect to his policyholder's equity interest, shall impair or otherwise affect his rights expressly conferred by his insurance contract which are in addition to those rights conferred by or arising under the charter of the guarantee capital insurer. The provisions of section seven thousand one hundred nineteen of this chapter shall not apply in case of a reorganization under this section. For purposes of this subsection, the provisions of section six hundred twenty-three of the business corporation law, other than paragraphs (i) and (m) thereof are applicable except that:

(1) The references to "this chapter" in paragraph (a) of section six hundred twenty-three of the business corporation law are deemed to refer to this section.

(2) The references used in section six hundred twenty-three of the business corporation law to "shareholder" and "shareholders" are deemed to include a policyholder or policyholders and the references therein to "shares" are, in the case of a policyholder, deemed to refer to his policyholder's equity interest.

(3) The term "shareholders authorization date" used in section six

hundred twenty-three of the business corporation law is deemed to refer to the date of the meeting required by subsection (h) of this section.

(4) In the case of a policyholder, the information with respect to shareholdings required by paragraphs (a) and (c) of section six hundred twenty-three of the business corporation law to be contained in the notice of election to dissent is deemed to refer to the policy number of the policyholder's insurance contract entitling him to a policyholder's equity interest.

(5) Notwithstanding paragraph (e) of section six hundred twenty-three of the business corporation law, upon filing by a policyholder of election to dissent the policyholder shall cease to have any rights with respect to his policyholder's equity interest, but his rights expressly conferred by his insurance contract and not conferred by or arising under the charter of the guarantee capital insurer shall be unaffected. In the case of a policyholder, the provisions of paragraph (e) thereof providing for the reinstatement of a shareholder's rights in certain events are deemed to provide for reinstatement of his policyholder's equity interest.

(6) In the case of a policyholder, the provision of paragraph (f) of section six hundred twenty-three of the business corporation law, referring to share certificates shall be deemed to refer to insurance contracts.

(7) Any provision of paragraph (g) of section six hundred twenty-three of the business corporation law to the contrary notwithstanding, the written offer made pursuant to said paragraph to the policyholders who have filed notices of election to dissent shall be made at prices such that the total price offered to all such policyholders shall be apportioned among the different classes and categories of said dissenting policyholders in the same manner as the plan of reorganization provides for the total consideration to be paid pursuant thereto to be apportioned among all of the classes and categories of policyholders.

§ 7311. Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers in rehabilitation. (a) A

domestic mutual insurer organized under article twelve of this chapter and licensed pursuant to article forty-one of this chapter and operating pursuant to an order of rehabilitation, or a domestic advance premium corporation organized and licensed under article sixty-six of this chapter and operating pursuant to an order of rehabilitation, may, upon application of the superintendent and pursuant to an order granted by the court in which the rehabilitation is pending, be converted by the superintendent into a domestic stock insurer in rehabilitation to be organized under article twelve and licensed under article forty-one of this chapter, in accordance with the provisions of subsection (b) of this section.

(b) Before making such application to the court, the superintendent shall hold a public hearing, notice of which shall be given by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state in which the insurer has underwritten insurance within one year preceding the date of the order of rehabilitation.

(c) If, after such hearing, the superintendent concludes that such conversion is appropriate and is necessary for a successful rehabilitation or is likely to materially enhance the probability of a successful rehabilitation, he may apply to the court in which the rehabilitation is pending for an order directing him to convert such insurer into a domestic stock insurer in rehabilitation, pursuant to the plan of conversion that the superintendent shall propose, subject to court approval. The primary objective of the plan shall be the successful rehabilitation of the insurer. In the development of such plan the superintendent shall take into account the policyholders' equity, if any, at the time of conversion and may in his discretion provide for a distribution of such equity to each person who had a policy in effect at any time during the three year period (or such shorter period that the superintendent determines is practicable) preceding the date of the filing of the application by the superintendent. The plan shall provide for appropriate procedures necessary for the implementation of the proposed conversion. Such stock insurer in rehabilitation shall be subject to all of the applicable provisions of this chapter, except those provisions relating to licensing and financial requirements from which it is exempted by the

superintendent. Upon the termination of the order of rehabilitation, the exemptions granted by the superintendent shall cease and the insurer shall become subject to all applicable provisions of this chapter.

(d) The authorized capital stock of the new domestic stock insurer shall be held for the benefit of the qualifying prospective shareholders or purchasers by an escrow agent appointed by the superintendent. Such stock shall be released to the owners of record after the court approves the conversion and the order of rehabilitation is terminated.

(e) All expenses of the conversion, including the expenses incurred by the department of financial services, shall be borne by the company being converted.

§ 7312. Reorganization of a domestic mutual life insurer into a domestic stock life insurer. (a) Definitions. As used in this section, the following terms shall have the following meanings:

(1) "Mutual life insurer" means a domestic mutual life insurer.

(2) "Policyholder" means a person, as determined by the records of a mutual life insurer, who is deemed to be the "policyholder" of a policy or annuity contract which is of a type described in paragraphs one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter for purposes of paragraph three of subsection (a) of section four thousand two hundred ten of this chapter.

(3) "Policyholders' membership interest" means and includes all policyholders' rights as members arising under the charter of the mutual life insurer or this chapter or otherwise by law including, but not limited to, the rights to vote and to participate in any distribution of surplus whether or not incident to a liquidation of the mutual life insurer. The term "policyholders' membership interest" does not include rights, including without limitation the right to participate in the distribution of surplus, expressly conferred upon the policyholders by their policies or contracts other than any right to vote.

(4) "Plan of reorganization" means a plan of conversion or conversion and merger in accordance with this section.

(5) "Reorganized insurer" means the domestic stock life insurer into which a mutual life insurer has been reorganized in accordance with this section.

(6) "Statement date" means the December thirty-first immediately prior to the date the plan of reorganization was adopted.

(7) "Person" means an individual, partnership, firm, association, corporation, joint-stock company, trust, any similar entity or any combination of the foregoing acting in concert.

(b) Demutualization. Any other provision of this chapter to the contrary notwithstanding, upon compliance with the requirements of and completion of the proceedings prescribed by this section and with the written approval of the superintendent, a mutual life insurer may either (1) reorganize into a domestic stock life insurer or (2) reorganize as part of a plan of reorganization in which a majority or all of the common shares of the domestic stock life insurer is acquired by another institution which may be an institution organized for such purpose. As part of the reorganization, the mutual life insurer may merge with a domestic stock insurer, provided that the merging insurers shall comply with the provisions of this chapter applicable to their participation in such a merger.

(c) Plan of reorganization. A plan of reorganization must: (1) demonstrate a purpose and specify reasons for the proposed reorganization; (2) be in the best interest of the mutual life insurer and its policyholders; (3) be fair and equitable to policyholders; (4) provide for the enhancement of the operations of the reorganized insurer; and (5) not substantially lessen competition in any line of insurance business.

(d) Reorganization. The proposed reorganization shall be accomplished by a plan which must be fair and equitable to the policyholders and must comply with the terms and conditions set forth in paragraph one, two or four of this subsection provided however, that a mutual life insurer which has surplus to policyholders, excluding contingently repayable obligations of the mutual life insurer under section one thousand three hundred seven of this chapter, of less than fifty million dollars and which has industrial insurance in force must comply with the terms and conditions set forth in paragraph one, two, three or four of this subsection. Nothing herein contained shall be deemed to give any class of policyholders priority with respect to the assets of any such reorganized insurer in liquidation, other than as expressly stated in paragraph two of this subsection.

(1) (A) The mutual life insurer's participating business comprised of its participating policies and contracts in force on the effective date of reorganization shall be operated by the reorganized insurer as a closed block of participating business in accordance with paragraph five of this subsection except that, at the option of the mutual life insurer, some or all classes of group policies and contracts may be excluded from the closed block of participating business and in such event such group policies and contracts shall continue to be eligible to receive dividends based on the experience of such class or classes; (B) subject to the provisions of subparagraph (D) of this paragraph, the plan of reorganization provides that the policyholders' membership interest will be exchanged for all of the common shares of the reorganized insurer or its parent company, if any, or for either, or a combination of (i) the common shares of the reorganized insurer or its parent company, if any, and (ii) consideration equal to the proceeds of the public sale in the market of such common shares by the issuer thereof or by a trust or other entity existing for the exclusive benefit of the policyholders and established solely for the purpose of effecting the reorganization to which such common shares are issued by the issuer on the effective date of reorganization, such consideration to be distributed to policyholders during a process of reorganization specified in the plan and not to last more than ten years after the effective date of reorganization or until notification of the death of a policyholder or the death of the insured, whichever occurs first; (C) the consideration to be given to the policyholders is allocated among the policyholders in a manner which is fair and equitable to policyholders and which may take into account the estimated proportionate contribution of each class of participating policies and contracts to the aggregate consideration being given to policyholders; (D) unless such issuance within a shorter or longer period is disclosed in the plan of reorganization, the issuer of such common shares has not issued and does not issue within two years of the effective date of the reorganization (i) any of its common shares, (ii) any securities convertible, with or without consideration, into such common shares or carrying any warrant or right to subscribe to or to purchase common shares, or (iii) any warrants or rights to subscribe to or purchase such common shares or other securities described in item (ii) of this

subparagraph, except for the issue of common shares to or for the benefit of the policyholders pursuant to the reorganization and the issue of stock in anticipation of options for the purchase of common shares being granted to officers or employees of the reorganized insurer or its holding company, if any, pursuant to this chapter and a plan approved by the superintendent; (E) the issuer shall use its best efforts to encourage and assist in the establishment of a public market for such common shares within two years of the effective date of the reorganization (or such longer period as may be disclosed in the plan of reorganization); (F) within one year after the offering of stock other than the initial distribution, but no later than six years after the effective date of the reorganization the insurer, under a plan approved by the superintendent, which he finds not to be harmful to the reorganized insurer, shall offer to make available to policyholders who received and retained shares of stock with minimal values on reorganization, a procedure to dispose of those shares of stock at market value without brokerage commissions or similar fees; and (G) the costs and expenses of the reorganization shall be borne by the insurer but no costs and expenses incurred in any manner in connection with the reorganization shall be charged to the closed block.

(2) (A) The mutual life insurer's participating business comprised of its participating policies and contracts in force on the effective date of the reorganization shall be operated by the reorganized insurer as a closed block of participating business in accordance with paragraph five of this subsection except that, at the option of the mutual life insurer some or all classes of group policies and contracts may be excluded from the closed block of participating business and in such event such group policies and contracts shall continue to be eligible to receive dividends based on the experience of such class or classes; (B) the reorganized insurer or its parent corporation is to issue and sell shares of one or more classes of stock having a total offering price equal to the estimated value in the public market of the mutual life insurer; (C) the policyholders' equity is equal to the excess of (i) the amount of the mutual insurer's assets accumulated from the operations of participating policies and contracts in force on the effective date of the reorganization, over the sum of (ii) the amount of assets allocated to the closed block of participating business and (iii) an amount equal

to the statutory reserves and other statutory liabilities attributable to any group participating policies and contracts in force on the effective date of reorganization and not included in the closed block of participating business, provided however, that the policyholders' equity cannot be less than the amount of the policyholders' preference account. The amount of the policyholders' equity shall be determined as of the statement date and adjusted by the estimated percentage change in the mutual insurer's total assets, as reported in its statutory statements, between the statement date and the effective date of the reorganization. Any determination of policyholders' equity shall include adjustments for any events or matters deemed by the superintendent appropriate, which have a material effect on policyholders' equity and occurred within seven years prior to the statement date; (D) the plan of reorganization provides that the policyholders' membership interest will be exchanged for consideration equal to (i) the policyholders' equity, (ii) nontransferable preemptive subscription rights to purchase all of the shares of such issuer, (iii) ten percent of the proceeds net of underwriting commissions and fees raised by the insurer upon the sale of its initial offering of shares, and (iv) the establishment of a policyholders' preference account for the benefit of policyholders existing on the effective date of reorganization, and for the benefit of the future policyholders of the reorganized insurer, in the event of a subsequent complete liquidation of the reorganized insurer, such policyholders' preference account having the terms described below in this paragraph; (E) the consideration to be given to the policyholders is allocated among the policyholders in a manner which is fair and equitable to policyholders and which may take into account the estimated proportionate contribution of each class of participating policies and contracts to the aggregate consideration being given to policyholders; (F) at the option of the mutual life insurer, any common shares of the reorganized insurer or its parent company, if any, included in the policyholders' consideration, other than those acquired as a result of a policyholder exercising any preemptive subscription rights, may be placed in a trust or other entity existing for the exclusive benefit of the policyholders and established solely for the purpose of effecting the reorganization to which such common shares are issued by the issuer on the effective date of reorganization, such consideration or the

proceeds of the sale of such consideration to be distributed to policyholders during a process specified in the plan and not to last more than ten years after the effective date of reorganization or until notification of the death of the policyholder or the death of the insured, whichever occurs first; (G) the issuer shall use its best efforts to encourage and assist in the establishment of a public market for such common shares within two years of the effective date of the reorganization; (H) within one year after the offering of stock other than the initial distribution, but no later than six years after the effective date of the reorganization the insurer, under a plan approved by the superintendent which he finds not to be harmful to the reorganized insurer, shall offer to make available to policyholders who received and retained shares of stock with minimal values on reorganization, including but not limited to shares acquired by policyholders exercising their preemptive subscription rights, a procedure to dispose of those shares of stock at market value without brokerage commissions or similar fees; (I) the costs and expenses of the reorganization shall be borne by the insurer, however if the reorganization is effected, no costs and expenses incurred in any manner in connection with the reorganization shall be charged to the participating business in force on the effective date of reorganization. Costs and expenses shall include but not be limited to legal fees, appraisal fees, printing and/or mailing costs; (J) notwithstanding subparagraph (I) of this paragraph, if the plan of reorganization provides for or permits a person to directly or indirectly acquire in any manner the beneficial ownership of five percent or more of the voting securities of such reorganized insurer or of any institution which owns a majority or all of the voting securities of the reorganized insurer, or if the superintendent determines that a person will control, as defined in paragraph sixteen of subsection (a) of section one hundred seven of this chapter, such reorganized insurer or any institution which owns a majority or all of the voting securities of the reorganized insurer then, unless the superintendent determines that it is in the policyholders' interest to waive all or part of this condition, the mutual life insurer shall not, directly or indirectly, pay for any of the costs or expenses of a proposed reorganization whether or not such reorganization is effected and in no event shall any of the costs and

expenses incurred in any manner in connection with the reorganization be charged to the participating business in force on the effective date of reorganization. Costs and expenses shall include but not be limited to legal fees, appraisal fees, printing and/or mailing costs; (K) the policyholders' preference account referred to above shall be equal to the excess of the amount of the mutual insurer's total admitted assets over the sum of (i) the total amount of assets allocated to the closed block of participating business and (ii) the policyholders' equity and (iii) statutory reserves and liabilities attributed to policies and contracts not included in the closed block of participating business. The policyholders' preference account shall be calculated as of the statement date and adjusted appropriately to reflect any changes in the components used in determining the amount of the policyholders' preference account between the statement date and the effective date of reorganization; (L) a mutual life insurer whose policyholders' equity is paid in the form of stock may show, as a write-in item labeled "Reorganization surplus" immediately following "Capital paid up" on the annual statement of the reorganized insurer, a negative amount equal to the excess of the policyholders' equity which was paid in the form of stock over its unassigned surplus on the date of reorganization; and (M) the policyholders' preference account shall be so designated and shown as a footnote to the surplus of the reorganized insurer in all of its published and filed statements. In the event of a subsequent complete liquidation of the reorganized insurer, and only in such event, the policyholders' preference account shall be allocated among the then policyholders in a manner found by the superintendent to be fair and equitable to policyholders, first to policyholders having participating policies and contracts in force on the effective date of the reorganization and then to all other policyholders of the reorganized insurer. The function of the policyholders' preference account shall be solely to establish a priority on liquidation and its existence shall not operate to restrict the use or application of the surplus of the reorganized insurer except that the reorganized insurer, after complying with all other requirements of this chapter, cannot declare or pay a cash dividend on, or repurchase any of, its shares if, after such declaration or payment, the amount of net preference assets of the reorganized insurer is less than the amount of the policyholders'

preference account. For this purpose, the net preference assets shall be equal to the insurer's total admitted assets less the sum of (i) the assets in the closed block of participating business (ii) the statutory reserves and liabilities with respect to business not in such closed block and (iii) the reorganized insurer's capital and paid in surplus.

(3) (A) The mutual life insurer's participating business comprised of its participating policies and contracts in force on the effective date of the reorganization shall be operated by the reorganized insurer as a closed block of participating business, for policyholder dividend purposes only, to which shall be allocated admitted assets of the mutual life insurer in an amount equal to the statutory reserves and statutory liabilities of the mutual life insurer; (B) the consideration to be given in exchange for the policyholders' membership interest shall be equal to the statutory surplus of the mutual life insurer; (C) the amount of statutory reserves and statutory liabilities and statutory surplus shall be determined as of the statement date and adjusted by the estimated percentage change in the mutual insurer's total admitted assets between the statement date and the effective date of reorganization. Any determination of statutory surplus shall include adjustments for any events or matters deemed by the superintendent appropriate, which have a material effect on policyholders' consideration and occurred within seven years prior to the statement date; (D) the consideration shall be allocated among the policyholders in a manner which is fair and equitable to the policyholders and which may take into account the estimated proportionate contribution of each class of participating policies and contracts to the aggregate consideration being given to policyholders; (E) the reorganized insurer or its parent corporation is to issue and sell shares of one or more classes of stock having a total offering price equal to the estimated value in the market of the mutual life insurer; (F) the costs and expenses of the reorganization shall be borne by the insurer; however, if the plan of reorganization provides for or permits a person to directly or indirectly acquire in any manner the beneficial ownership of five percent or more of any class of a voting security of such reorganized insurer or of any institution which owns a majority or all of the voting securities of the reorganized insurer, or if the superintendent determines that a person will control, as defined in

paragraph sixteen of subsection (a) of section one hundred seven of this chapter, such reorganized insurer or any institution which owns a majority or all of the voting securities of the reorganized insurer then, unless the superintendent determines that it is in the policyholders' interest to waive all or part of this condition, the mutual life insurer shall not, directly or indirectly, pay for any of the costs or expenses of a proposed reorganization whether or not such reorganization is effected. Costs and expenses shall include but not be limited to legal fees, appraisal fees, printing and/or mailing costs; and (G) none of the assets, including the revenue therefrom, allocated in accordance with subparagraph (A) of this paragraph shall revert to the benefit of the stockholders of the reorganized insurer.

(4) (A) Any method approved by the superintendent under which the policyholders' membership interest is converted into or exchanged for consideration determined by the superintendent to be fair and equitable to policyholders and meeting the requirements of this section; (B) the consideration to be given to the policyholders is allocated among the policyholders in a manner which is fair and equitable; (C) unless the superintendent determines that it is in the policyholders' interest to waive all or part of this condition, the mutual life insurer does not, directly or indirectly, pay for any of the costs or expenses of a proposed reorganization whether or not such reorganization is effected. Costs and expenses shall include but not be limited to legal fees, appraisal fees, printing and/or mailing costs; and (D) in determining whether any reorganization is fair and equitable, the superintendent shall be guided by the legitimate economic interests of participating policyholders as delineated in this section.

(5) (A) When the mutual life insurer's participating business comprised of its participating policies and contracts in force on the effective date of the reorganization shall be operated by the reorganized insurer as a closed block of participating business in accordance with paragraphs one and two of this subsection, then it shall be so operated for the exclusive benefit of such policies and contracts included therein, for policyholder dividend purposes only; (B) to such closed block shall be allocated assets of the mutual life insurer in an amount which together with anticipated revenue from such business is reasonably expected to be sufficient to support such business including,

but not limited to, provisions for payment of claims, expenses and taxes, and to provide for continuation of current payable dividend scales, if the experience underlying such scales continues and for appropriate adjustments in such scales if the experience changes; (C) the amount of such assets shall be determined as of the statement date and brought forward to the effective date of the reorganization using methods which would have been used had the closed block been established on the statement date with appropriate recognition of new issues; and (D) none of the assets, including the revenue therefrom, allocated in accordance with subparagraph (B) of this paragraph shall revert to the benefit of the stockholders of the reorganized insurer.

(6) If any amount of the policyholders' consideration for certain classes of policies or contracts is to be paid in the form of increased annual dividends to the policyholders in those classes, that amount is to be added to the assets previously allocated in accordance with paragraph three or five of this subsection and is to be paid out to those classes in a fair and equitable manner.

(e) Adoption of plan of reorganization. (1) A mutual life insurer seeking to reorganize under this section shall, by action of three-fourths of its entire board of directors, adopt a plan consistent with the provisions of this section and that it finds is fair and equitable to the policyholders. The board of directors of the mutual life insurer, in selecting one of the methods described in subsection (d) of this section, shall set forth the basis for their selection. The plan of reorganization shall set forth (A) a demonstration of the purpose for the proposed reorganization; (B) the form of the reorganization; (C) the proposed charter of the reorganized insurer set out in accordance with section one thousand two hundred one of this chapter and its proposed by-laws which shall provide for the removal of the word "mutual" from the name of the company; (D) the manner and basis by which the reorganization shall take place; (E) the consideration to be given to the policyholders in exchange for their policyholders' membership interest or the manner of converting the policyholders' membership interest into securities or other consideration; (F) the method of allocating the consideration among policyholders; (G) the method of operation of the mutual life insurer's participating business comprised of its participating policies and contracts in force on the

effective date of the reorganization; and (H) a plan of operation for the reorganized insurer including actuarial projections for a ten-year period and a statement indicating its intentions with regard to issuing any nonparticipating business. If the reorganized insurer proposes to continue to issue for delivery in this state participating policies or contracts, the plan of reorganization shall so specify. In such event, upon the superintendent's approval of the plan of reorganization pursuant to this section, the superintendent shall, in accordance with section four thousand two hundred thirty-one of this chapter, issue a revocable permit to the reorganized insurer authorizing it to issue participating policies and contracts in this state. The plan of reorganization may contain any other conditions and provisions which the board of directors of the mutual life insurer may deem necessary or advisable in connection with the proposed reorganization.

(2) The consideration to be given in exchange for the policyholders' membership interest or into which such membership interest is to be converted may consist of cash, securities of the reorganized insurer or securities of another institution or institutions, a certificate of contribution, additional life insurance or annuity benefits, increased dividends or other consideration or any combination of such forms of consideration. The consideration, if any, given to any class or category of policyholder need not be the same as the consideration given to any other class or category of policyholder. The certificate of contribution referred to above shall be repayable in five years and bear annual interest at the published monthly average, as defined in section three thousand two hundred six of this chapter, for the calendar month ending two months before the effective date of reorganization.

(3) The policyholders who shall be entitled to notice of and to vote upon the proposal to approve the plan of reorganization and to notice of the public hearing required by this section shall be the policyholders whose policies or contracts are in force on the date of adoption of the plan of reorganization. Each such policyholder whose policy has been in force on such date shall be entitled to the consideration, if any, provided for such policyholder in the plan based on such policyholder's membership interest determined pursuant to this section but only to the extent that such policyholder's membership interest arose from policies or contracts that shall be in force on the date of adoption of the plan.

(4) Upon adoption of the plan of reorganization, it shall be duly executed by the chairman of the board, the president or a vice president and attested by the secretary or an assistant secretary of the mutual life insurer under such insurer's corporate seal and shall be submitted to the superintendent with a copy of the resolutions adopting such plan and finding that it is fair and equitable to the policyholders, accompanied by a certificate of adoption of such resolutions subscribed by such officers and affirmed by them as true under penalties of perjury and under the seal of the mutual life insurer.

(f) Amendment or withdrawal of plan. The mutual life insurer may, by action of a majority of the entire board of directors, at any time before the plan of reorganization becomes effective as provided by this section (1) amend the plan of reorganization; or (2) withdraw the plan of reorganization. On adoption of an amendment it shall be duly executed by the chairman of the board, the president or a vice president and attested by the secretary or an assistant secretary of the mutual life insurer under such insurer's corporate seal and shall be submitted to the superintendent with a copy of the resolutions adopting such amendments subscribed by such officers and affirmed by them as true under penalties of perjury and under the seal of the mutual life insurer. In case of an amendment, all references in this section to the plan of reorganization shall be deemed to refer to the plan as amended. No amendment made after any public hearing required by this section or after approval by the policyholders as provided in this section shall change the plan in a manner which the superintendent determines is materially disadvantageous to any of the policyholders unless a further public hearing is held on the plan as amended if the amendment is made after the public hearing, or the plan as amended is submitted for reconsideration by the policyholders if the amendment is made after the plan has been approved by the policyholders, under the conditions and procedures determined by the superintendent in accordance with this section.

(g) Additional information. Upon submission to him of the plan of reorganization, the superintendent may request any additional documents or information and may examine the mutual life insurer or any of its affiliates, to the extent he may determine to be necessary to enable him to make the findings required by this section for the approval by him of

the plan of reorganization. If the reorganized insurer proposes to continue to issue for delivery in this state participating policies or contracts, the superintendent may also request such information or agreements relative thereto as he may require pursuant to section four thousand two hundred thirty-one of this chapter.

(h) Consultants and certifications. (1) The superintendent may appoint one or more qualified disinterested persons or institutions as consultants to advise him on any matters related to the reorganization. The appointment of a consultant shall be in writing and shall set forth the duties and responsibilities of the consultant. Copies of such appointment shall be given to the consultant and concurrently to the mutual life insurer.

(2) If the plan of reorganization satisfies the conditions set forth in paragraph one or two of subsection (d) of this section, the superintendent shall appoint one or more qualified and disinterested actuaries for the purpose specified in paragraph three of this subsection. Such actuary shall be a member of the American Academy of Actuaries, and shall be knowledgeable and experienced as to the matters to be certified.

(3) Such actuary shall certify in writing as to (A) in the case of a plan of reorganization pursuant to paragraph two of subsection (d) of this section, the amount of the mutual insurer's assets accumulated from the operations of participating policies and contracts in force on the effective date of the reorganization and (B) in the case of a plan of reorganization pursuant to paragraphs one or two of subsection (d) of this section, the reasonableness and sufficiency of the asset allocation referred to in subparagraph (B) of paragraph five of subsection (d) of this section. Such certification shall be in form satisfactory to the superintendent and shall be made in accordance with professional standards and practices generally accepted by the actuarial profession and such other factors as such actuary in his professional judgment believes are reasonable and appropriate at the time such certification is made. Any such certification shall be accompanied by a memorandum of the actuary, in form satisfactory to the superintendent, describing the calculations made in support of such certification and the assumptions used in such calculations.

(4) The consultant and the actuary may request of the mutual life

insurer access to its books and records and the furnishing by it of any other information in its possession, to the extent it may reasonably be deemed necessary to make the valuations and certifications contemplated by this subsection, or to advise the superintendent on any matters related to the reorganization. The consultant and the actuary shall report to the superintendent any instance in which the mutual life insurer fails to provide any information requested by them. The consultant and the actuary shall not, under judicial process or otherwise, be obligated or permitted to divulge to any one except the superintendent any information not otherwise publicly available which is so obtained by them. The consultant and the actuary shall receive reasonable compensation and shall be reimbursed for reasonable expenses incurred in performing their duties.

(5) The report of the consultant and the certification of the actuary shall be made to the superintendent. In making the determinations contemplated by this section, the superintendent shall not be bound by any findings, conclusions, certifications or recommendations made by the consultant or the actuary. All information obtained by the superintendent pursuant to this section, including without limitation information obtained through examinations by him, the report of the consultant, the certification of the actuary, the memorandum of the actuary and other information secured by the consultant or the actuary and turned over to the superintendent, are hereby specifically exempted, as contemplated by paragraph (a) of subdivision two of section eighty-seven of the public officers law, from disclosure by the superintendent under said section eighty-seven of such law. Such exemption shall not preclude or exempt the superintendent from disclosure of such information pursuant to judicial process under provisions of law other than said section eighty-seven of the public officers law, nor prohibit any disclosure which in the opinion of the superintendent, and after an opportunity for the insurer to be heard, the superintendent deems should be made public for the benefit of the insurer, its policyholders or the public. If the department intends to make any report or certification public, then such report or certification shall be made available to the company at least fifteen days prior to such public disclosure.

(6) Nothing contained in this section shall be construed to exclude

any person or employee or member of an institution from the category of "disinterested person" solely because such individual is a policyholder of the insurer or that such person or institution is to be one of the underwriters of any shares to be sold pursuant to the plan of reorganization.

(i) Public hearing. The superintendent shall hold a public hearing upon the fairness of the terms and conditions of the plan of reorganization, the reasons and purposes for the mutual life insurer to demutualize, and whether the reorganization is in the interest of the mutual life insurer and its policyholders, and not detrimental to the public. Notice stating the time, place and purpose of the hearing shall be mailed by the mutual life insurer to each policyholder entitled to notice of the hearing in accordance with paragraph three of subsection (e) of this section, at his last known address as shown on the records of the mutual life insurer; such notice shall be mailed at least thirty days before the date of the hearing. Such notice shall be preceded or accompanied by a true and complete copy of the plan, or by a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require. In addition, the mutual life insurer shall give notice of the time, place and purpose of the hearing by publication in three newspapers of general circulation, one in the county in which the insurer has its principal office and two in other cities within or without this state approved by the superintendent. Such newspaper publications shall be made not less than fifteen days nor more than sixty days before the hearing, and shall be in a form approved by the superintendent.

(j) Approval of plan by superintendent. The superintendent shall after the public hearing required by subsection (i) of this section approve the plan of reorganization if he finds that the proposed reorganization, in whole and in part, does not violate this chapter, is fair and equitable to the policyholders and is not detrimental to the public and that, after giving effect to the reorganization, the reorganized insurer will have an amount of capital and surplus the superintendent deems to be reasonably necessary for its future solvency. If approval is denied, the denial shall be in writing setting forth a statement of the reasons therefor and the mutual life insurer shall have the right to a hearing before the superintendent within thirty days of the date of such denial.

The superintendent shall not disapprove of a plan of reorganization for the reason that the mutual life insurer selected one of the methods provided for in subsection (d) of this section rather than another. The superintendent shall approve or disapprove the plan in writing on or before sixty days after the conclusion of the public hearing required by subsection (i) of this section.

(k) Approval by policyholders. (1) A proposal to approve the plan of reorganization shall be submitted to policyholders. Notice stating the date, time and place for voting on such proposal shall be mailed by the mutual life insurer to each policyholder entitled to notice of and to vote on the proposal in accordance with paragraph three of subsection (e) of this section, at his last known address as shown on the records of the mutual life insurer; such notice shall be mailed at least thirty days before the date of the action. Such notice may be combined with notice of the public hearing required by this section. Such notice shall be preceded or accompanied by a true and complete copy of the plan, or by a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require.

(2) Each policyholder entitled to vote on the proposal shall be entitled to cast one vote, unless otherwise provided in the charter or by-laws of the mutual life insurer, on the proposal, either in person or by mail or by proxy, irrespective of the number or amount of the policies or contracts he holds. Any proxy shall be revocable at any time except to the extent that, at the time of exercise, the power conferred thereby has been exercised. All votes shall be by written ballot cast in person or by mail by policyholders entitled to vote or by proxy agents duly appointed by policyholders entitled to vote. The voting on the proposal shall be held at the home office of the mutual life insurer. The polls shall be opened at ten o'clock in the forenoon and remain open until four o'clock in the afternoon of the day fixed for such voting, at which time they shall be closed. The proposal to approve the plan of reorganization may be adopted by the affirmative vote of two-thirds of all votes cast by policyholders entitled to vote.

(3) The superintendent shall have power to supervise and direct and prescribe rules governing the procedure for the conduct of the voting on the proposal to such extent, consistent with the provisions of this section, as he deems necessary to insure a fair and accurate vote. Such

powers shall include, but not be limited to, power to supervise and regulate (A) the determination of policyholders entitled to notice of and to vote on the proposal; (B) the giving of notice of the proposal; (C) the receipt, custody, safeguarding, verification and tabulation of proxy forms and ballots; and (D) the resolution of disputes.

(4) The superintendent shall appoint as inspectors an adequate number of personnel of the department of financial services or other competent and disinterested persons and may appoint, if necessary, expert accountants and other assistants and may authorize the procurement of stationery and supplies necessary for conducting the voting on the proposal and canvassing the votes. The inspectors shall have power to determine all questions concerning the verification of the ballots and proxies, the ascertainment of the validity thereof, the qualifications of the voters and the canvass of the vote, and with respect thereto shall act under such rules as shall be prescribed by the superintendent. Any disagreement among the inspectors shall be reported to and shall be resolved by the superintendent. Any determinations by the inspectors or the superintendent shall be subject to judicial review.

(5) Representatives of the policyholders, including representatives of policyholders favoring or opposing the approval of the plan, shall be entitled to be present during the casting, verification and canvassing of the proxies and ballots and shall be entitled to examine and object to any such proxy or ballot. The superintendent or the inspectors may limit the number of persons representing any interested person or group and may specify fair and reasonable procedures for the examination of and presentation of objections to the proxies and ballots. Costs and expenses incurred in providing such representation shall not be a charge upon or paid from the funds of the mutual life insurer or the person responsible for the costs and expenses of the reorganization.

(6) Neither the mutual life insurer nor any officer, agent or employee thereof shall knowingly omit, from any list of policyholders entitled to notice of and to vote on the proposal, the name of any policyholder required to be included therein, or shall, in connection with any such list, knowingly omit to give the name and address, as last shown on the records of the mutual life insurer, of any policyholder. No person shall conceal or withhold or aid or abet any other person in concealing or withholding any proxy or ballot from the authorized custodians thereof

or from the inspectors. No policyholder shall sell or offer to sell any vote or proxy for any sum of money or anything of value other than the consideration provided for in the plan or reorganization if such plan becomes effective.

(7) All ballots and proxies received by the inspectors shall immediately upon the completion of the canvass be placed in sealed packages and shall be preserved by the inspectors for a period of four years, subject to the order of any court having jurisdiction of any proceedings relating thereto, and then shall be turned over to the mutual life insurer, or the reorganized insurer if the reorganization has become effective.

(8) The conduct of the voting on the proposal shall at all times, on petition of the superintendent or of any person or persons whose rights may be affected, be subject to the supervision and control of the supreme court in the judicial district in which the mutual life insurer has its home office.

(9) The inclusion by the mutual life insurer of the name of any person in any list of policyholders required by this section shall not be construed as an admission by such insurer of the validity of any policy or contract and no such list shall be competent evidence against such insurer in any action or proceeding in which the question of the validity of any policy or contract or of any claim under it is involved.

(10) The provisions of section four thousand two hundred ten of this chapter shall not apply to the action by policyholders pursuant to this section.

(11) Upon the conclusion of the vote, the mutual life insurer shall submit to the superintendent (A) a certified copy of the plan of reorganization, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or an assistant secretary of the mutual life insurer; (B) a certificate, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or assistant secretary of the mutual life insurer, or subscribed by the person or persons, if any, designated by the superintendent to supervise the giving of notice of the date for action on the proposal, to the effect that such notice was given in accordance with this section to all policyholders entitled to such notice; and (C) a certificate subscribed by the inspectors of the

results of the vote, as evidenced by valid ballots received before the polls were closed. Each such certificate shall be affirmed as true under the penalties of perjury by the person or persons subscribing the same and, in the case of a certificate signed by officers of the mutual life insurer, shall be affirmed under the corporate seal of the mutual life insurer.

(l) Effective date of reorganization. When the superintendent has given his approval of the plan of reorganization as provided in subsection (j) of this section and certification of approval of the plan has been made to the superintendent as provided in subsection (k) of this section, a copy of the plan of reorganization, with the superintendent's approval endorsed thereon, shall be filed in the office of the superintendent. A copy of such plan certified by the superintendent shall also be filed by the mutual life insurer in the office of the clerk of the county where the principal office of the mutual life insurer is located. The plan of reorganization shall take effect in accordance with its terms on the date when the filings required by this subsection have been made or on such later date, if any, as may have been specified in or determined in accordance with said plan or pursuant thereto. The superintendent shall issue an amended certificate of authority to the reorganized insurer and such license, if any, as may be required under section one thousand two hundred four of this chapter for the sale of its securities as specified in its plan of reorganization.

(m) Corporate existence. Upon the reorganization of the mutual life insurer in the manner herein provided, the reorganized insurer shall be deemed a continuation of the corporate existence of the mutual life insurer or, in the case of a merger, of the company specified in the plan of reorganization as the continuing company, which may be either the mutual life insurer or the domestic stock life insurer with which it is merged. All the rights, franchises and interests of the mutual life insurer and, in the case of a merger, of the domestic stock insurer, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed transferred to and vested in the continuing company, without any other deed or transfer; and simultaneously therewith such continuing company shall be deemed to have assumed all of the obligations and liabilities of the mutual life

insurer and, in the case of a merger, of the domestic stock insurer, other than obligations and liabilities with respect to the policyholders' membership interest eliminated by the plan of reorganization.

(n) Actions and proceedings. No action or proceeding pending at the time of the reorganization to which the mutual life insurer may be a party shall be abated or discontinued by reason of such reorganization, but the same may be prosecuted to final judgment in the same manner as if the reorganization had not taken place, or the reorganized insurer may be substituted in place of such mutual life insurer by order of the court in which the action or proceeding may be pending.

(o) Directors and officers. The directors and officers of the mutual life insurer, unless otherwise specified in the plan of reorganization, shall serve as directors and officers of the reorganized insurer until new directors and officers have been duly elected and qualified pursuant to the charter and by-laws of the reorganized insurer.

(p) Costs and expenses. (1) The mutual life insurer shall deliver to the superintendent at the time of submission of the plan of reorganization a written undertaking in form and substance satisfactory to the superintendent and signed by the mutual life insurer, and by such other persons as the superintendent may require, specifying the manner in which all costs and expenses incurred in any manner in connection with the plan of reorganization shall be paid or reimbursed. Such undertaking shall provide for the payment or reimbursement of all expenses incurred by the superintendent or the department in connection with the plan of reorganization, other than normal operating expenses of the department.

(2) Such undertaking, other than a reorganization pursuant to paragraph one of subsection (d) of this section, shall also provide that no payment of costs and expenses by the mutual life insurer or the reorganized insurer shall, after giving effect to any reimbursement or contribution received by such insurer with respect thereto, have the effect of reducing the consideration, other than the policyholders' preference account referred to in paragraph two of subsection (d) of this section, to be paid to the policyholders pursuant to the plan of reorganization. The requirements of this paragraph may be waived in a reorganization pursuant to paragraphs three and four of subsection (d)

of this section if the superintendent determines that it is in the policyholders' interest to do so.

(3) The said undertaking shall apply to costs and expenses incurred prior to the submission of the plan of reorganization as well as those incurred thereafter and shall be binding whether or not the plan of reorganization takes effect. The consideration to be given to policyholders pursuant to the plan shall not be deemed a cost or expense of the reorganization subject to this subsection nor to such undertaking.

(q) Notice of proposed reorganization. Notice of the pendency of the proposed reorganization and of the effect thereof shall be given by the mutual life insurer in a manner satisfactory to the superintendent to all persons to whom the mutual life insurer delivers policies or contracts which are issued after the date on which the plan of reorganization is adopted by the mutual life insurer and before the plan takes effect or is withdrawn. Such persons shall have the right, unless the laws of their domiciliary state gives other rights, to rescind such policies or contracts, and to be refunded any amounts paid with respect thereto, by written notice to such insurer or its agent given within ten days of their receipt of the aforesaid notice given by such insurer.

(r) Effect of reorganization. If the plan of reorganization takes effect, the rights of all policyholders thereafter shall be as specified in their policies or contracts, in the charter of the reorganized insurer and in the plan of reorganization, except for the elimination of the right to vote, if any, and they shall have no rights under the charter of the mutual life insurer. The reorganized insurer shall thereafter be subject to all laws, rules and regulations applicable to domestic stock life insurers and shall not be subject to any laws, rules or regulations of this state applicable to domestic mutual insurers and not to domestic stock life insurers.

(s) Failure to give notice. If the mutual life insurer complies substantially and in good faith with the requirements of this section with respect to the giving of any required notice to policyholders, its failure in any case to give such notice to any person or persons entitled thereto shall not impair the validity of the actions and proceedings taken under this section or entitle such person to any injunctive or other equitable relief with respect thereto, but this

subsection shall not impair any claim for damage such person or persons would otherwise have due to such failure.

(t) Limitation of actions; security. (1) Any action challenging the validity of or arising out of acts taken or proposed to be taken under this section must be commenced within one year after a copy of the plan of reorganization, with the superintendent's approval endorsed thereon, shall be filed in the office of the superintendent or six months from the effective date of the reorganization, whichever is later, or if the plan of reorganization is withdrawn, within six months of such withdrawal.

(2) In any action arising out of acts taken or proposed to be taken under this section, the mutual life insurer of the reorganized insurer shall be entitled at any stage of the proceedings before final judgment to petition the court to require plaintiff or plaintiffs to give security for the reasonable expenses, including attorneys' fees, which may be incurred by it in connection with such action and by any other parties defendant in connection therewith or for which the mutual life insurer or the reorganized insurer may become liable under this chapter, under any contract or otherwise by law, to which security the mutual life insurer or the reorganized insurer shall have recourse in such amount as the court having jurisdiction of such action shall determine upon the termination of such action. The amount of security may thereafter from time to time be increased or decreased in the discretion of the court having jurisdiction of such action upon showing that the security provided has or may become inadequate or excessive.

(u) Modification or exchange of existing policies. Nothing in this section shall preclude either the mutual life insurer or the reorganized insurer, on compliance with all applicable requirements of this chapter, from offering at any time or from time to time to any class or category of policyholders to modify their policies or contracts or to exchange their policies or contracts for other policies or contracts in the manner set forth in the offer.

(v) Prohibitions on certain offers to acquire and acquisitions of shares. Prior to, and for a period of five years following the date when the distribution of consideration to the policyholders in exchange for their membership interests is completed pursuant to such plan of reorganization, no person, other than the reorganized insurer or an

institution referred to in subsection (b) of this section that is a part of the plan of reorganization as provided by said subsection (b) or an institution that is formed, with the approval of the superintendent, subsequent to the effective date of the reorganization in order to acquire all of the common shares of the reorganized insurer in a transaction where holders of common shares of the reorganized insurer receive all of the common shares of such institution on a basis that is proportionate to the number of common shares of the reorganized insurer held by each such holder, shall directly or indirectly offer to acquire or acquire in any manner the beneficial ownership of five percent or more of any class of a voting security of such reorganized insurer or of any institution which owns a majority or all of the voting securities of the reorganized insurer, without the prior approval of the superintendent. In the event of any violation of this subsection, or of any action which, if consummated, might constitute such a violation, (1) all voting securities of the reorganized insurer or of such institution acquired by any person in excess of the maximum amount permitted to be acquired by such person pursuant to this subsection shall be deemed to be non-voting securities of the reorganized insurer or of such institution, as the case may be, and (2) such violation or action may be enforced or enjoined, as the case may be, by appropriate proceeding commenced by the reorganized insurer, such institution or the superintendent, the attorney general or any policyholder or stockholder of the reorganized insurer or such institution on behalf of the reorganized insurer or such institution in the supreme court in the judicial district in which the reorganized insurer has its home office or in any other court having jurisdiction, and such court may issue any order, injunctive or otherwise, it finds necessary to cure such violation or to prevent such action. For the purposes of this subsection, the term "beneficial ownership", with respect to any security, means the sole or shared power to vote, or direct the voting of, such security and/or the sole or shared power to dispose, or direct the disposition, of such security; the term "voting security" includes voting securities as defined in paragraph forty-five of subsection (a) of section one hundred seven of this chapter, any preorganization certificate or subscription (including subscription rights issued pursuant to a plan of reorganization), or any security convertible (with

or without consideration) into any such security, or carrying any warrant or right to subscribe for or purchase any such security, or any such warrant or right; the term "offer" includes every offer to buy or acquire, solicitation of an offer to sell, tender offer for, or request or invitation for tenders of, a security or interest in a security for value; and the term "person" means an individual, group, firm, corporation, partnership, association, joint stock company, trust, any similar entity or any combination of the foregoing acting in concert.

(w) Prohibited transactions by officers, directors or employees. (1) Prior to, and for a period of five years following the date when the distribution of consideration to the policyholders in exchange for their membership interests is completed pursuant to such plan of reorganization, no officer, director or employee of the mutual insurer or of the reorganized insurer, including family members and their spouses, shall directly or indirectly offer to acquire or shall acquire in any manner the beneficial ownership of any securities of the reorganized insurer or of the institution referred to in subsection (b) of this section unless the acquisition is (A) made pursuant to a stock option plan approved by the superintendent; (B) made pursuant to the plan of reorganization; (C) made by employees, including their family members and their spouses, from a broker or dealer registered with the Securities and Exchange Commission at the then quoted prices on the date of purchase; or (D) made by officers or directors, including their family members and their spouses, at least two years after the initial public offering from a broker or dealer registered with the Securities and Exchange Commission at the then quoted prices on the date of purchase.

(2) For purposes of this subsection, the term "beneficial ownership", with respect to any security, means the sole or shared power to vote, or direct the voting of, such security and/or the sole or shared power to dispose, or direct the disposition, of such security.

(3) For purposes of this subsection, the term "securities", includes voting securities as defined in section one hundred seven of this chapter, any preorganization certificate or subscription (including subscription rights issued pursuant to a plan of reorganization), or any security convertible (with or without consideration), into any such security, or carrying any warrant or right to subscribe for or purchase

any such security, or any such warrant or right.

(4) For purposes of this subsection, the term "family member", includes a brother, sister, spouse, ancestor or descendant of the officer, director or employee of the mutual insurer or of the reorganized insurer.

(5) No officer, director or employee shall receive any fee or other consideration, other than regular salary, director fees, or consideration as a policyholder in connection with any proposed reorganization. This paragraph, however, shall not prohibit the mutual life insurer from compensating in cash any firm with which one of its directors is associated for services rendered in connection with any proposed reorganization.

(x) Effect on department personnel. Notwithstanding subsection (a) of section five hundred one of the financial services law, the superintendent, any deputy or other employee of the department shall be permitted to receive and exercise any rights received as a policyholder in connection with a reorganization.

§ 7313. Reorganization of domestic mutual accident and health insurance companies.

(a) In this section:

(1) "Affiliate" of a mutual insurer means any person who controls, is controlled by or is under common control with, the mutual insurer being converted. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of persons manage the two corporations.

(2) "Control" has the meaning assigned to it in paragraph two of subsection (a) of section one thousand five hundred one of this chapter.

(3) A "domestic mutual insurer" or "mutual insurer" means a domestic mutual accident and health insurance company organized under article twelve of this chapter and licensed under article forty-two of this chapter and not operating under an order of rehabilitation.

(4) "Policyholder" means a person, as determined by the records of a mutual accident and health insurer, who is deemed to be the "policyholder" of a policy that is of a type described in paragraph three of subsection (a) of section one thousand one hundred thirteen of

this chapter.

(5) "Policyholders' membership interest" means and includes all policyholders' rights as members arising under the charter of the mutual accident and health insurer or this chapter or otherwise by law, including the rights to vote and to participate in the distribution of surplus whether or not incident to a liquidation of a mutual accident and health insurer. The term "policyholders' membership interest" does not include rights, including without limitation the right to participate in the distribution of surplus, expressly conferred upon the policyholders by their policies or contracts other than any right to vote.

(6) "Reorganization" means a conversion in accordance with this section.

(b)(1) A domestic mutual insurer may apply to the superintendent for permission to reorganize and convert into a domestic stock accident and health insurer complying with the relevant organization and licensing provisions of articles twelve and forty-two of this chapter. The application to the superintendent shall be pursuant to a resolution, adopted by no less than a majority of the entire board of directors, specifying the reasons for and the purposes of the proposed conversion and the manner in which the conversion is expected to benefit policyholders and the public. A copy of the resolution, together with a statement of its adoption, both certified by the president and secretary, or officers corresponding to either of them, and affirmed by them as true under the penalties of perjury and under the seal of the mutual insurer, and such other information as the superintendent may require shall accompany the application.

(2) The superintendent shall order an examination of the mutual insurer pursuant to section three hundred ten of this chapter as of the last day of the period covered in the insurer's latest filed statement, except that the proposed conversion shall terminate without an examination if the superintendent finds that:

(A) the resolution is defective upon its face;

(B) the proposed conversion is contrary to law or is not in the best interests of the policyholders or the public; or

(C) the mutual insurer does not have a surplus to policyholders at least equal to the minimum capital and surplus required to be maintained

for a newly organized stock insurer doing the same kinds of insurance.

(c) The superintendent shall also appoint one or more qualified disinterested persons to appraise and report to the superintendent the fair market value of the mutual insurer and, to the extent necessary, its affiliates, on the basis of its latest filed annual or quarterly statement, and of any significant subsequent developments. The appraisers shall consider the assets and liabilities of the mutual insurer and any factors bearing on the value of the mutual insurer or its affiliates. The appraisers shall receive reasonable compensation and be reimbursed for reasonable expenses incurred in discharging their duties. The appraisers may, as necessary, employ consultants to advise them on any technical matters.

(d) The superintendent shall make copies of such examination report and appraisal report available to the board of directors within fifteen days of the superintendent's receipt of the reports. After receiving the reports, the superintendent may grant or deny permission to the board of directors to submit to the superintendent a plan of conversion. If permission is granted, the plan shall include the provisions, and be submitted in the manner and under the conditions, required by subsection (e) of this section. If permission is denied, the superintendent shall make a written statement of the superintendent's findings and the board shall have the right to a hearing before the superintendent within thirty days of the date of denial.

(e)(1) In order for the conversion to proceed:

(A) the plan must be adopted by a majority of the entire board;

(B) the plan must be signed by the president and attested to by the secretary, or officers corresponding to either of them, under the corporate seal of the insurer; and

(C) a copy of the plan and resolution, both certified by such officers as true under the penalties of perjury and under the seal of the insurer, shall be submitted to the superintendent not later than forty-five days after permission was granted under subsection (d) of this section.

(2) The plan shall include:

(A) the proposed charter and by-laws of the insurer as a stock corporation set out in accordance with paragraph five of subsection (a) of section one thousand two hundred one of this chapter;

(B) the manner of treating a holder of an agreement subject to section one thousand three hundred seven of this chapter, if any; the holder, if otherwise qualified, may, at its option, exchange such agreement for an equitable share of the securities or other consideration, or both, of the corporation into which the insurer is to be converted.

(C)(i) the manner and basis of exchanging the equitable share of each eligible mutual policyholder's membership interests for securities or other consideration, or both, of the stock corporation into which the mutual insurer is to be converted and the disposition of any unclaimed shares.

(ii) The plan shall also provide that each person who had a policy of insurance in effect at any time during the three-year period immediately preceding the date of adoption of the resolution described in subsection (b) of this section shall be entitled to receive in exchange for the equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both. The equitable share of the policyholder in the mutual insurer shall be determined by the ratio that the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) of this section bears to the total net premiums received by the mutual insurer from such eligible policyholders. In computing a policyholder's equitable share, no credit shall be given for any net premiums which result from an endorsement which is effective on or after the date of adoption of the resolution.

(iii) Notwithstanding item (ii) of this subparagraph, credit shall be given for any net premiums resulting from an audit or retrospective premium adjustment that is billed within one hundred eighty days after the date of adoption of the resolution described in subsection (b) of this section, provided the premium is paid timely.

(iv) If the equitable share of the eligible policyholder entitles the policyholder to the purchase of a fractional share of stock, the policyholder shall have the option to receive the value of the fractional share in cash or purchase a full share by paying the balance in cash;

(D) the number of voting common shares proposed to be authorized for

the stock corporation, their par value and the price at which they shall be offered, which price may not exceed one-half of the median equitable share of all policyholders under item (ii) of subparagraph (C) of paragraph two of this subsection.

(E) any other information or other item that the superintendent may require.

(f) The mutual insurer shall give prompt notice to all persons who become policyholders or holders of agreements subject to section one thousand three hundred seven of this chapter on or after the date of the adoption of the resolution described in subsection (b) of this section. The notice shall specify the pendency of a proposed conversion and the effect the conversion shall have on them.

(g) The superintendent shall hold a public hearing, adequate notice of which shall be mailed by the mutual insurer to each policyholder on the day preceding the date of adoption of the resolution described in subsection (b) of this section, accompanied by a copy of the plan of conversion and any comment the superintendent considers necessary for the adequate information of the policyholders. The mutual insurer shall also immediately cause the notice to be posted on its website. In addition, the mutual insurer shall give notice of the hearing by publication in a newspaper of general circulation in the county in which the mutual insurer has its principal office and in the two largest cities in each state in which the insurer has underwritten insurance within the five years preceding the date of the adoption of the resolution described in subsection (b) of this section. The notice shall be accompanied by a summary approved by the superintendent of the plan and any comment the superintendent considers necessary for the adequate information of former policyholders and the public.

(h) (1) After the hearing, the superintendent shall approve the plan as submitted, refuse to approve the plan, or request modification of the plan before granting approval. The superintendent may approve the plan unless the superintendent finds that the plan violates this chapter, is inconsistent with law, or is not fair and equitable or in the best interests of the policyholders and the public. If the superintendent finds that the plan does not meet the foregoing standards for approval, the superintendent shall either refuse to approve the plan and the plan shall become null and void or return the plan to the mutual insurer for

modification to meet the superintendent's stated objections.

(2) If within ninety days after receipt of the superintendent's request for modifications the mutual insurer does not submit an amended plan satisfactory to the superintendent and that meets the superintendent's objections and complies with the standards for approval, the plan shall become null and void.

(i) After approval by the superintendent the plan shall be submitted to a vote of the persons who were policyholders of the mutual insurer on the day preceding the date of adoption of the resolution described in subsection (b) of this section. The plan shall provide for proxy voting in a manner to be prescribed by the superintendent. The board shall submit the question of the plan to the policyholders at a meeting thereof, by causing a full, true and correct copy or a summary thereof approved by the superintendent, together with notice, stating the time, place and purpose of the meeting, to be delivered personally, or deposited in the post office, postage prepaid, at least thirty days (unless a shorter time, not less than ten days, be approved by the superintendent) prior to the time fixed for such meeting, addressed to each policyholder at the policyholder's last post office address appearing on the records of the insurer or other form of delivery intended to encourage participation acceptable to the superintendent.

(j) Each such policyholder eligible to vote pursuant to subsection (i) of this section shall be entitled to the number of votes as may be provided for in the by-laws of the mutual insurer. The votes of two-thirds of all the votes cast by policyholders represented at the meeting in person or by proxy, or by such other means acceptable to the superintendent intended to encourage participation, shall be necessary for the adoption of the plan. Upon the conclusion of the vote the insurer shall submit to the superintendent a certified copy of the plan voted on together with a certificate setting forth the results of the vote, both of which shall be subscribed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of the mutual insurer, and affirmed by them as true under the penalties of perjury.

(k) If at any stage in the process of a conversion under this section the superintendent finds that the mutual insurer is impaired or that the further transaction of business by the mutual insurer will be hazardous

to its policyholders, its creditors, or the public, the proposed conversion shall terminate.

(l) If the conversion plan is adopted pursuant to subsection (j) of this section, the superintendent, upon being satisfied that the insurer will have at least the minimum capital and surplus required to be maintained for a newly organized domestic stock insurer doing the same kinds of insurance, shall issue a new certificate of authority to the insurer, thereby converting the mutual insurer into a stock insurer. At the same time, the superintendent may issue such license as may be required pursuant to section one thousand two hundred four of this chapter.

(m) Upon the conversion, the stock insurer shall give notice thereof by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state in which the insurer shall be licensed to do business. In addition, the stock insurer shall also immediately cause the notice to be posted on its website. The notice shall include a correct copy of the plan, or a summary thereof approved by the superintendent.

(n) Upon the conversion of the mutual insurer in the manner herein provided, all the rights, franchises and interests of the former mutual insurer, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed as transferred to and vested in the stock insurer, without any other deed or transfer; and simultaneously therewith such company shall be deemed to have assumed all of the obligations and liabilities of the former mutual insurer.

(o) No action or proceeding, pending at the time of the conversion to which the mutual insurer may be a party shall be abated or discontinued by reason of such conversion, but the same may be prosecuted to final judgment in the same manner as if the conversion had not taken place, or the stock corporation may be substituted in place of the mutual insurer by order of the court in which the action or proceeding may be pending.

(p) The directors and officers of the mutual insurer shall serve until new directors and officers have been duly elected and qualified pursuant to the charter and by-laws of the stock insurer.

(q) The insurer, whether before or after conversion, shall pay no compensation of any kind to any person other than regular salaries to

existing personnel, in connection with the proposed conversion, other than for clerical and mailing expenses, except that, with the superintendent's approval, payment may be made at reasonable rates for printing costs, and for legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the department, shall be borne by the insurer.

(r) No voting common shares shall be subscribed by or issued to persons other than eligible policyholders or holders of agreements subject to section one thousand three hundred seven of this chapter until all subscriptions by such policyholders or agreement holders have been filled or other consideration has been provided in accordance with the plan. Thereafter, any new issue of common shares within three years after the conversion shall first be offered to the persons who have become voting common shareholders, pursuant to subsection (e) of this section in proportion to their holdings of such shares.

(s) No insurer becoming a domestic stock insurer under the provisions of this section shall:

(1) for a period of ten years after conversion, redomesticate directly or indirectly or remove its principal offices from within the state; or

(2) for a period of five years after conversion:

(A) enter into any agreement by the terms of which any person, partnership or corporation agrees to pay all or a portion of the expenses of management of the insurer in consideration of the insurer's agreement to pay such person or other entity either commissions on premiums due the insurer or any other compensation for services, or

(B) enter into any agreement with an officer or director of the insurer or with any firm or corporation in which any officer or director of the insurer is pecuniarily interested, directly or indirectly, under which agreement the insurer agrees to pay, for the acquisition of business, any commissions or other compensation that by the terms of such agreement varies with the amount of the business or with the earnings of the insurer on the business.

(t) Nothing in this section shall in any way impede or impair the exercise by the superintendent of the superintendent's authority under any other provision of this chapter.

§ 7315. Reorganization of domestic life insurance companies. Notwithstanding any other provision of this chapter, a domestic mutual life insurance company which has a surplus of less than one million dollars as shown on its last filed annual statement may reorganize into a domestic stock life insurance company in accordance with a plan of reorganization found by the superintendent to be fair and equitable.

§ 7316. Conversion of savings banks life insurance into a mutual life insurance company. (a) (1) Upon compliance with the requirements of this section, the life insurance business conducted by all savings and insurance banks as defined in article six-A of the banking law may be converted into and transferred to a corporation formed as set forth in subsection (b) of this section and licensed as a mutual life insurance company to do the kinds of insurance business specified in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter. Such conversion and transfer shall be effected pursuant to a plan approved by the superintendent and the superintendent of banks. Such plan shall be submitted by the trustees of savings banks life insurance fund to the superintendent and the superintendent of banking in writing and shall set forth in full the terms and conditions thereof.

(2) Prior to the submission thereof to the superintendent and the superintendent of banks, such plan shall be approved by the vote of at least three-fourths of the trustees of savings banks life insurance fund and then by the vote of at least three-fourths of all the savings and insurance banks at a meeting of all such banks called for the purpose of submitting such plan to such banks for approval. Written notice of such meeting shall be given to each such bank by first class mail addressed to the chairman or president of the bank at the bank's principal office not less than thirty days prior to the date of such meeting. Such notice shall state the purpose for which the meeting is called and shall be accompanied by a true and complete copy of such plan. At such meeting the vote of each such bank shall be cast by the chairman or president thereof or by an officer thereof designated by the chairman or president in a writing addressed to and received by the secretary of savings banks life insurance fund prior to the date of such meeting. The results of

the vote and the minutes of the meeting shall be submitted to the superintendent and the superintendent of banks.

(3) The superintendent and the superintendent of banks each may approve the plan if he finds that it conforms to the requirements of law and is fair and equitable to the holders of insurance policies issued by the life insurance departments of the savings and insurance banks. The plan submitted shall include a filing in accordance with section thirteen hundred twenty-two of this chapter which shows that the proposed mutual insurer's risk based capital level is in excess of the company action level and there is no company action level event. Upon the approval by the superintendent and the superintendent of banks of the plan, the trustees of savings banks life insurance fund shall form a corporation as set forth in subsection (b) of this section to which the life insurance business conducted by all the savings and insurance banks shall be transferred.

(b)(1) To form the corporation described in subsection (a) of this section, the trustees of savings banks life insurance fund shall submit to the superintendent, in writing, a proposed declaration, charter and by-laws for such corporation. Such submission to establish a licensed corporation shall conform to the requirements of section one thousand two hundred one of this chapter.

(2) If the superintendent finds that the submission complies with the requirements of section one thousand two hundred one of this chapter, he shall file the declaration, charter and by-laws in his office. Coincident with such filing, the corporation that is the subject of such declaration, charter and by-laws shall be licensed as a mutual life insurance company to do the kinds of insurance business specified in paragraphs one, two and three of subsection (a) of section one thousand one hundred thirteen of this chapter and shall have all the powers of such a corporation under this chapter. If requested by the corporation, the superintendent shall issue a certified copy of the declaration and charter and a certificate of incorporation executed by him in the name or the people of the state.

(3) The corporation formed pursuant to the provisions of this subsection shall be liable for, and shall hold savings banks life insurance fund, its trustees, officers and employees harmless from, all obligations of and claims against savings banks life insurance fund, its

trustees, officers or employees related to or arising out of the powers or duties of savings banks life insurance fund under article six-A of the banking law. Such corporation shall be liable for, and shall hold each savings and life insurance bank, its directors, officers and employees harmless from, all obligations of and claims against such savings and life insurance bank, its directors, officers and employees related to or arising out of each and every insurance policy and each and every annuity contract issued by the life insurance department of such bank.

§ 7317. Conversion of certain article 43 corporations. (a) (1) An article forty-three corporation which was the subject of an initial opinion and decision issued by the superintendent on or before December thirty-first, nineteen hundred ninety-nine, as the same may be amended or one or more article forty-three corporations whose main offices on January first, two thousand seven were located in one of the counties listed in section one thousand two hundred sixty-two of the public authorities law and its or their not-for-profit subsidiaries (including, without limitation, any such subsidiary licensed as a health service corporation pursuant to this chapter or as a health maintenance organization organized pursuant to article forty-four of the public health law), hereinafter referred to in the singular, which seeks to convert into one or more corporations or other entities organized for pecuniary profit or into one or more for-profit organizations of any kind shall submit a proposed plan of conversion to the superintendent for approval pursuant to this section.

(2) This section shall apply to any transaction the effect of which is to change the status, orientation or operation of the applicant from a not-for-profit organization to a for-profit organization, including:

(A) Any sale, lease, transfer, exchange, option, conveyance, gift, joint venture, merger, consolidation or disposition of all or a material portion of the assets of the applicant over a period of five years;

(B) Any transfer of control, responsibility or governance over all or substantially all of the assets of the applicant; or

(C) Continuation of the corporate existence of the applicant by reconstituting the corporate form of the applicant from a not-for-profit

corporation to a business corporation by the filing of a restated certificate of incorporation regardless of whether such changes occur in one transaction or in a series of transactions.

(b) The proposed plan of conversion shall include all items and address all issues as may be required by the superintendent in order for the superintendent to assure that the conversion process will not adversely affect the applicant's contractholders or members, will protect the interests of and will not negatively impact on the delivery of health care benefits and services to the people of the state of New York and results in the fair, equitable and convenient winding down of the business and affairs of the applicant. The superintendent may adopt such rules or regulations or establish such procedures as he or she deems necessary or proper to implement the provisions of this section.

(c)(1) The proposed plan shall address the following items and issues, if applicable, to the satisfaction of the superintendent:

(A) The transition of contract forms from the not-for-profit corporation to the converted corporation or health maintenance organization including any related holding companies, subsidiaries or other entities involved in the proposed conversion;

(B) Any transfer of assets agreements;

(C) Any corporate resolutions or authorizations by the board of directors;

(D) Any reinsurance arrangements;

(E) An explanation of any transfers of employees, records and equipment;

(F) Any management contracts or administrative service agreements;

(G) Any guarantees or cross-guarantee agreements;

(H) Any trust agreements;

(I) That the applicant's financial reserves are funded prior to the conversion at the level required by law and provide a detailed description of the financial structure and reserve levels of the converted corporation or organization;

(J) The governance structure and the character and competence of directors and officers;

(K) Any administrative agreements among related companies, including fair and equitable terms and reasonable fees;

(L) A detailed description of any proposed public sale of stock or

securities or any initial public offering;

(M) New or revised contract forms together with notices of discontinuance or any other explanation to contractholders of the conversion process;

(N) A plan for outreach to consumers to explain in simple terms the transaction and the steps, if any, consumers need to take to preserve their coverage;

(O) Any necessary protections for contractholders to preserve contract form anniversary dates, calculation of deductibles and consistent premiums as part of the contract transfer process; and

(P) That sufficient safeguards are in place to ensure that the affected community has continued or increased access to health care coverage.

(2) The proposed plan shall explain in detail the method of transfer of contract forms or other methods of assuring uninterrupted continuance of coverage for all covered persons, with particular focus on medicare supplement, policies issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this chapter, policies subject to chapter six hundred sixty-one of the laws of nineteen hundred ninety-seven, and any other types of coverage designated by the superintendent which may warrant special attention.

(d) (i) The superintendent shall review the proposed plan of conversion and may require, prior to issuing any approval, that the applicant make any changes to the proposed plan that the superintendent deems necessary. The superintendent shall establish a date certain by which the initial public offering shall occur. In the event the proposed plan of conversion affects an organization certified under article forty-four of the public health law, the superintendent shall solicit the views of the commissioner of health and the superintendent shall not issue any approvals of the plan of conversion unless the commissioner has consented in writing to those elements of the plan of conversion which are under the commissioner's jurisdiction with respect to the applicant's certificate of authority under article forty-four of the public health law.

(ii) For purposes of granting his approval pursuant to subsection (f) of this section, the superintendent may deem sufficient and as meeting all legal requirements any or all portions of the conversion transaction

completed by an applicant organized under article forty-three of this chapter which was the subject of an initial opinion and decision issued by the superintendent on or before December thirty-first, nineteen hundred ninety-nine, as the same may be amended.

(e) The superintendent shall provide in an opinion and decision approving the conversion for the timely transfer of the public asset consistent with the purposes of this chapter so as to maximize the value of the public asset. The public asset shall be deposited in a special fund to be known as the "public asset fund." Such fund shall consist of assets or moneys paid to it as a result of the creation of a "public asset", as defined in paragraph three of subsection (j) of section four thousand three hundred one of this chapter, together with any earnings thereon. Such fund shall be separate and apart from any other fund and from all other state moneys. The comptroller shall be the sole custodian of the fund. Custodial authority of the fund shall be limited to the rights set forth in this subsection, and any and all other rights, including shareholder rights with respect to the public asset shall be vested in the board, as set forth in paragraph four of subsection (j) of section four thousand three hundred one of this chapter. All disbursements shall be made by the comptroller upon vouchers signed by the superintendent, or his deputy, upon the direction of the board established pursuant to subparagraph (B) of paragraph four of subsection (j) of section four thousand three hundred one of this chapter. The moneys of the fund shall be invested by the comptroller, pursuant to the direction of such board, so as to maximize the value of the assets in such fund consistent with the board's statutory obligation to direct disbursements as described herein and in subsection (j) of section four thousand three hundred one of this chapter. The fund shall continue until there are no longer any assets or moneys therein available for distribution.

(f) (i) Notwithstanding any other provision of law, the superintendent's approval of the conversion transaction shall constitute final approval of the transaction and no further authorizations or approvals shall be required. Notwithstanding any other provision of law, sole jurisdiction for any challenge of the superintendent's final determination regarding the conversion transaction shall rest with the New York supreme court and shall be commenced within thirty days of the

superintendent's final determination. Judicial review shall be limited to a determination as to whether the superintendent acted in an arbitrary or capricious manner with respect to reaching a determination.

(ii) This section shall be deemed to supercede all otherwise applicable laws and legal requirements and compliance with this section and subsection (j) of section four thousand three hundred one of this chapter and the use of such funds as provided in such section, and in subsection (k) of this section, shall be deemed to constitute compliance with and shall supercede all such other legal requirements, including, but not limited to, statutory, common law and any other requirements relating to not-for-profit corporations and fiduciary requirements applicable to the board of directors of any company filing a plan pursuant to this section. In addition, and not in limitation of the foregoing, a transaction approved by the superintendent shall be deemed for all purposes to be a transaction that is fair and reasonable to an applicant and to promote the purposes of that applicant, and the use of proceeds as described herein shall be deemed for all purposes to be a use for a purpose that is consistent with and as near as may be to the purposes for which the applicant was originally organized and subsequently operated.

(g) The conversion transaction shall not result in inurement to any private person or entity. The converted corporation shall not issue to any employee or member of the board of directors of either the applicant or the converted corporation, any stock options, warrants or stock appreciation rights unless the value of such options, warrants or rights is initially set at the publicly traded price of the stock of the converted insurer on a date no earlier than six months after the commencement of the initial public offering. In no event shall a director of the applicant receive stock options in his or her capacity as a director of the applicant.

(h) After the superintendent deems the proposed plan of conversion sufficiently complete, the superintendent shall hold one or more public hearings regarding the proposed plan of conversion within the geographic area served by the applicant. The number and locations of the hearings shall be sufficient to ensure adequate public involvement and comment. The applicant shall provide notice of the public hearings throughout the geographic area affected by the application by distributing a form or

notice approved by the superintendent and including such notices in the state register, in accordance with the provisions of the state administrative procedure act, in newspapers of general circulation and electronic notices posted on the internet. The applicant shall notify contractholders, subscribers and enrollees, as well as participating providers of health care services under the applicant's health plan, in writing of the application and hearings. In the event that there is an amendment to the application, additional hearings shall be held with due notice provided that the superintendent determines that such changes to the plan are materially adverse to the interests of policyholders, subscribers or enrollees. Upon receipt of a complete application, the application and any supporting material submitted to the superintendent in conjunction with the application shall be deemed to be public records and shall be made available to the public for inspection during normal business hours, at no cost, at the applicant's main office within the state of New York and at the office of the superintendent. Prior to the hearing date, the applicant shall post its application and all such supporting material electronically on the internet. The superintendent shall cause a transcript to be made of each public hearing and such transcript and any submitted written comments shall become public records. The superintendent shall similarly promptly provide copies of transcripts of any hearings held by the superintendent to the commissioner of health and all members of the board.

(i) Within a reasonable time after receipt of a final plan of conversion, the superintendent shall render a written decision determining whether the proposed plan of conversion shall become effective as filed, shall become effective as modified or shall be disapproved.

(j) To assist in the review of the proposed plan of conversion, the superintendent shall be authorized to hire independent financial, health, legal and other experts and consultants, the reasonable and necessary costs of which shall be paid by the applicant. The applicant shall deliver to the superintendent at the time of submission of the proposed plan of conversion a written undertaking in form and substance satisfactory to the superintendent and signed by the applicant and by such other persons as the superintendent may require specifying the manner in which all costs and expenses incurred in any manner in

connection with the plan of conversion shall be paid or reimbursed. Such undertaking shall provide for the payment or reimbursement of all expenses incurred by the superintendent or the department in connection with the plan of conversion, other than normal operating expenses of the department.

(k) (1) A charitable organization shall be established for the purpose of receiving the charitable asset and shall operate as a tax exempt organization pursuant to section 501(c)(3) of the federal internal revenue code for the purposes of receiving the charitable asset. Whether or not the charitable organization is classified as a private foundation under section 509 of the internal revenue code, as amended or any comparable provision of any successor law, it shall be subject to the restrictions and limitations that apply to private foundations in sections 4941 through 4945 of the federal internal revenue code, as amended or any comparable provision of any successor law. The superintendent shall provide in an opinion and decision approving the conversion for the timely transfer of the charitable asset consistent with the purposes of this chapter. In the case of the conversion of a corporation or corporations which occurs after the effective date of the chapter of the laws of two thousand seven which amended this paragraph, the superintendent shall provide in an opinion and decision approving such conversion for the timely transfer of the charitable asset to the New York state health foundation created pursuant to this subsection and in compliance with all applicable provisions of this subsection.

(2) The charitable organization shall be governed by a board of directors composed of nine members, three of whom shall be voting members and six of whom shall be non-voting members, which shall be appointed as follows: one voting member and two non-voting members shall be appointed by each of the governor, the temporary president of the senate, and the speaker of the assembly. Each member shall have a term of three years and may be reappointed at the end of said term by the same person that made the original appointment. A vacancy in the membership of the board shall be filled for the unexpired portion of the term provided for by the original appointment by the same person that made the original appointment. Members may not be officers or employees of the state or any municipal subdivision thereof. The board of such charitable organization shall be broadly representative of the community

and include representatives of patient, consumer and public interest organizations and individuals with expertise in public health, health care delivery and financing, patient health issues, investments and philanthropic administration, provided further, no more than three board members of the entire board shall be representatives from any one organization or provider group and board vacancies shall be filled from eligible representatives who are not represented or who are under represented on the board. The charitable organization's structure shall provide mechanisms for ongoing community consultation and engagement including, but not limited to, the establishment of a community advisory board. A vacancy in the membership of the board shall be filled for the unexpired portion of the term provided for by the original appointment by the same person that made the original appointment.

(3) The mission of such charitable organization shall include:

(A) expansion of access to health care by extending health insurance coverage to state residents who cannot afford to purchase their own coverage or who have coverage that is inadequate to meet their needs;

(B) expansion and enhancement of access to health care by augmenting and creating health care programs that deliver services to populations that are unable to access health care or that improve public health; and

(C) augmentation of its other program priorities by supporting programs that inform and educate New Yorkers about public health issues and empower communities to address these issues by becoming more effective at identifying and articulating health care needs and implementing solutions.

Programs or initiatives instituted by the charitable organization shall not neglect the residents or institutions served by the applicant prior to the conversion.

(4) The members of the board of directors of the charitable organization shall serve without compensation for their services as members, but shall be entitled to reimbursement for actual and necessary expenses incurred in the performance of their official duties. Such members, except as otherwise provided by law, may engage in private employment, or in a profession or business.

(5) The members of the board of directors of the charitable organization and its corporate existence shall continue until there are

no longer any assets or moneys comprising the charitable asset available for distribution.

(6) The affirmative vote of all three voting members of the board of directors of the charitable organization shall be necessary for the transaction of any business or the exercise of any power or function of such board. Such board may delegate to one or more of its members, or its agents, such powers and duties as it may deem proper.

(7) The members of the board of directors of the charitable organization shall have the power to make and execute contracts and all other instruments, and to exercise such other powers, necessary or convenient for the exercise of its powers and functions.

In directing investments pursuant to this subparagraph, the board of directors of the charitable organization shall not be limited by any restrictions on investments contained in any other section of law, subject only to the board's obligations and the considerations set forth above.

(8) (A) Neither the members of the board of directors of the charitable organization nor any agent or other person or persons acting on its behalf, while acting within the scope of their authority as members or agents of the board, shall be subject to any personal liability resulting from the carrying out of the powers conferred hereunder; and (B) the provisions of section seventeen of the public officers law shall apply to members of the board and agents or other persons acting on its behalf, in connection with any and all claims, demands, suits, actions or proceedings which may be made or brought against any of them arising out of any determination made or actions taken or omitted to be taken in compliance with any obligations under or pursuant to the terms of this section or section four thousand three hundred one of this chapter. The provisions of this subparagraph shall be severable from and shall survive any legal challenge to the legality, validity, or constitutionality of this section.

(9) The charitable organization receiving the charitable asset agrees in writing to register and file annual financial reports with the attorney general in compliance with section 8-1.4 of the estates, powers, and trusts law and to post its registration filing and annual reports electronically on the internet.

(10) The charitable organization receiving the charitable asset, its directors, officers, and staff shall be and will remain independent of any control or influence by the surviving corporation or other surviving entity organized for pecuniary profit and its affiliates and successors. Such requirement shall not prevent the charitable organization from voting its equity shares in the for-profit organization in accordance with the voting and shareholders rights agreement entered into by the board with respect to the public asset and the charitable organization shall be subject to such voting and shareholders rights agreement and the asset preservation agreement between the board with respect to the public asset and the converted corporation. No person who is an officer, director, or staff member of the applicant at the time such corporation applies to the superintendent for permission to convert, or thereafter shall be an officer, director, or staff member of the charitable organization receiving the charitable asset. No director, officer, agent, or employee of the applicant or the charitable organization receiving the charitable asset will receive additional compensation arising from the conversion transaction.

(11) The charitable organization receiving the charitable asset will establish formal mechanisms to avoid conflicts of interest and to prohibit grants benefitting the surviving corporation or other surviving entity organized for pecuniary profit, or its affiliates or successors, directors, management, and staff.

(12) Any action or proceeding in which any question arises as to the validity of any provision in this subsection or in section seven thousand three hundred seventeen of this chapter, shall be preferred over all other civil causes except election causes in all courts of the state of New York and shall be heard and determined in preference to all other civil business pending therein except election causes, irrespective of position on the calendar. The same preference shall be granted upon application of counsel to the board in any action or proceeding questioning the validity of any provision herein in which he or she may be allowed to intervene.

(13) To assist in carrying out its functions, the board shall be authorized to hire independent financial, legal and other experts and consultants.

(14) Inconsistent provisions of other laws are superseded. Insofar as

any provision herein is inconsistent with the provisions of any other law, general, special or local, the provisions herein shall be controlling.

(15) This section, being necessary for the welfare of the state and its inhabitants, shall be liberally construed so as to effectuate its purposes.

(l) For the purposes of this section, fair market value shall consist of either; (i) one hundred percent of the stock that is transferred, provided that a portion of the shares may be sold in an initial public offering and that the net proceeds shall be transferred, together with the remaining unsold shares, (provided further that additional stock may be sold for fair market value that is transferred to the converted corporation), or (ii) in the case where one hundred percent of the stock is not transferred and a public stock offering is not anticipated, an independent valuation that takes into account market value, investment or earnings value and not asset value. Within five days of the superintendent's final determination of the fair market value, the superintendent shall forward to the attorney general such independent valuation. The attorney general may, within thirty days after having received such valuation, provide the superintendent with written objections to such valuation. The superintendent shall respond to such written objections within seven days stating either that the superintendent accepts such objections and has modified his or her determination accordingly, or that the superintendent rejects such objections. The attorney general may, thereafter, pursue an action in supreme court seeking to have the valuation adjusted in accordance with the attorney general's objections. Such action shall be preferred over all other civil causes except election causes in all courts of the state of New York and shall be heard and determined in preference to all other civil business pending therein except election causes, irrespective of position on the calendar.

ARTICLE 74

REHABILITATION, LIQUIDATION, CONSERVATION AND DISSOLUTION OF INSURERS

Section 7401. Application of article; definitions.

7402. Grounds for rehabilitation of domestic insurer.
7403. Order of rehabilitation; advances from property/casualty insurance security fund; termination.
7404. Grounds for liquidation.
7405. Order of liquidation; rights and liabilities.
7406. Grounds for conservation of assets of foreign or alien insurer.
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7409. Conduct of delinquency proceedings against insurers domiciled in this state.
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§ 7401. Application of article; definitions. (a) This article shall apply to all corporations, associations, societies, orders, firms, and individuals to which this chapter is applicable, or which are subject to examination or supervision by the superintendent under this chapter or under any other law of this state, or which are doing or attempting to do or representing that they are doing the business of insurance in this state, or which are in process of organization for the purpose of or intending to do such business therein, anything in this chapter or any other law of this state to the contrary notwithstanding.

(b) In this article:

(1) "insurer" includes all corporations, associations, societies, orders, firms, and individuals specified in subsection (a) hereof;

(2) "assets" includes all deposits and funds of a special or trust nature.

§ 7402. Grounds for rehabilitation of domestic insurer. The superintendent may apply under this article for an order directing him to rehabilitate a domestic insurer which:

(a) Is insolvent within the meaning of section one thousand three hundred nine of this chapter.

(b) Has refused to submit its books, papers, accounts or affairs to the reasonable inspection of the superintendent, his deputy or examiner.

(c) Has failed or refused to comply, within the time designated by the superintendent, with an order of the superintendent, pursuant to law, to

make good an impairment of its capital, or minimum surplus to policyholders, if a stock insurer, or of its minimum surplus, if a mutual insurer, a reciprocal insurer, Lloyds underwriters or a co-operative fire insurance corporation.

(d) Has transferred or attempted to transfer, by contract of reinsurance or otherwise, substantially its entire property or business, or entered into any transaction which merges substantially its entire property or business into the property or business of any other corporation, association, society, order, firm or individual, without having first obtained the approval of the superintendent.

(e) Is found, after examination, to be in such condition that its further transaction of business will be hazardous to its policyholders, creditors, or the public.

(f) Has wilfully violated its charter or any law of the state.

(g) Has an officer who refused to be examined under oath, concerning its affairs.

(h) If organized under article five-a, six, seven, eight, ten or ten-b of the former insurance law constituting chapter twenty-eight of the consolidated laws of nineteen hundred nine, or if organized as a mutual or non-stock insurer under article nine-a, nine-c, ten, eleven-a, eleven-b, twelve or fourteen of the former insurance law constituting chapter twenty-eight of the consolidated laws in effect immediately before the effective date of this chapter or article forty-one, forty-two, forty-four, forty-five, sixty-one or sixty-six of this chapter, including amendments thereto in force at the time of such organization, is found to be in such condition, after examination, that it could not meet the requirements for incorporation and authorization specified in such articles except with respect to having any required initial surplus.

(i) Has ceased to do the business of insurance for a period of one year as provided in subsection (b) of section one thousand two hundred three of this chapter.

(j) Has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this article.

(k) Has been the subject of an application for the appointment of a receiver, trustee, custodian or sequestrator of the insurer or its property, or if a receiver, trustee, custodian, or sequestrator is appointed by a federal court or if such appointment is imminent.

(l) Has consented to such an order through a majority of its directors, shareholders, or members.

(m) Has not organized or completed its organization and obtained a license or certificate authorizing it to commence the doing of an insurance business within one year from the date of its incorporation, as provided in subsection (a) of section one thousand two hundred three of this chapter.

(n) Has failed or refused to take such steps as may be necessary to remove from office any officer or director whom the superintendent has found, after notice to and hearing of such insurer and of such officer or director, to be a dishonest or untrustworthy person.

(o) Has an occurrence of an authorized control level event or a mandatory control level event pursuant to subsection (f) or (g) of section one thousand three hundred twenty-two or subsection (f) or (g) of section one thousand three hundred twenty-four of this chapter.

§ 7403. Order of rehabilitation; advances from property/casualty insurance security fund; termination. (a) An order to rehabilitate a domestic insurer shall direct the superintendent and his successors in office, as rehabilitator, forthwith to take possession of the property of such insurer and to conduct the business thereof, and to take such steps toward the removal of the causes and conditions which have made such proceeding necessary as the court shall direct.

* (b) (1) If: (i) provision is made therefor in an order to rehabilitate a domestic insurer, (ii) more than fifty percent of the insurer's net direct premiums in the preceding three calendar years were derived from business in this state which is protected by the property/casualty insurance security fund, and (iii) such insurer has consented to rehabilitation, the commissioner of taxation and finance shall advance monies of such fund, in such amounts as specified in the court's order, to the rehabilitator to enable the insurer to comply with any surplus requirement or other requirement of this chapter.

(2) Before issuing such order, the court shall determine that the insurer has the potential and capability, pursuant to a plan submitted by the rehabilitator, of complying with all surplus and other requirements of this chapter and repaying such advance to the fund within two years after termination of the rehabilitation proceeding, at a rate of interest approved by the superintendent to be determined annually which shall not be less than the average rate of return of the fund as determined by the superintendent for the preceding calendar year.

(3) The plan shall include: (i) an explanation of the factors leading to the insurer's condition requiring rehabilitation and the procedures proposed to improve its condition, and (ii) a provision for posting collateral with the rehabilitator as security for the advance, to the extent that the insurer's assets permit.

(4) The court shall not order any advance to the rehabilitator without his specific request or if the insurer's required capital or surplus is impaired in an amount exceeding the greater of thirty million dollars or fifteen percent of the insurer's net direct premium writings in the previous calendar year. Total advances to an insurer shall not exceed the greater of forty million dollars or twenty percent of such net direct premium writings. No advance shall be made on or after July first, two thousand which would lower the amount of assets in the fund below one hundred ninety-five million dollars.

(5) Advances shall, in all respects except as to rate of interest, be subject to the provisions of section one thousand three hundred seven of this chapter, provided that in the event that an insurer which has received an advance pursuant to this subsection is subsequently the subject of an order of liquidation, the claim of the fund for the advance and any accrued interest shall be paid to the fund in accordance with the provisions of section seven thousand four hundred thirty-four of this article.

(6) This subsection shall expire July first, two thousand, provided that the insurer's obligation to repay to the fund moneys advanced to it under this subsection, and the fund's claim for the advance, and any accrued interest, as a priority over all non-secured creditors, shall survive such expiration date.

* NB Expired July 1, 2000

(c) If at any time the superintendent deems further efforts to rehabilitate such insurer would be futile, he may apply to the court under this article for an order of liquidation.

(d) The rehabilitator or any interested person upon due notice to the superintendent, at any time, may apply for an order terminating any rehabilitation proceeding and permitting such insurer to resume possession of its property and the conduct of its business, but no such order shall be granted except when, after a full hearing, the court shall determine that the purposes of the proceeding have been fully accomplished.

§ 7404. Grounds for liquidation. The superintendent may apply under this article for an order directing the superintendent to liquidate the business of a domestic insurer, or of the United States branch of an alien insurer having trusteed assets in this state, upon any of the grounds specified in subsections (a) through (o) of section seven thousand four hundred two of this article, whether or not there has been a prior order directing the superintendent to rehabilitate such insurer.

§ 7405. Order of liquidation; rights and liabilities. (a) An order to liquidate the business of a domestic insurer shall direct the superintendent and his successors in office, as liquidator, forthwith to take possession of the property of such insurer and to liquidate the business of the same and deal with such property and business of such insurer in their own names as superintendents or in the insurer's name as the court may direct, and to give notice to all creditors to present their claims.

(b) The superintendent and his successors shall be vested by operation of law with the title to all property, contracts and rights of action of such insurer as of the date of the entry of the order so directing them to liquidate. The filing or recording of such order in any record office of the state shall impart the same notice that a deed, bill of sale or other evidence of title duly filed or recorded by such insurer would have imparted. The rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons

interested in its estate shall, unless otherwise directed by the court, be fixed as of the date the order is entered in the office of the clerk of the county where such insurer had its principal office on the date the proceeding commenced, subject, however, to the provisions of section seven thousand four hundred thirty-three of this article to the rights of claimants holding contingent claims.

(c) The liquidator of any domestic insurance corporation shall reinsure all its policy obligations in any solvent corporation authorized to do business in this state if the unearned premium reserve of the insurer is sufficient to effect such reinsurance. If such reserve is insufficient for that purpose, the liquidator shall reinsure a percentage of each policy obligation of the insurer outstanding to the extent that the reserve may be sufficient for that purpose. No contract of reinsurance shall be entered into by the liquidator except pursuant to an order of the court in which the liquidator was appointed directing the reinsurance and establishing the general form of the reinsurance contract.

(d) An order to liquidate the business of the United States branch of an alien insurer having trusteed assets in this state shall be in the same terms as those hereinbefore prescribed, except that only the assets of the business of such United States branch shall be included therein.

(e) Where the trustee of a mortgage series consisting in whole or in part of certificated mortgage investments guaranteed by a domestic insurer has distributed all of the trust estate collateral, or has been permitted by court order to abandon all or part of such collateral not distributed, the court, by order, may, upon the consent of the liquidator of the insurer, direct the superintendent, upon being furnished with a list of certificate holders certified to by the trustee, to record subsequent transfers of certificates and charge and collect a reasonable fee therefor, and distribute dividends applicable thereto upon liquidation of company assets in his hands, to the record owners of such certificates, and make and deduct from such dividend payments a reasonable charge for such services. The duty of the superintendent under such order shall terminate upon the termination of the liquidation proceedings.

(f) (1) No later than one hundred eighty days after a final order of liquidation with an adjudication of insolvency of an insurer by a court

of competent jurisdiction of this state, the liquidator may in his sole discretion make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to any fund established by article seventy-six of this chapter, article six-A of the workers' compensation law and any foreign entity performing a similar function, having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application authorized by this subsection shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(A) reserving amounts for the payment of expenses of administration, claims of secured creditors to the extent of the value of the security held, and claims falling within the priorities established in section seven thousand four hundred twenty-six of this article;

(B) disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(C) disbursements to the funds and entities entitled thereto under this subsection in amounts estimated to be at least equal to all claim payments for which such funds or entities could assert claims against the liquidator, and if the assets available for disbursement from time to time do not at least equal such claim payments, then disbursements in the amount of available assets;

(D) equitable allocation of disbursements to each of such funds or entities;

(E) the securing by the liquidator from each of such funds or entities of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section seven thousand four hundred twenty-six of this article in accordance with such priorities. No bond shall be required of any such fund or entity; and

(F) a full report to be made by each such fund or entity to the liquidator accounting for all assets so disbursed to the fund or entity, all disbursements made therefrom, any income earned by the fund or entity on such assets and any other matters as the court may direct.

(3) Notice of such application shall be given to such funds and

entities and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty days prior to submission of such application to the court. Action on the application may be taken by the court if the required notice has been given and the liquidator's proposal complies with subparagraphs (A), (B) and (D) of paragraph two of this subsection.

(g) (1) No later than one hundred twenty days after the end of the calendar or fiscal year of a domestic insurance corporation subject to rehabilitation or liquidation, upon whichever standard the corporation conducts its financial affairs, the rehabilitator or liquidator shall submit to the department an annual report of the preceding calendar or fiscal year's activity of such corporation. Such report, which shall pertain only to such corporation's activities and those of the rehabilitator or liquidator as they relate to such corporation, shall include a financial review of the assets and liabilities of the corporation, the claims accrued or paid in that period, and a summary of all other corporate activity and a narrative of the actions of the rehabilitator or liquidator respecting such corporation.

(2) No later than August first of each year, the rehabilitator or liquidator shall submit to the department and the legislature separate or combined annual financial statements for the domestic insurance corporations subject to rehabilitation or liquidation. Upon whichever standard each corporation conducts its respective financial affairs, showing their condition at last calendar year end or at the last fiscal year end ending on or prior to last calendar year end, together with an opinion or other report of an independent certified public accountant on such financial statements, provided that such corporations were placed into rehabilitation or liquidation prior to the commencement of the calendar or fiscal years covered by such financial statements.

(3) No later than August first of each year, the superintendent as receiver shall submit to the department and the legislature an annual financial statement of the liquidation bureau showing its cash receipts and disbursements for the prior calendar year, together with an opinion or other report of an independent certified public accountant on such financial statement.

(4) The reports and statements required under this subsection shall be

separate and apart from other reports and statements issued by the liquidation bureau of the department in the normal course of its business.

§ 7406. Grounds for conservation of assets of foreign or alien insurer. (a) The superintendent may apply under this article for an order directing the superintendent to conserve the assets within the state of a foreign insurer upon:

(1) any of the grounds specified in subsection (a) through (g), (j), (k) or (o) of section seven thousand four hundred two of this article, or

(2) upon the ground that such insurer has consented to such an order through a majority of its directors, shareholders or members, or has had its property sequestrated in its domiciliary country or state or in any other country or state.

(b) The superintendent may apply under this article for an order directing him to conserve the assets within this state of an alien insurer, except one which has its trusteed assets in this state, on any of the grounds specified in subsection (a), (b), (d) through (g), (j) or (k) of section seven thousand four hundred two of this article, or upon the ground that it has failed or refused to comply, within the time designated by the superintendent, with an order of the superintendent, pursuant to law, to rectify an impairment of its trusteed surplus, or that it has consented to such an order through a majority of its directors, shareholders or members, or has had its property sequestrated in its domiciliary country or elsewhere.

§ 7407. Order of conservation or ancillary liquidation of a foreign or alien insurer. (a) An order to conserve the assets of a foreign or alien insurer shall direct the superintendent and his successors in office, as conservator, forthwith to take possession of, and conserve, the insurer's property within this state, subject to the court's further direction.

(b) Where the superintendent has been appointed pursuant to the provisions of section seven thousand four hundred six of this article as

conservator of the assets within the state of a foreign or alien insurer, for which a domiciliary receiver is subsequently appointed for such insurer in its domiciliary state which is also a reciprocal state, as defined in section seven thousand four hundred eight of this article, the superintendent, upon request of the domiciliary receiver, shall, notwithstanding subsection (a) of section seven thousand four hundred ten of this article, apply to the court in which such conservation proceeding was commenced for an order appointing the superintendent as ancillary receiver for such foreign or alien insurer.

(c) Whenever a domiciliary receiver is appointed for any insurer in its domiciliary state which is also a reciprocal state, as defined in section seven thousand four hundred eight of this article, the superintendent, upon request of the domiciliary receiver, shall, notwithstanding subsection (a) of section seven thousand four hundred ten of this article, apply to a court of competent jurisdiction for an order appointing the superintendent as ancillary receiver of such insurer.

(d) Notwithstanding subsection (a) of section seven thousand four hundred ten of this article, the court may on the application of the superintendent pursuant to subsection (b) or (c) of this section appoint the superintendent as the ancillary receiver in this state, subject to the provisions of sections seven thousand four hundred eight through seven thousand four hundred fifteen of this article. Subject to the provisions of such sections, the rights and duties of the superintendent with reference to such insurer and such assets shall include those heretofore exercised by and imposed upon ancillary receivers of foreign corporations in this state.

§ 7408. Uniform insurers liquidation act; title; definitions. (a) This section and sections seven thousand four hundred nine through seven thousand four hundred fifteen of this article may be cited as the uniform insurers liquidation act.

(b) In this act:

(1) "Insurer" means any person, firm, corporation, association, or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation,

reorganization, or conservation by, the superintendent of financial services of this state, or the equivalent insurance supervisory official of another state.

(2) "Delinquency proceeding" means any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer.

(3) "Foreign country" means territory not in any state.

(4) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, as to an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has, at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States; and any such insurer is deemed to be domiciled in such state.

(5) "Ancillary state" means any state except a domiciliary state.

(6) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of this act are in force, including the provisions requiring that the insurance commissioner or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(7) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge all sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders, or all policyholders and creditors in the United States, are general assets.

(8) "Preferred claim" means any claim with respect to which the law of a state or of the United States accords priority of payment from the general assets of the insurer.

(9) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class of persons, but not including any general assets.

(10) "Secured claim" means any claim secured by mortgage, trust, deed,

pledge, deposit as security, escrow, other security interest, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(11) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require.

§ 7409. Conduct of delinquency proceedings against insurers domiciled in this state. (a) Whenever under the laws of this state a receiver is to be appointed in delinquency proceedings for an insurer domiciled in this state, the court shall appoint the superintendent as such receiver and direct the superintendent forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

(b) As domiciliary receiver the superintendent and his successors in office shall be vested by operation of law with the title to all property, contracts, and rights of action, and all books and records of the insurer wherever located, as of the date of entry of the order directing him to liquidate a domestic insurer or the United States branch of an alien insurer domiciled in this state, and he shall have the right to recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers hereinafter prescribed for ancillary receivers appointed in this state as to assets located in this state. The filing or recording of the order directing possession to be taken, or a certified copy thereof, in the office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded. The superintendent as domiciliary receiver shall be responsible for the proper administration of all assets coming into his possession or control. The court may at any time require bond from him or his deputies if deemed desirable for the protection of the assets.

(c) Upon taking possession of the assets of a delinquent insurer the domiciliary receiver shall, subject to the direction of the court,

immediately proceed to conduct the business of the insurer or to take such steps as are authorized by the laws of this state for the purpose of liquidating, rehabilitating, reorganizing, or conserving the affairs of the insurer. In connection with delinquency proceedings he may appoint special deputy superintendents, and employ such counsel, clerks, and assistants as he deems necessary. Their compensation and all expenses of taking possession of the insurer and of conducting the delinquency proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of the duties imposed upon them special deputies shall possess all the powers given to, and, in the exercise of those powers, shall be subject to all duties imposed upon, the receiver with respect to delinquency proceedings.

(d) Notwithstanding subsections (a), (b) and (c) of this section, or any other provision of this article, the receiver shall not disavow, reject, or repudiate a federal home loan bank security agreement or any pledge agreement, security agreement, collateral agreement, guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a federal home loan bank is a party.

§ 7410. Conduct of delinquency proceedings against insurers not domiciled in this state. (a) Whenever under the laws of this state an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the superintendent as ancillary receiver. The superintendent shall file a petition requesting the appointment if he finds that there are sufficient assets of such insurer located in this state to justify the appointment of an ancillary receiver, or if ten or more persons resident in this state having claims against such insurer file a petition with the superintendent requesting the appointment of such ancillary receiver.

(b) The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all books and records of the insurer located in this state, and shall have the immediate right to recover balances due from local agents

and obtain possession of any books and records of the insurer found in this state. He shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets he shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insurer domiciled in this state.

(c) The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which he may be entitled under the laws of this state.

§ 7411. Filing and proving of claims of non-residents against delinquent insurers domiciled in this state. (a) In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) (1) Controverted claims of claimants residing in reciprocal states may either be proved in this state as provided by law, or, if ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings.

(2) If a claimant elects to prove his claim in ancillary proceedings and if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in section seven thousand four hundred twelve of this article with respect to ancillary proceedings in this state, the final allowance of such claim by the courts in the ancillary state shall be accepted in this state as

conclusive as to its amount, and as to its priority, if any, against special deposits or other security located within the ancillary state.

§ 7412. Filing and proving of claims of residents against delinquent insurers domiciled in reciprocal states. (a) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants residing in this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary proceeding.

(b) (1) Controverted claims belonging to claimants residing in this state may be proved either in the domiciliary state as provided by the law of that state, or in ancillary proceedings, if any, in this state.

(2) If the claimant elects to prove his claim in this state, he shall file it with the ancillary receiver in the manner provided by the law of this state for the proving of claims against insurers domiciled in this state, and he shall give notice in writing to the receiver in the domiciliary state either by registered mail or by personal service at least forty days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which it is based, and the priorities asserted, if any. If the domiciliary receiver, within thirty days after the giving of such notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

§ 7413. Priority of preferred claims, special deposit claims and secured claims. (a) In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states

shall be preferred claims if like claims are preferred under the laws of this state. All such claims whether owing to residents or non-residents shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

(c) The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(d) The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this act, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

§ 7414. Attachment and garnishment of assets. During the pendency of delinquency proceedings in this or any reciprocal state no action or proceeding in the nature of an attachment, garnishment, or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action

or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

§ 7415. Uniformity of interpretation. The uniform insurers liquidation act shall be interpreted and construed to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions, when applicable, conflict with other provisions of this chapter, the provisions of this act shall control.

§ 7416. Grounds for dissolution of domestic insurer. The superintendent may apply under this article for an order dissolving the corporate existence of a domestic insurer: (i) upon his application for an order of liquidation of its business, or at any time after such order has been granted; or (ii) upon the grounds specified in subsection (m) of section seven thousand four hundred two of this article, regardless of whether an order of liquidation is sought or has been obtained.

§ 7417. Commencement of a proceeding. The superintendent represented by the attorney general shall commence any proceeding under this article by an application to the supreme court, in the judicial district in which the principal office of the insurer is located, for an order directing such insurer to show cause why the superintendent should not have the requested relief. On the return of such order, and after a full hearing, which shall be held without delay, such court shall either deny the application or grant it together with such other relief as the nature of the case and the interests of policyholders, creditors, shareholders, members, or the public may require.

§ 7418. Service of order to show cause. (a) The order to show cause and the papers upon which it is granted shall be served upon the insurer named therein by delivering true copies to, and leaving them with:

(1) If a domestic corporation: its president or other head, the

secretary or clerk to the corporation, the cashier, the treasurer or any director or managing agent.

(2) If a foreign or alien corporation: its president, vice-president, treasurer or assistant treasurer, secretary or assistant secretary, or any director or managing agent or, if the corporation has no such officers within this state, to the officer performing corresponding functions.

(3) If a voluntary, unincorporated or a joint stock association, order or society: the president, vice-president, treasurer, director, trustee or other officer or a member with managerial powers.

(4) If a reciprocal insurer or Lloyds underwriters: the duly designated attorney-in-fact.

(b) When it is satisfactorily proved by the verified report of an examiner to the superintendent or by affidavit of any other person familiar with the facts that the persons upon whom service is required to be made have departed from the state or keep themselves concealed therein or have resigned from their offices within forty days prior to the application for an order to show cause under the provision of this section, or that service cannot be made immediately by the exercise of reasonable diligence, such order may provide for service in such manner as the court directs.

§ 7419. Injunctions. (a) Upon application by the superintendent for an order to show cause under this article or at any time thereafter, the court in which such order is made, or any justice thereof may without notice issue an injunction restraining the insurer, its officers, directors, shareholders, members, trustees, agents, servants, employees, policyholders, attorneys, managers, and all other persons from the transaction of its business or the waste or disposition of its property until further order of the court.

(b) Such court or justice may at any time during a proceeding under this article issue such other injunctions or orders as it deems necessary to prevent interference with the superintendent or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the

insurer, its assets or any part thereof.

(c) Notwithstanding subsections (a) and (b) of this section and any other provision of this article, a federal home loan bank shall not be stayed, enjoined, or prohibited from exercising any right or enforcing any obligation under a federal home loan bank security agreement relating to collateral pledged by an insurer-member to such federal home loan bank.

§ 7420. Annual report. The superintendent shall transmit to the legislature in his annual report the names of all insurers proceeded against under this article together with such facts as shall acquaint the policyholders, creditors, shareholders, and the public with all proceedings. To that end the special deputy superintendent in charge of any such insurer shall file annually with the superintendent a report of the affairs of such insurer.

§ 7421. Removal of proceedings. Any time after commencement of a proceeding under this article, the superintendent may apply ex parte to the court or any justice thereof for an order changing the venue of and removing the proceeding to Albany county, or, in the discretion of the superintendent, to any other county of this state in which he deems that such proceeding may be most economically and efficiently conducted. Upon the filing of any such application, the court or any justice thereof shall direct the clerk of the county wherein such proceeding is pending to transmit all papers filed therein with such clerk to the clerk of the county to which such proceeding is removed. The proceeding shall thereafter be conducted in such other county as though it had been commenced in such county.

§ 7422. Appointment of deputies; employment of assistants. (a) For the purposes of this article the superintendent shall have power to appoint special deputy, and assistant special deputy, superintendents as his agents, and to employ such counsel, clerks and assistants as may by him be deemed necessary and to give them such powers to assist him as he

considers wise.

(b) The compensation of such special and assistant special deputy superintendents, counsel, clerks and assistants, and all expenses of conducting any proceeding under this article shall be fixed by the superintendent, subject to the approval of the court, and shall be paid out of the funds or assets of such insurer.

§ 7423. Exemption from filing fees. The superintendent shall not be required to pay any fee to any county clerk, register or other public officer in this state for filing, recording, issuing a transcript or certificate, or authenticating any paper or instrument pertaining to the exercise by the superintendent of any of the powers or duties conferred upon him by any of the provisions of this article, whether or not such paper or instrument be executed by the superintendent or his deputies or attorneys of record and whether or not it is connected with the commencement of an action or judicial proceeding by or against the superintendent, or with the subsequent conduct of such an action or proceeding.

§ 7424. Deposit of monies collected; preference. Monies collected by the superintendent in a proceeding under this article shall be deposited in one or more state or national banks, savings banks, or trust companies. In the case of insolvency or voluntary or involuntary liquidation of any such depositary organized and supervised under the laws of this state, such deposits shall be entitled to priority of payment on an equality with any other priority given by the banking law of this state. The superintendent may in his discretion deposit such monies or any part thereof in a national bank or trust company as a trust fund.

§ 7425. Voidable transfers. (a) Any transfer of, or lien created upon, the property of an insurer within twelve months prior to the granting of an order to show cause under this article with the intent of giving to any creditor or enabling him to obtain a greater percentage of his debt

than any other creditor of the same class and which is accepted by such creditor having reasonable cause to believe that such a preference will occur, shall be voidable.

(b) Every director, officer, employee, shareholder, member or other person acting on behalf of such insurer who shall be concerned in any such prohibited act and every person receiving thereby any property of such insurer or the benefit thereof shall be personally liable therefor and shall be bound to account to the superintendent.

(c) The superintendent, as liquidator, rehabilitator or conservator in any proceeding under this article, may avoid any transfer of, or lien upon, the property of an insurer which any creditor, shareholder or member of such insurer might have avoided and may recover the property transferred or its value from the transferee unless he was a bona fide holder for value prior to the date of the granting of an order to show cause under this article. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value.

(d) Notwithstanding the provisions of subsection (a) of this section, a commutation of a reinsurance agreement, approved by the superintendent pursuant to section one thousand three hundred twenty-one of this chapter, shall not be voidable as a preference.

(e) (1) Notwithstanding subsection (a) of this section or any other provision of this article to the contrary, (i) a receiver shall not void a transfer of money or other property arising under or in connection with a federal home loan bank security agreement that is made before the commencement of a formal proceeding under this article in the ordinary course of business and in compliance with the security agreement unless such transfer was made with actual intent to hinder, delay or defraud the insurer-member, a receiver appointed for the insurer-member or existing or future creditors; and (ii) a receiver shall not void a redemption or repurchase of any stock or equity securities which was made by the federal home loan bank within four months of a formal commencement of the delinquency proceedings or which received prior approval of the receiver.

(2) Following the appointment of a receiver for an insurer-member and upon request of the receiver, the federal home loan bank shall in good faith, within five days of such request, provide a process and establish timing for all of the following:

(i) the release of collateral that exceeds the lending value, as determined in accordance with the federal home loan bank security agreement, required to support secured obligations remaining after any repayment of advances;

(ii) the release of any collateral remaining in the federal home loan bank's possession following repayment in full of all outstanding secured obligations;

(iii) the payment of fees and the operation of deposits and other accounts with the federal home loan bank; and

(iv) the redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer-member is required to own consistent with federal law and regulations, the federal home loan bank's capital plan, and the capital stock practices currently applicable to the federal home loan bank's entire membership.

(3) Upon the request of the receiver for an insurer-member, the federal home loan bank shall provide any available options that are acceptable to the federal home loan bank for such insurer-member to renew or restructure an advance to defer associated prepayment fees, to the extent that market conditions, the terms of the advance outstanding to the insurer-member, the applicable policies of the federal home loan bank and compliance with the federal home loan bank act and corresponding regulations permit.

(4) Prior to and during a proceeding under this article against an insurer-member, the department, its receiver or rehabilitator shall be entitled to make reasonable requests to the federal home loan bank, and the federal home loan bank shall, to the fullest extent permitted by federal law, support the department with efforts to:

(i) permit and facilitate collateral substitutions;

(ii) permit and facilitate transfer of agreement to a purchaser and/or another federal home loan bank member;

(iii) permit additional advances in case of the need for additional liquidity; or

(iv) take other actions that may facilitate orderly proceedings prior to and during a delinquency.

(5) To the extent permitted by applicable law and for the purposes of a federal home loan bank assisting the department, a federal home loan bank shall upon request of the department provide in confidence to the

department periodic information concerning its financial condition, underwriting, and credit opinions regarding an insurer-member.

(6) Nothing in this subsection shall affect the federal home loan bank's rights pursuant to 12 CFR 1266.4, which relates to limitations on access to advances.

§ 7427. Offsets. (a) In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) hereof.

(b) No offset shall be allowed in favor of any such person, however, where:

(1) the obligation of the insurer to such person would not at the date of the entry of any liquidation order, or otherwise, as provided in section seven thousand four hundred five of this article, entitle him to share as a claimant in the assets of such insurer, or

(2) the obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset, or

(3) the obligation of such person is to pay an assessment levied against the members of a mutual insurer or to pay a balance upon a subscription to the shares of a stock insurance corporation.

§ 7428. Disposition of assets and compromise of claims. (a) The superintendent may, subject to the approval of the court:

(1) sell or otherwise dispose of all or any part of the real and personal property of an insurer against whom a proceeding has been brought under this article, and

(2) sell or compound all doubtful or uncollectible debts or claims owed by or to such insurer including claims based upon an assessment levied against a member of a mutual insurer.

(b) If the amount of any such real or personal property owned by, or debt or claim owed by or to, such insurer does not exceed twenty-five thousand dollars, then the superintendent may sell or dispose of all or

any part of the real or personal property, or compromise or compound the debt or claim, upon such terms as the superintendent may deem for the best interests of such insurer without obtaining the approval of the court.

(c) The superintendent may, subject to the approval of the court, sell, or agree to sell, or offer to sell, any assets of such an insurer to such of its creditors who may desire to participate in the purchase, to be paid for in whole or in part out of dividends payable to such creditors.

(d) Upon application of the superintendent, the court may designate representatives to act for such creditors in the purchase, holding and/or management of such assets, and the superintendent may, subject to the approval of the court, advance the expenses of such representatives against the security of the claims of such creditors.

§ 7429. Borrowing on the pledge of assets. To facilitate the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this article the superintendent may, subject to the approval of the court, borrow money and issue evidences of indebtedness therefor and secure repayment by a security interest in any or all property, real, personal or mixed of such insurer. Subject to court approval, the superintendent may take all other action necessary and proper to consummate such loans and provide for their repayment. The superintendent shall be under no obligation personally or in his capacity as superintendent to repay any loan made pursuant to this section.

§ 7430. Levy of assessments; determination of liability of members. (a) Within three years from the date of an order of rehabilitation or liquidation of a domestic mutual insurer filed in the office of the clerk of the county in which the insurer had its principal office, the superintendent may make a report to the court setting forth:

(1) the reasonable value of the insurer's assets;

(2) its probable liabilities; and

(3) the probable necessary assessment, if any, to pay all possible

claims and expenses in full, including expenses of administration.

(b) (1) Upon the basis of such report, including any amendments, the court, ex parte, may levy one or more assessments against all members of such insurer who, as shown by the records of the company, were members at any time within one year prior to the date of the issuance of the order to show cause under section seven thousand four hundred seventeen of this article.

(2) The assessments shall cover the excess of the insurer's probable liabilities over the reasonable value of its assets and the estimated cost of collection and percentage of uncollectibility thereof.

(3) The total assessments against any member with respect to any policy, whether levied by the board of directors of such insurer, the superintendent in liquidation or rehabilitation of such insurer, or otherwise, and whether levied to make good an impairment of required minimum surplus or for any other purpose under this chapter, shall be for no greater amount than that specified in the by-laws and policies of that member and may be limited as prescribed in subsection (a) of section four thousand one hundred eleven of this chapter. However, if the court finds that such policy was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, the court may determine the upper limit of such assessment upon the basis of an adequate rate for such insurance.

(4) No such assessment shall be levied against any member with respect to any non-assessable policy issued in accordance with the laws of this state.

(c) Thereafter, upon the filing of a further detailed report by the superintendent, the court shall issue an order directing each member of such insurer if he shall not pay the amount assessed against him to the superintendent on or before a day to be specified in said order, to show cause why he should not be held liable to pay such assessment together with costs as set forth in subsection (e) hereof and why the superintendent should not have judgment therefor.

(d) The superintendent shall at least twenty days before the return day of the order cause a notice of such order setting forth a brief summary of the contents of such order to be published in such manner as shall be directed by the court and mailed to each member at his last known address appearing on the records of the insurer, or at his last

known address, if no address so appears.

(e) On the return day of such order to show cause, if such member shall not appear and serve verified objections upon the superintendent, the court shall make an order adjudging that such member is liable for the amount of such assessment together with ten dollars costs and directing that the superintendent may have judgment therefor. If the member shall appear and serve verified objections upon the superintendent there shall be a full hearing before the court or a referee to hear and determine, who, after such hearing, shall make an order either negativing the liability of such member to pay the assessment or directing that the superintendent may have judgment for the whole or some part of the assessment and twenty-five dollars costs and necessary disbursements incurred at such hearing.

(f) A judgment upon any such order, whether granted by a court or referee, shall have the same force and effect, and may be entered and docketed, and may be appealed from as if it were a judgment in an original action brought in the court in which the proceeding is pending.

§ 7431. Determination of liability of members for other indebtedness. (a) If it shall appear that a member of a domestic mutual insurer is indebted to such insurer, apart from his liability to assessment, the court may, upon the application of the superintendent, in any order under section seven thousand four hundred thirty of this article directing such member to show cause why he should not be held liable to pay an assessment, likewise direct him to show cause why he should not be held liable to pay such indebtedness.

(b) The liability of such member for such indebtedness shall be determined in the same manner, and at the same time, as his liability for such assessment is determined, and the superintendent may have judgment therefor, without any additional costs.

§ 7432. Adjudication of insolvency of insurer; time to file claims. (a) If upon the granting of an order of liquidation pursuant to section seven thousand four hundred four of this article or at any time thereafter during such liquidation proceeding, such insurer shall not be

clearly solvent, the court shall, after such notice and hearing as it deems proper, make an order declaring such insurer to be insolvent.

(b) Where a liquidation, rehabilitation or conservation order has been entered in a proceeding against an insurer under this article, all persons who may have claims against such insurer shall present the same to the liquidator, rehabilitator or conservator at a place specified by him within four months from the date of the entry of such order, or, if the superintendent shall certify that it is necessary, within such longer time as the court shall prescribe. The superintendent shall notify all persons who may have claims against such insurer as disclosed by its books and records, to present the same to him within the time as fixed. The last day for the filing of proofs of claim shall be specified in the notice. Such notice shall be given in a manner determined by the court.

(c) Proofs of claim may be filed subsequent to the date specified, but, no such claim shall share in the distribution of the assets until all allowed claims, proofs of which were filed before such specified date, have been paid in full with interest.

§ 7433. Proof and allowance of claims. (a) (1) A proof of claim shall consist of a written statement subscribed and affirmed by the claimant as true under the penalties of perjury, setting forth the claim, the consideration therefor, any securities held therefor, any payments made thereon, and that the sum claimed is justly owing from the insurer to the claimant.

(2) If a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim. After the filing of such instrument the superintendent may in his discretion permit the claimant to retain such instrument until final disposition of the claim. If such instrument is lost or destroyed, a statement of such fact and of the circumstances of such loss or destruction shall be filed under oath with the claim.

(b) (1) Upon the liquidation of any domestic insurer or United States branch which has issued policies insuring the lives of persons, the superintendent shall, within thirty days after the last day set for filing claims, make a list of the persons who have not filed proofs of

claim with him, to whom it appears to his entire satisfaction, from the records of the company, that there are owing amounts on such policies and he shall set opposite the name of each person such amount so owing to such person. Each person whose name shall appear upon such list shall be deemed to have duly filed, prior to the last day set for the filing of claims, a proof of claim for the amount set opposite his name.

(2) Upon the liquidation of any domestic insurer or United States branch which has issued property/casualty policies, the superintendent shall, within thirty days after the last day set for filing claims, make a list of all persons whose name appears on the books and records of the company as policyholders or claimants. Each person whose name appears upon such list shall be deemed to have duly filed a proof of claim prior to the last day set for the filing of claims.

(c) No contingent claim shall share in a distribution of assets of an insurer adjudicated to be insolvent by an order made pursuant to section seven thousand four hundred thirty-two of this article except that any such claim shall be considered if properly presented and may be allowed to share if:

(1) it becomes absolute against the insurer on or before the last day fixed for filing of proofs of claim, or

(2) there is a surplus and the liquidation is thereafter conducted upon the basis that such insurer is solvent.

(d) (1) Where a liquidation, rehabilitation or conservation order has been entered in a proceeding against an insurer under this article, any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer, shall have the right to file a claim in the proceeding, even though the claim is contingent.

(2) The claim may be allowed:

(A) if it may be reasonably inferred from the proof presented that such person would be able to obtain a judgment upon such cause of action against such insured;

(B) if such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims against such insurer arising out of his cause of action other than those already presented can be made; and

(C) if the total liability of such insurer to all claimants arising

out of the same act of its insured shall be no greater than its total liability would be were it not in liquidation, rehabilitation or conservation.

(3) No judgment against such an insured taken after the date of the entry of the liquidation, rehabilitation or conservation order shall be considered in the proceedings as evidence of liability or of the amount of damages. No judgment against an insured taken by default, inquest or collusion prior to the entry of a liquidation order shall be considered as conclusive evidence in the proceeding either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

(e) Debts owing to a state, county, district or municipality, or any subdivision thereof, as a penalty or forfeiture, shall not be allowed except for the amount of the pecuniary loss sustained by the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby, and such interest as may have accrued thereon according to law.

(f) No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and the value of the security itself as of the date of entry of the order of liquidation or such other date set by the court for fixation of rights and liabilities as provided in section seven thousand four hundred five of this article, unless the claimant shall surrender his security to the superintendent in which event the claim shall be allowed in the full amount of its value.

§ 7433-a. Loan to workers' compensation security fund. (a) Upon certification by the superintendent that further sums, not exceeding seventy million dollars in the aggregate, are required by the workers' compensation security fund to meet its obligations and accomplish the purposes of article six-A of the workers' compensation law, the superintendent is hereby authorized to make one or more loans to such fund from the assets of one or more liquidation estates in such amounts as shall be specified by the superintendent. For purposes of this section, "liquidation estate" shall mean the assets of an insurer against which an order of liquidation has been commenced pursuant to

this article. Such sums, not exceeding seventy million dollars in the aggregate, shall be a liability of the workers' compensation security fund.

(b) Notwithstanding any law, rule or regulation to the contrary, in the event that a complaint is filed in a court of competent jurisdiction concerning the superintendent's authority to loan monies to the workers' compensation security fund pursuant to this section, the superintendent shall oppose such complaint, and appeal any adverse rulings of the court. In the event a court of competent jurisdiction issues an injunction that expressly prohibits the superintendent from making loans under this section, and such injunction has been unsuccessfully opposed in court by the superintendent, the superintendent may accomplish the purposes of this section through one or more loans from the assets of the property/casualty insurance security fund to the workers' compensation security fund. Such loans shall be made subject to the conditions set forth in this section, including the certification requirement set forth in subsection (c) of this section and shall not occur more frequently than once every two months, and not be greater in amount than that needed to sustain the workers' compensation security fund for the two month period.

(c) Upon written certification by the superintendent that the assets from the liquidation estates are otherwise unavailable, loans may also be made under the terms specified in this section from the assets of the property/casualty insurance security fund. Loans made pursuant to this subsection shall not exceed the sum of thirty million dollars in the aggregate. Such loans shall not occur more frequently than once every two months, and not be greater in amount than that needed to sustain the workers' compensation security fund for the two month period. Monies from such loans shall not be used to pay administrative expenses. Each loan must be accompanied by such certification, which shall set forth the specific reason or reasons why the assets of the liquidation estates are unavailable. The certification shall be provided to the temporary president of the senate, the speaker of the assembly, the chair of the senate finance committee and the chair of the assembly ways and means committee.

(d) Any loan pursuant to this section shall be a liability of the workers' compensation security fund, and shall be repaid pursuant to a

plan of repayment to be prescribed by the superintendent which, notwithstanding any other law, may provide, at the discretion of the superintendent, for an increase in the level of payments into the fund provided for in subdivision two of section one hundred eight of the workers' compensation law upon written notice by the superintendent to the governor and both houses of the legislature of the necessity of any such increase, including the reasons therefor. Such plan shall among other things require: (i) that any loan be made upon commercially reasonable terms and in accordance with the superintendent's fiduciary responsibilities, and (ii) immediate repayment, from the assets of the liquidation estates as referred to in subsection (a) of this section, of any loans from the property/casualty insurance security fund made pursuant to subsection (b) or (c) of this section upon sufficient monies becoming available from loans from liquidation estates pursuant to subsection (a) of this section, and (iii) that one-fourth of the payments collected pursuant to section one hundred eight of the workers' compensation law be dedicated to the repayment of any loans made pursuant to this section.

§ 7434. Distribution of assets. (a) (1) Upon the recommendation of the superintendent, and under the direction of the court, distribution payments shall be made in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims. The priority of distribution of claims from an insolvent insurer other than a life insurer in any proceeding subject to this article shall be in accordance with the order in which each class of claims is set forth in this paragraph and as provided in this paragraph. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be:

(A) Class one. Claims with respect to the actual and necessary costs

and expenses of administration, incurred by the liquidator, rehabilitator or conservator under this article.

(B) Class two. All claims under policies including such claims of the federal or any state or local government for losses incurred, third party claims, claims for unearned premiums, and all claims of a security fund, guaranty association or the equivalent except claims arising under reinsurance contracts.

(C) Class three. Claims of the federal government except those under class two above.

(D) Class four. Claims for wages owing to employees of an insurer against whom a proceeding under this article is commenced for services rendered within one year before commencement of the proceeding, not exceeding one thousand two hundred dollars to each employee, and claims for unemployment insurance contributions required by article eighteen of the labor law. Such priority shall be in lieu of any other similar priority which may be authorized by law.

(E) Class five. Claims of state and local governments except those under class two above.

(F) Class six. Claims of general creditors including, but not limited to, claims arising under reinsurance contracts.

(G) Class seven. Claims filed late or any other claims other than claims under class eight or class nine below.

(H) Class eight. Claims for advanced or borrowed funds made pursuant to section one thousand three hundred seven of this chapter.

(I) Class nine. Claims of shareholders or other owners in their capacity as shareholders.

(2) Severability. If any classification or priority provided for in paragraph one of this subsection is held to be unconstitutional or otherwise invalid, the remaining classifications and priorities shall continue in effect.

(b) No creditor shall be entitled to interest on any dividend by reason of delay in payment of such dividend.

(c) Any claimant of another state or foreign country who is entitled to, or receives, a dividend upon his claim out of a statutory deposit or the proceeds of any qualifying bond or other asset located in such other state or foreign country shall not be entitled to any further dividend from the superintendent until all other claimants of the same class

irrespective of residence or place of the acts or contracts upon which their claims are based shall have received an equal dividend upon their claims. After such equalization, such claimant shall be entitled to share in the distribution of further dividends by the superintendent like all other creditors of the same class wherever residing.

(d) If, after an adjudication of insolvency, a mutual insurer is found clearly solvent upon re-examination, its surplus shall be distributed among all persons, partnerships or corporations whose membership did not cease earlier than five years prior to the date on which the insurer ceased issuing policies. The distribution shall be in the proportion which the total premium contributions of each such member during his or its entire membership in the insurer bear to the total premium contributions of all such members entitled under this subsection to any distributive share of such surplus.

(e) The provisions of this section shall apply to distributions made after the effective date of this subsection in any proceeding under this article, regardless of the date such proceeding was commenced under this article, provided that the foregoing provisions of this subsection shall not apply to distributions made pursuant to a final court order of distribution entered on or before the effective date of this subsection.

§ 7435. Distribution for life insurers. (a) The priority of distribution of claims from the estate of a life insurance company in any proceeding subject to this article shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall, subject to such limitations as may be prescribed by law and do not directly conflict with the express provisions of this section, be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class one. Claims with respect to the actual and necessary costs and expenses of administration, incurred by the liquidator, rehabilitator, conservator or ancillary rehabilitator under this article, or by The Life Insurance Guaranty Corporation or The Life and Health Insurance Company Guaranty Corporation of New York, and claims

described in subsection (d) of section seven thousand seven hundred thirteen of this chapter.

(2) Class two. Debts due to employees for services performed to the extent that they do not exceed one thousand two hundred dollars and represent payment for services performed within one year before the commencement of a proceeding under this article. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(3) Class three. All claims for payment for goods furnished or services rendered to the impaired or insolvent insurer in the ordinary course of business within ninety days prior to the date on which the insurer was determined to be impaired or insolvent, whichever is applicable.

(4) Class four. All claims under insurance policies, annuity contracts and funding agreements, and all claims of The Life and Health Insurance Company Guaranty Corporation of New York or any other guaranty corporation or association of this state or another jurisdiction, other than claims provided for in paragraph one of this subsection and claims for interest.

(5) Class five. Claims of the federal or any state or local government. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed to this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph eight of this subsection.

(6) Class six. Claims of general creditors and any other claims other than claims under paragraphs seven and eight of this subsection.

(7) Class seven. Surplus, capital or contribution notes, or similar obligations.

(8) Class eight. The claims of (i) policyholders, other than claims under paragraph four of this subsection, and (ii) shareholders or other owners.

(b) Every claim under a separate account agreement providing, in effect, that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurer shall

be satisfied out of the assets in the separate account equal to the reserves maintained in such account for such agreement and, to the extent, if any, not fully discharged thereby, shall be treated as a class four claim against the estate of the life insurance company.

(c) For purposes of this section:

(1) "The estate of the life insurance company" shall mean the general assets of such company less any assets held in separate accounts that, pursuant to section four thousand two hundred forty of this chapter, are not chargeable with liabilities arising out of any other business of the insurer.

(2) "Insurance policies, annuity contracts and funding agreements" shall mean all policies and contracts of any of the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter and all funding agreements described in section three thousand two hundred twenty-two of this chapter, including all separate account agreements, except that separate account agreements referred to in subsection (b) of this section shall be included only to the extent referred to therein.

(3) "Separate account agreement or agreements" shall mean any agreement or agreements for separate accounts referred to in section four thousand two hundred forty of this chapter.

§ 7436. Claims-made policies; special requirements. (a) Where a policy has been issued on a claims-made basis by an insurer against which an order of liquidation, rehabilitation or conservation has been entered pursuant to this article, the superintendent shall provide, at an appropriate additional premium by the insured and consistent with the terms of such policy, for the issuance of coverage for claims based on occurences prior to the termination of the policy which are reported after the termination of the policy, in the event that the insured seeks to purchase such coverage in accordance with the terms of such policy.

(b) If the order of liquidation, rehabilitation or conservation is entered against an insurer which has issued medical malpractice policies on a claims-made basis, then notwithstanding the entry of such order, the superintendent shall comply with the requirements for claims-made policies as set forth in subsections (b), (c) and (d) of section three

thousand four hundred thirty-six of this chapter and paragraphs two, three and four of subsection (f) of section five thousand five hundred four of this chapter.

(c) In the event that an insured, who has been issued a medical malpractice policy on a claim-made basis by an insurer against which an order of liquidation has been entered pursuant to this article, chooses to purchase coverage from a successor insurer, the superintendent shall expedite the transfer of coverage that has been accrued, for claims based on occurrences prior to the termination of the policy which are reported after the termination of the policy, to the successor insurer of each insured, in accordance with the requirement for claims-made policies as set forth in subsections (b), (c) and (d) of section three thousand four hundred thirty-six and paragraphs two, three and four of subsection (f) of section five thousand five hundred four of this chapter.

§ 7437. Qualified financial contracts. (a) As used in this section:

(1) "Actual direct compensatory damages" means and includes normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities or other market for the contract and agreement claims but does not include punitive or exemplary damages, damages for lost profit or lost opportunity or damages for pain and suffering.

(2) "Business day" means a day other than a Saturday, a Sunday or any day on which either the New York stock exchange or the Federal Reserve Bank of New York is closed.

(3) "Commodity contract" means: (A) a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the Commodity Exchange Act (7 U.S.C. § 1, et seq.) or a board of trade outside the United States; (B) an agreement that is subject to regulation under section 19 of the Commodity Exchange Act (7 U.S.C. § 1, et seq.) and that is commonly known to the commodities trade as a margin account, margin contract, leverage account or leverage contract; (C) an agreement or transaction that is subject to regulation under section 4c(b) of the Commodity Exchange Act (7 U.S.C. § 1, et seq.) and that is commonly known to the

commodities trade as a commodity option; (D) any combination of the agreements or transactions referred to in this paragraph; (E) any option to enter into an agreement or transaction referred to in this paragraph; or (F) any other contract that is included from time to time as a commodity contract as defined in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D).

(4) "Contractual right" means and includes any right set forth in a rule or bylaw of a derivatives clearing organization (as defined in the Commodity Exchange Act), a multilateral clearing organization (as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991), a national securities exchange, a national securities association, a securities clearing agency, a contract market designated under the Commodity Exchange Act, a derivatives transaction execution facility registered under the Commodity Exchange Act, or a board of trade (as defined in the Commodity Exchange Act) or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law, or under law merchant, or by reason of normal business practice.

(5) "Forward contract" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D).

(6) "Netting agreement" means: (A) a contract or agreement (including the terms and conditions incorporated by reference in such agreement), including a master agreement (which master agreement, together with all schedules, confirmations, definitions and addenda thereto and transactions under any thereof, shall be treated as one netting agreement), that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, offset, liquidation, termination, acceleration or close out, under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements thereunder (including liquidation or close-out values relating to such obligations or entitlements) among the parties to the netting agreement; (B) any master agreement or bridge agreement for one or more master agreements described in subparagraph (A) of this paragraph; or (C) any security arrangement related to one or more contracts or agreements described in subparagraph (A) or (B) of this paragraph; provided that any contract or

agreement described in subparagraph (A) or (B) of this paragraph relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

(7) "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the superintendent determines by regulation to be a qualified financial contract for the purposes of this article.

(8) "Repurchase agreement" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D).

(9) "Securities contract" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D).

(10) "Security arrangement" means any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation, including a pledge, security, collateral or guarantee agreement or credit support document.

(11) "Separate account" means an account established pursuant to section four thousand two hundred forty of this chapter.

(12) "Swap agreement" shall have the meaning set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D).

(13) "Walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a non-defaulting party.

(b) (1) Notwithstanding any other provision of this article, including any other provision of this article permitting the modification of contracts, or other law of this state, no person shall be stayed or prohibited from exercising: (A) a contractual right to cause the termination, liquidation, acceleration or close out of any obligation under or in connection with a netting agreement or qualified financial contract with an insurer, other than an insurer licensed to write financial guaranty insurance, because of: (i) the insolvency, financial

condition or default of the insurer at any time, provided that the right is enforceable under applicable law other than this article; or (ii) the commencement of any proceeding under this article; (B) any right under a security arrangement relating to one or more netting agreements or qualified financial contracts, other than a right against an insurer licensed to write financial guaranty insurance; or (C) subject to any provision of subsection (b) of section seven thousand four hundred twenty-seven of this article, any right to offset or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts, other than a right against an insurer licensed to write financial guaranty insurance, where the counterparty or its guarantor is organized under the laws of the United States, a state, or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(2) If a counterparty to a master netting agreement or a qualified financial contract with an insurer, other than an insurer licensed to write financial guaranty insurance, subject to a proceeding under this article terminates, liquidates, closes out or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, close out or acceleration. The amount of a claim for damages shall be actual direct compensatory damages.

(c) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application has been filed under this article, other than an insurer licensed to write financial guaranty insurance, shall be transferred to or on the order of the superintendent, as liquidator, rehabilitator or conservator for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract. Any limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full two-way payment or second method provision as against the defaulting insurer. Any such property or amount shall, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, be an asset of the insurer.

(d) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this article, other than an insurer licensed to write financial guaranty insurance, the superintendent, as liquidator, rehabilitator or conservator for the insurer, shall either:

(1) transfer to one party (other than an insurer subject to a proceeding under this article) all netting agreements and qualified financial contracts between a counterparty or any affiliate of such counterparty and the insurer that is the subject of the proceeding, including: (A) all rights and obligations of each party under each such netting agreement and qualified financial contract; and (B) all property, including any guarantees or other credit enhancement, securing any claims of each party under each such netting agreement and qualified financial contract; or

(2) transfer none of the netting agreements, qualified financial contracts, rights, obligations or property referred to in paragraph one of this subsection (with respect to such counterparty and any affiliate of such counterparty).

(e) If the superintendent, as liquidator, rehabilitator or conservator for an insurer, other than an insurer licensed to write financial guaranty insurance, makes a transfer of one or more netting agreements or qualified financial contracts, then the superintendent shall use his or her best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12:00 noon, New York time, on the business day following the transfer.

(f) Notwithstanding any other provision of this article, the superintendent, as liquidator, rehabilitator or conservator for an insurer, other than an insurer licensed to write financial guaranty insurance, may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any security arrangement relating to a netting agreement or qualified financial contract, that is made before the commencement of a liquidation, rehabilitation or conservation proceeding under this article, except that a transfer may be avoided under section seven thousand four hundred twenty-five of this article if the transfer was made with actual intent to hinder, delay or defraud the insurer, the superintendent, as liquidator, rehabilitator or conservator of the

insurer, any other receiver appointed for the insurer, or existing or future creditors.

(g)(1) In exercising any rights of disaffirmance or repudiation of a liquidator, rehabilitator or conservator with respect to any netting agreement or qualified financial contract to which an insurer is a party, other than an insurer licensed to write financial guaranty insurance, the superintendent, as liquidator, rehabilitator or conservator for the insurer shall either: (A) disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of such counterparty and the insurer that is the subject of the proceeding; or (B) disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subparagraph (A) of this paragraph (with respect to such person or any affiliate of such person).

(2) Notwithstanding any other provision of this article, any claim of a counterparty against the estate, other than the estate of an insurer licensed to write financial guaranty insurance, arising from the superintendent's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation proceeding or in the immediately preceding rehabilitation proceeding shall be determined and shall be allowed or disallowed: (A) as if the claim had arisen before the date of the filing of the application for liquidation; or (B) if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the application for rehabilitation.

(3) The amount of the claim identified in paragraph two of this subsection shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

(h) All rights of a counterparty under this article shall apply to a netting agreement and a qualified financial contract entered into on behalf of or allocated to: (1) the general account of the insurer; or (2) a separate account of the insurer, other than an insurer licensed to write financial guaranty insurance, if the assets of the separate account are available only to a counterparty to a netting agreement and a qualified financial contract entered into on behalf of, or allocated

to, that separate account.

ARTICLE 75

LIFE INSURANCE GUARANTY FUND

Section 7501. Purpose of article.
7502. Definitions.
7503. The Life Insurance Guaranty Corporation.
7504. The guaranty fund.
7505. Taxes.
7506. Companies excluded from article.
7507. Authorization for member companies.

§ 7501. Purpose of article. The purpose of this article is to continue the life insurance guaranty fund, a fund arising from assessments upon domestic life insurance companies to be used for the promotion of the stability of such companies and the performance of their contractual obligations. In the judgment of the legislature, the foregoing objects and purposes are not capable of accomplishment by a corporation created under general laws, so the continuation of the non-profit corporation, "The Life Insurance Guaranty Corporation", is provided by this article.

§ 7502. Definitions. In this article:

(a) "Board" means the board of directors of The Life Insurance Guaranty Corporation.

(b) "Assessment" means a payment made by a company into the guaranty fund.

(c) "Contributor" means a company paying an assessment.

(d) "Corporation" means "The Life Insurance Guaranty Corporation."

(e) "Fund" means the guaranty fund provided by this article.

(f) "Member company" means any domestic life insurance company having a representative serving as a director upon the board of directors of the corporation.

(g) "Policies" means insurance policies; "contracts" means annuity contracts; both terms include policies or contracts of reinsurance

issued by a member company.

§ 7503. The Life Insurance Guaranty Corporation. (a) The non-profit body corporate known as "The Life Insurance Guaranty Corporation" created pursuant to chapter four hundred eighty-one of the laws of nineteen hundred forty-one, is hereby continued. It shall be composed of the superintendent ex-officio and one representative of each life insurance company incorporated or organized under any law of this state which shall have actively and continuously transacted business in this state for a period of at least three years prior to the effective date of article seventy-seven of this chapter. No company shall be eligible for membership in the corporation if a proceeding instituted by the superintendent pursuant to article seventy-four of this chapter is pending against it in which event such company shall not be eligible until the superintendent shall certify that it is so eligible.

(b) Every such company which shall become eligible for membership in the corporation shall, within forty-five days from the date on which it becomes so eligible, file with the superintendent a certificate designating its representative for the purposes of such corporation. Upon failure of any company to make such designation within the forty-five day period, the superintendent shall forthwith make such designation for and on its behalf and by mail give notice thereof to such company. The designation, whether made by the company or the superintendent, may be revoked by the company at any time with or without cause. Any vacancy by death, resignation or removal shall be filled in the same manner as for the original designation of a representative.

(c) Each such representative shall also be known as a director and all representatives and the superintendent shall constitute the board of directors which shall have complete charge and control of the management of the corporation in accordance with the corporate powers hereinafter set forth, including power to adopt administrative rules, regulations and by-laws advisable for the purposes and objects of the corporation. The superintendent shall be ex-officio chairman of the board.

(d) No director, officer, agent or other representative of the corporation shall be individually liable to any person, firm or

corporation, including the corporation, for any act or omission to act, or for any liability incurred or assumed, on behalf of the corporation or by virtue hereof. Any such liability so incurred or assumed shall be collectible only out of the fund; nor shall any member company be subject to any liability except for assessment as herein provided.

(e) The corporation shall be under the immediate supervision of the superintendent and shall be subject to such provisions of this chapter as the superintendent shall deem applicable.

(f) The corporation shall have the power:

(1) to use a corporate seal, to contract, to sue and be sued and to possess and exercise all powers necessary or convenient for the purposes of this article;

(2) with the approval of the superintendent, to assume, reinsure or guaranty, or cause to be assumed, reinsured or guaranteed, partially or wholly, any or all policies or contracts of any member company and to make available from the fund such sums as may be necessary for such purposes;

(3) to carry out the provisions of this article, the corporation shall have and may exercise all necessary rights, powers, privileges and franchises of a domestic life insurance company except that it shall not be authorized to issue contracts or policies unless they replace contracts or policies representing obligations in whole or in part of another domestic life insurance company or of the corporation;

(4) to borrow money for the purposes of the fund with or without security and pledge such assets in the fund as security for such loans and in connection therewith to rehypothecate any securities or collateral pledged to it by a company, provided, however, that obligations of the corporation shall be legal investments for domestic life insurance companies and to the extent authorized by the superintendent may be carried as admitted assets;

(5) to collect, or enforce by legal proceedings, if necessary, the payment of, all assessments for which any contributor may be liable under this article; to collect any obligation due to the corporation or to the fund; and

(6) to fund a resolution facility established pursuant to section seven thousand seven hundred nineteen of this chapter.

(g) The corporation shall, subject to such terms and conditions as it

may impose with the approval of the superintendent, assume, reinsure or guaranty the performance of the policies and contracts issued prior to the effective date of article seventy-seven of this chapter by any impaired or insolvent member company, and shall have power to receive, own and administer any assets acquired in connection with such assumption, reinsurance or guaranty; provided, however, that after the effective date of article seventy-seven of this chapter the corporation shall have no responsibility with respect to any claim under any such policy or contract except (i) to the extent that the amount of such claim exceeds the portion thereof that is covered under article seventy-seven of this chapter, and (ii) with respect to any claim not covered under article seventy-seven of this chapter. As to any policy not in default in the payment of premiums subsequent to any such assumption, reinsurance or guaranty, the corporation shall make prompt payment of the death benefit due under the terms of the policy.

(h) Notwithstanding any other provision of this section, no assumption by a member company after the effective date of article seventy-seven of this chapter, of the policies or contracts of another member company issued prior to the effective date of article seventy-seven of this chapter, for which assumption certificates have been issued, shall result in loss by such policies or contracts of the protection provided under this article.

§ 7504. The guaranty fund. (a) The corporation shall provide a guaranty fund from which all corporate administrative costs may be paid as well as such payments and advances as may be made in connection with any assumption, reinsurance or guaranty agreement. Such fund shall be raised by assessments which may be made from time to time by the corporation upon all member companies in proportion to their admitted assets as shown by their annual statements required by this chapter for the year next preceding the date of such assessment. The net realized gains and income from investments of the fund shall belong, and be refunded, to the contributors in proportion to the amounts contributed by them. The corporation may provide by resolution or by-law the necessary procedure for making assessments, the payment thereof, and the refund of any net realized gains and income from investments of the

fund.

(b) The amount of the fund shall be kept at such a sum as will enable the corporation to meet its immediate obligations and liabilities.

(c) Upon payment of assessments the corporation shall issue to the contributors certificates showing the dates and amounts of such payments, and any other matters deemed proper. All outstanding certificates shall be of equal dignity and priority irrespective of amounts or dates of issue. Such certificates may be carried by member companies as admitted assets to the extent authorized by the superintendent.

(d) Whenever the amount of the fund exceeds the immediate requirements of the corporation, with the approval of the superintendent, the corporation may distribute such excess by retirement of the aforesaid certificates previously issued or any part thereof. Such distribution shall be made pro rata upon the basis of outstanding certificates, except that by unanimous consent of all the directors and with the approval of the superintendent any other method of retirement of the certificates may be adopted.

(e) Upon dissolution of the fund by the repeal of this article or otherwise, the fund shall be distributed in the manner provided for the repayment or retirement of certificates. If the amount of the fund at the time of dissolution exceeds the outstanding certificates, the excess shall be paid in such equitable manner as shall be approved by the superintendent.

(f) The aggregate of the outstanding certificates shall at no time exceed fifty million dollars.

§ 7505. Taxes. (a) The corporation shall be exempt from all taxes and fees imposed by this state or by any county, municipality, or local authority or subdivision, except that real property owned by the corporation shall be subject to county, municipal or local authority or subdivision taxation to the same extent, according to its value, as other similar real property.

(b) Any company whose policies have been assumed, reinsured or guaranteed by the corporation shall remain liable for the taxes required by article thirty-three of the tax law, and shall remain liable as to

taxes accrued before January first, nineteen hundred seventy-four, which were required by section one hundred eighty-seven of the tax law as in effect before January first, nineteen hundred seventy-four, on all premiums received on policies issued by it, but payment of such taxes shall be suspended. Payment of or on account of such taxes shall be made under such terms and conditions as the superintendent prescribes, except that no such payment may be required or made if such company would become impaired by the making of such payment or if such payment would reduce its capital and surplus below the minimum statutory requirements for organization of a like new life insurance company. No dividends to shareholders shall be declared unless all premium taxes have been fully paid.

§ 7506. Companies excluded from article. There is hereby excluded from the provisions of this article any life insurance company organized and operated, without profit to any private shareholder or individual, exclusively to aid and strengthen charitable, religious, missionary, educational or philanthropic institutions by issuing policies or contracts only to or for the benefit of such institutions, to individuals engaged in serving such institutions and to members of their immediate families.

§ 7507. Authorization for member companies. Each member company and its officers, directors and agents shall have authority to do and permit to be done any act and to make any payment herein authorized or contemplated.

ARTICLE 76

PROPERTY/CASUALTY SECURITY FUNDS

Section 7601. Property/casualty insurance security fund; public motor vehicle liability security fund.
7602. Definitions.
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§ 7601. Property/casualty insurance security fund; public motor vehicle liability security fund. (a) The property and liability insurance security fund is continued and shall hereafter be known as "the property/casualty insurance security fund".

(b) The public motor vehicle liability security fund is continued.

(c) The property/casualty insurance security fund shall consist of all payments made to it by insurers and of securities acquired by and through the use of moneys belonging to it, together with interest and accretions earned upon such payments or investments earned prior to January first, nineteen hundred seventy-four.

(d) The public motor vehicle liability security fund shall consist of all payments made to it by insurers and of securities acquired by and through the use of moneys belonging to it, together with interest and accretions earned upon such payments or investments.

(e) Each fund shall be administered separately by the superintendent in accordance with this article.

§ 7602. Definitions. In this article, unless the context or subject matter otherwise requires:

(a) "Fund" means either the property/casualty insurance security fund or the public motor vehicle liability security fund.

(b) "Fund year" means the calendar year.

(c) "Insurer" means any insurer (other than an insolvent insurer, or a municipal reciprocal insurer which issues policies not covered by the

property/casualty insurance security fund, or a risk retention group as defined in article fifty-nine of this chapter, or a provider of service contracts pursuant to article seventy-nine of this chapter) authorized to transact the kinds of business specified in paragraphs four through fourteen, sixteen, seventeen, nineteen through twenty-one of subsection (a) of section one thousand one hundred thirteen of this chapter.

(d) "Policy" means a policy issued by an insurer authorized to do business in this state, including a policy or surety bond filed pursuant to article six or seven of the vehicle and traffic law, insuring against legal liability arising out of the ownership, operation or maintenance of motor vehicles, including surety bonds or insurance policies issued to meet the requirements of section three hundred seventy of the vehicle and traffic law.

(e) "Net direct written premiums" means direct gross premiums written on policies subject to this article, insuring:

(1) property or risks located or resident in this state,

(2) legal liability arising out of the ownership, operation or maintenance of motor vehicles which are principally garaged in this state, less return premiums thereon and dividends paid to policyholders on such direct business.

For the purposes of this article premiums written by any authorized insurer on policies issued to self insurers, whether or not designated as reinsurance contracts, shall be deemed "net direct written premiums".

(f) "Motor vehicle accident" means either an accident occurring within or without this state arising out of the ownership, operation or maintenance of a motor vehicle which is principally garaged in this state or an accident occurring within this state arising out of the ownership, operation or maintenance of a motor vehicle which is not principally garaged in this state.

(g) "Allowed claim" means a claim that has been allowed by the superintendent in a proceeding under article seventy-four of this chapter or, if such claim exceeds twenty-five thousand dollars, has been allowed by the court in a proceeding under article seventy-four of this chapter, and which is based upon:

(1) a policy insuring property or risks located or resident in this state, or

(2) a policy issued in this state to a resident of this state insuring

property or risks, located or resident outside this state but within the United States, its possessions and territories, and Canada, provided that, with respect to policies covered under this paragraph:

(A) irrespective of the amount of claim that has been allowed, no person shall recover any amount from this fund until such person has exhausted all rights of recovery from any security fund, guaranty association, or the equivalent in the jurisdiction where such property or risks are located or resident; and, thereafter, such person's recovery from this fund, when combined with amounts recovered or recoverable from any other security fund, guaranty association, or the equivalent in such jurisdiction, shall not exceed the maximum limit available to a qualified claimant for a recovery solely from such other security fund, guaranty association, or the equivalent; and

(B) the aggregate limit for all claims arising out of any one policy, excluding claims with respect to property or risks located or resident in this state, shall not exceed the lesser of the aggregate limit of the policy or five million dollars.

(h) "Injured party claim" means a claim of a person, other than a policyholder or assured, who suffered an injury to his person or property arising out of an insured incident within the coverage of the policy.

(i) "Policyholder claim" means a claim of a policyholder or assured within the coverage of the policy, wherein such person suffered loss or damage under the coverage of the policy or where such person has paid an injured party claim, subject to allowance of such policyholder claim in a proceeding under article seventy-four of this chapter.

(j) "Commissioner" means the commissioner of taxation and finance of this state.

§ 7603. Property/casualty insurance security fund. (a) (1) The property/casualty insurance security fund shall be used in the payment of allowed claims remaining unpaid, in whole or in part, by reason of the inability due to insolvency of an authorized insurer to meet its insurance obligations under policies:

(A) on account of claims from motor vehicle accidents as defined in subsection (f) of section seven thousand six hundred two of this

article,

(B) for all of the kinds of insurance specified in paragraphs four through fourteen, sixteen, nineteen through twenty-one, twenty-four and subparagraphs (A) and (B) of paragraph twenty-six of subsection (a) of section one thousand one hundred thirteen of this chapter with respect to coverage of property or risks located or resident in this state, or outside this state but within the United States, its possessions and territories, and Canada,

(C) for the kind of insurance providing disability benefits pursuant to article nine of the workers' compensation law issued by an authorized insurer licensed under article forty-one, sixty-one or sixty-six of this chapter with respect to coverage of risks located or resident in this state,

(D) in the kind of insurance providing workers' compensation insurance pursuant to subsection (j) of section three thousand four hundred twenty of this chapter,

(E) for the insurance provided by the medical malpractice insurance association,

(F) for the insurance provided pursuant to subdivision two-a of section seventy-six of the workers' compensation law if and when operative,

(G) for the kinds of credit insurance as defined in subparagraphs (B) and (C) of paragraph seventeen of subsection (a) of section one thousand one hundred thirteen of this chapter, and

(H) any obligation for the return of unearned premiums on any policy specified in subparagraphs (A), (B), (C), (D), (E), (F) and (G) hereof, which shall, for the purposes of this article, be deemed to include the obligations of an insurer and the medical malpractice insurance association under medical malpractice claims-made policies to pay to successor entities the actuarially appropriate amounts for the provision of coverage to comply with the requirements of subsections (b), (c) and (d) of section three thousand four hundred thirty-six and paragraphs two, three and four of subsection (f) of section five thousand five hundred four of this chapter.

(2) No payment from the property/casualty insurance security fund shall be made to any person who owns or controls ten percent or more of the voting securities of the insolvent insurer and no payment on any one

claim shall exceed one million dollars, provided that the amount of payment on a claim and the aggregate for all claims shall be further limited by the provisions of paragraph two of subsection (g) of section seven thousand six hundred two of this article.

(b) (1) Contributions to the property/casualty insurance security fund shall be determined on the basis of net direct written premiums on policies insuring property or risks located or resident in this state.

(2) Every insurer shall pay into such fund, upon filing each quarterly return pursuant to section seven thousand six hundred five of this article, one-half of one percent of its net direct written premiums as shown for the period covered by such return.

(c) (1) Whenever the superintendent determines, pursuant to section seven thousand six hundred six of this article, that the net value of the property/casualty insurance security fund is at least one hundred fifty million dollars, no further contributions shall be made after the fund year in which the determination is first made, but if thereafter the superintendent determines that payments made from the fund by the commissioner to the superintendent acting as liquidator, rehabilitator or conservator have reduced the net value to an amount less than such amount, the superintendent shall cause contributions to be resumed until the end of the fund year in which he first determines that such net value exceeds such amount.

(2) If contributions are so resumed, they shall be apportioned:

(A) ratably among those kinds of insurance as to which the commissioner made payments during the fund year in which the net value of the property/casualty insurance security fund was reduced below such amount, and

(B) among insurers in accordance with their respective amounts of net direct premiums written in each such kind of insurance.

(d) (1) All income earned on moneys in the fund (after deducting any amounts paid for allowed claims and administrative expenses during the preceding year) shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury; except that with respect to all such income earned on or after July first, nineteen hundred seventy-nine such moneys shall be distributed annually in the following manner:

(A) Pursuant to regulations of the superintendent, the deficit from

the operations of the New York property insurance underwriting association shall be credited with such income earned, upon certification by the superintendent to the commissioner, in a sum not exceeding such total income earned or the sum of fifteen million dollars whichever is the lesser in any one year. Such credit shall be in lieu of a transfer of such funds to the general fund of the state treasury.

(B) Any balance of earned income shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury; but only when the value of the fund exceeds the sum of two hundred forty million dollars.

(2) The superintendent, after consultation with the commissioner, may by regulation provide for contributions to be made in the form of acceptable securities, and for the management and disposition of such securities. The income from such securities shall be included in the distribution outlined in paragraph one hereof.

(3) The superintendent is authorized to use the income earned on the moneys of the fund to offset the deficit of the New York property insurance underwriting association in accordance with subsection (d) of section five thousand four hundred five of this chapter, provided that any income earned on the moneys of the fund which in any one year exceeds fifteen million dollars or which the superintendent has not utilized for the purposes of such subsection shall be credited to the corpus of the fund until the superintendent determines that its net value is two hundred forty million dollars, and thereafter shall be credited, upon certification by the superintendent to the commissioner, to the general fund of the state treasury.

(e) (1) (A) Notwithstanding any other provision of law to the contrary, the superintendent shall annually no later than November first in each year submit to the director of the budget a request for an appropriation of ninety million dollars. The governor shall include such amount in a budget bill for the next state fiscal year. The state comptroller shall encumber the amount so appropriated before the end of the fiscal year for which any such appropriation is made. If for any fiscal year commencing on or after April first, nineteen hundred eighty-three, the governor fails to submit a budget bill containing an appropriation in the amount requested by the superintendent or the legislature fails to appropriate the amount in a budget bill submitted

by the governor for such fiscal year, the amount appropriated for and encumbered during the preceding fiscal year shall be payable forthwith to the fund on July first of such year in the manner prescribed by law, provided, however, that such amount shall not exceed the amount of moneys transferred to the general fund from the fund pursuant to the provisions of chapter fifty-five of the laws of nineteen hundred eighty-two.

(B) Any appropriation made to the fund pursuant to this section shall be included as an asset for the purposes of computing the value or net value of the fund pursuant to this section.

(C) Any transfer of moneys from the fund to the general fund in accordance with the provisions of chapter fifty-five of the laws of nineteen hundred eighty-two is deemed a proper and prudent legal undertaking for any state officer with the responsibility for the custody or the investment of the assets of the fund, notwithstanding any other provision of law to the contrary.

(2) Upon certification by the superintendent that further sums, not exceeding fifty million dollars in the aggregate, are required by the public motor vehicle liability security fund to meet its obligations and accomplish the purposes of this article the commissioner shall transfer from the assets of the property/casualty insurance security fund to the public motor vehicle liability security fund amounts to be specified by the superintendent. Such sums, not exceeding fifty million dollars in the aggregate, shall be a liability of the public motor vehicle liability security fund and shall be repaid to the property/casualty insurance security fund pursuant to a plan of repayment to be prescribed by the superintendent which may provide for an increase in the level of payments into the fund provided for in subsection (b) of section seven thousand six hundred four of this article.

§ 7604. Public motor vehicle liability security fund. (a) The purpose of the public motor vehicle liability security fund is to secure the benefits contemplated by section three hundred seventy of the vehicle and traffic law in those cases where a policy of insurance or corporate surety bond, therein described, of a solvent and responsible insurer is accepted by the commissioner of motor vehicles as a compliance with such

section. The fund shall be used to pay allowed claims of injured parties and policyholders under insurance policies or surety bonds, remaining unpaid, in whole or in part, by reason of the insurer's insolvency or its inability to meet its insurance obligations (including any obligation for the return of unearned premiums) provided the insurer has made payments to the fund as required by subsection (b) hereof.

(b) (1) Contributions to this fund shall be determined on the basis of net direct written premiums on insurance policies or surety bonds issued to meet the requirements of section three hundred seventy of the vehicle and traffic law.

(2) Every insurer issuing such policies or bonds, upon filing its quarterly return pursuant to section seven thousand six hundred five of this article, shall pay into the fund three percent of its net direct written premiums as shown for the period covered by such return.

§ 7605. Quarterly returns. With respect to each fund subject to this article, every insurer on or before the fifteenth days of February, May, August and November of each year, shall file, with the commissioner and the superintendent identical returns, subscribed and affirmed by the insurer to be true under the penalties of perjury, on a form prescribed by the superintendent, stating the amount of net direct written premiums charged by such insurer during the quarter year ending on the last day of the second month preceding that in which the report is required to be filed.

§ 7606. Determination of net value of funds; limits. (a) The superintendent shall annually, on or before March first, ascertain and determine the net value of each fund as of the next preceding December thirty-first by deducting from the value of the assets of each fund, ascertained pursuant to this article, the aggregate actual and estimated liabilities of each fund as determined by the superintendent. When the net value of a fund, as thus determined, reaches an amount equal to fifteen percent of the outstanding claim reserves of all authorized insurers, incurred under policies or bonds providing benefits as specified in subsection (a) of section seven thousand six hundred three

or subsection (a) of section seven thousand six hundred four of this article, as the case may be, no further contributions to such fund shall be required to be made.

(b) Whenever, thereafter, the amount of a fund is reduced below such fifteen percent, by reason of payments from, and known and estimated liabilities of, that fund, then contributions to such fund shall be resumed and continued until that fund, over and above its known and estimated liabilities, reaches such amount.

§ 7607. Management and investment of funds. (a) Each of the two funds governed by this article shall be separate and apart. Each fund shall also be separate and apart from any other fund and from all other state moneys, and the faith and credit of the state of New York is pledged for their safekeeping. The commissioner shall be the custodian of the funds. All disbursements shall be made by the commissioner upon vouchers signed by the superintendent, or his deputy. The moneys of the funds may be invested by the commissioner in obligations of the United States or of this state and in interest bearing certificates of deposit of a bank or trust company located and authorized to do business in this state, or of a national bank located in this state, secured by a pledge of direct obligations of the United States or of the state of New York in an amount equal to the amount of such certificates of deposit, or in accordance with the provisions of section ninety-eight-a of the state finance law.

(b) With respect to the moneys in the property/casualty insurance security fund the commissioner may also invest in:

(1) obligations of public benefit corporations whose obligations are legal for investment by public officers and bodies of this state;

(2) up to thirty-three and one-third percent of the net value of the fund in mortgage loans or deeds of trust on real property improved by one, two, three or four family residences owned by one or more individuals and occupied by an owner and located in this state. The amount invested in mortgage loans and deeds of trust may not exceed the lesser of ninety percent of the appraised value of the real property or thirty-five thousand dollars if a one-family residence, forty thousand dollars if a two-family residence, forty-five thousand dollars if a

three-family residence, or fifty thousand dollars if a four-family residence. The mortgage or deed of trust shall provide for monthly principal and interest payments in amounts sufficient to pay all interest and effect full repayment of principal within seventy-five percent of the estimated remaining useful life of the building or thirty years, whichever is less.

(c) The commissioner may sell any investment of either fund, if advisable, for proper administration or in the best interests of the fund.

§ 7608. Payments from funds; subrogation; limit on payments. (a) Payments from the funds shall be made by the commissioner to the superintendent acting as liquidator, rehabilitator or conservator pursuant to article seventy-four of this chapter upon the authority of appropriate certificates filed with him by the superintendent acting in such capacity.

(b) (1) Payments from the funds upon allowed claims give no right of recovery by the commissioner as custodian of the funds against principals or assureds under policies of insurance or surety bonds, for the benefit and reimbursement of the fund.

(2) Any assured under such a policy of insurance or surety bond who pays, in whole or in part, any injured party claim which is eligible for payment, in whole or in part, from the funds, shall thereupon be subrogated to the injured party's rights against the fund but not in excess of the subrogee's claim as allowed in the proceeding under article seventy-four of this chapter.

(c) No payment from the funds shall exceed the limit of liability provided for in the insurance policy or surety bond.

§ 7609. Rights of funds against insolvent insurers. (a) The commissioner as custodian of each of the funds shall be entitled to a valid claim against an insurer which becomes insolvent or unable to meet its insurance obligations, or its liquidator, rehabilitator, conservator, receiver, or trustee in bankruptcy, in an amount equal to the liabilities, including loss adjustment expenses relating to such

liabilities, of the insurer paid from the fund less the net payments paid into the fund by such insurer.

(b) All moneys recovered through the prosecution of claims in the liquidation, rehabilitation or conservation proceeding shall be forthwith placed to the credit of the appropriate fund by the commissioner.

§ 7610. Defense of claims. (a) The superintendent may, in his discretion, designate or appoint a duly authorized representative to appear before any court or other body or official having jurisdiction and defend any action or proceeding against principals or assureds on insurance policies or bonds issued to them where the insurer has become insolvent or unable to meet its insurance obligations. The superintendent shall have, as of the date of such insolvency or inability to meet its insurance obligations, only the rights which the insurer would have had if not insolvent or unable to meet its insurance obligations.

(b) For the purposes of this section, the superintendent shall have power to employ such counsel, clerks and assistants as may be necessary.

§ 7611. Expense of administering funds. (a) The expense of administering each fund shall be paid out of such fund. Prior to the first days of January, April, July and October, there shall be submitted to the director of the budget for approval an estimated budget of expenditures for the succeeding three months.

(b) There may not be expended for the purpose of administering the funds more than the amounts as authorized by the director of the budget. The superintendent shall serve as administrator of the funds without additional compensation, but may be allowed and paid from the funds the expenses incurred in performing his duties in connection with the funds. The compensation of persons employed by the superintendent, within the amounts approved by the director of the budget, shall be deemed administration expense payable from the funds.

§ 7612. Foreign and alien insurers. Every foreign or alien insurer subject to this article is deemed to have consented to the adjudication of all claims secured by this article in a proceeding under article seventy-four of this chapter.

§ 7613. Rules and regulations. The superintendent may adopt, amend and enforce all reasonable rules and regulations necessary for the proper administration of the funds.

§ 7614. Penalties. (a) If any insurer fails to file any return or make any payment required by this article, or if the superintendent has cause to believe that any return or other statement filed is false or inaccurate in any particular, or that any payment made is incorrect, he may examine all the books and records of the insurer to ascertain the facts and determine the correct amount to be paid and may proceed in any court of competent jurisdiction to recover for the benefit of the fund any sums shown to be due upon such examination and determination.

(b) Any insurer which fails to make any such required statement, or to make any payment to the fund when due, shall thereby forfeit to the appropriate fund a penalty of five percent of the amount determined to be due plus one percent of such amount for each month of delay, or fraction thereof, after the expiration of the first month of such delay. If satisfied that the delay was excusable, the superintendent may remit all or any part of the penalty.

(c) The superintendent, in his discretion, may revoke the certificate of authority to do business in this state of any foreign insurer which fails to comply with this article or to pay any penalty imposed hereunder.

ARTICLE 77
THE LIFE AND HEALTH INSURANCE COMPANY GUARANTY CORPORATION OF NEW YORK ACT

Section 7701. Short title.

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§ 7701. Short title. This article shall be known and may be cited as "The Life and Health Insurance Company Guaranty Corporation of New York Act".

§ 7702. Purpose. The purpose of this article is to provide funds to protect policy owners, insureds, health care providers, beneficiaries, annuitants, payees and assignees of life insurance policies, health insurance policies, annuity contracts, funding agreements and supplemental contracts issued by life insurance companies, health insurance companies, and property/casualty insurance companies, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing such policies, contracts, or funding agreements. In the judgment of the legislature, the foregoing objects and purposes not

being capable of accomplishment by a corporation created under general laws, the creation of a not-for-profit corporation of insurers is provided for by this article to enable the guarantee of payment of benefits and of continuation of coverages, and members of the corporation are subject to assessment to carry out the purposes of this article.

§ 7703. Scope. (a) (1) This article shall apply to direct life insurance policies, health insurance policies, annuity contracts, funding agreements, and supplemental contracts issued by a life insurance company, health insurance company, or property/casualty insurance company licensed to transact life or health insurance or annuities in this state at the time the policy, contract, or funding agreement was issued or on the date of entry of a court order of liquidation or rehabilitation with respect to such a company that is an impaired or insolvent insurer, as the case may be.

(2) Except as otherwise provided in this section, this article shall apply to the policies, contracts, and funding agreements specified in paragraph one of this subsection with regard to a person who is:

(A) an owner or certificate holder under a policy, contract, or funding agreement and in each case who:

(i) is a resident of this state; or

(ii) is not a resident of this state, but only under all of the following conditions:

(I) the insurer that issued the policy, contract, or agreement is domiciled in this state;

(II) the state or states in which the person resides has or have a guaranty entity similar to the corporation created by this article; and

(III) the person is not eligible for coverage by a guaranty entity in any other state because the insurer was not licensed or authorized in that state at the time specified in that state's guaranty entity law;

(B) the beneficiary, assignee, or payee of the person specified in subparagraph (A) of this paragraph, regardless of where the person resides; or

(C) a health care provider that has rendered services to a person specified in subparagraph (A) of this paragraph.

(3) Except as otherwise provided in this section:

(A) with regard to a group annuity contract (or portion of any such contract) that does not guarantee annuity benefits with respect to any specific individual identified in the contract, this article shall apply to a person who is the owner of such a contract:

(i) if the contract is issued to or in connection with a specific benefit plan where the plan sponsor has its principal place of business in this state; provided, however, that for the purpose of this subparagraph:

(I) "plan sponsor" shall mean:

(aa) the employer in the case of a benefit plan established or maintained by a single employer;

(bb) the employee organization in the case of a benefit plan established or maintained by an employee organization, provided that "employee organization" shall mean any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and that exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships, or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan; or

(cc) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan; and

(II) "principal place of business" shall mean:

(aa) the state in which the individuals who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, except that if more than fifty percent of the participants in the benefit plan are employed in a single state, then that state shall be deemed to be the principal place of business of the plan sponsor; or

(bb) with regard to a plan sponsor of a benefit plan described in subitem (cc) of clause (I) of this item, the principal place of business, as determined pursuant to subitem (aa) of this clause, of the

employer or employee organization that has the largest investment in the benefit plan; or

(ii) issued to or in connection with a government lottery if the owner is a resident; and

(B) with regard to a structured settlement annuity, this section shall apply to a person who is a payee under the structured settlement annuity, or the beneficiary of a payee if the payee is deceased, if the payee (or beneficiary):

(i) is a resident, regardless of where the owner of the structured settlement annuity resides; or

(ii) is not a resident, but only under the following conditions:

(I) (aa) the owner of the structured settlement annuity is a resident; or

(bb) the owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the owner resides has a guaranty entity similar to the corporation created by this article; and

(II) neither the payee (or beneficiary) nor the owner of the structured settlement annuity is eligible for coverage by a guaranty entity of the state in which the payee (or beneficiary) or owner resides.

(b) This article shall not apply to:

(1) that portion or part of a variable life insurance policy, variable annuity contract or variable funding agreement not guaranteed by an insurer;

(2) that portion or part of any policy, contract or agreement under which the risk is borne by the holder thereof;

(3) any policy, contract, or agreement, or part thereof, assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(4) any policy, contract, or agreement issued by or through the facilities of the New York Insurance Exchange, Inc., or any similar entity, or pursuant to article sixty-three of this chapter;

(5) any policy, contract, or agreement issued or issued for delivery outside the United States, to the extent it covers persons not citizens or permanent residents of the United States; and

(6) any policy, contract, or agreement payable other than in United

States dollars.

(c) This article shall not apply to a person:

(1) who is a payee, or the beneficiary of a payee if the payee is deceased, of an owner resident if the payee (or beneficiary) is afforded any coverage by a guaranty entity of another state; or

(2) covered under subparagraph (A) of paragraph three of subsection (a) of this section if the guaranty entity of another state provides any coverage to the person.

§ 7704. Construction. This article shall be liberally construed to effect the purpose under section seven thousand seven hundred two of this article which shall constitute an aid and guide to interpretation.

§ 7705. Definitions. As used in this article:

(a) "Account" means any of the two accounts created under section seven thousand seven hundred six of this article.

(b) "Contractual obligations" means any obligation under covered policies, but shall not include any obligation with respect to policyholder dividends unpaid or unapplied, retrospective rate credits or similar benefits or provisions.

(c) "Corporation" means The Life and Health Insurance Company Guaranty Corporation of New York created under section seven thousand seven hundred six of this article unless the context otherwise requires.

(d) "Covered policy" means any of the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter, any supplemental contract, or any funding agreement referred to in section three thousand two hundred twenty-two of this chapter, or any portion or part thereof, within the scope of this article under section seven thousand seven hundred three of this article, except that any certificate issued to an individual under any group or blanket policy or contract shall be considered to be a separate covered policy for purposes of section seven thousand seven hundred eight of this article.

(e) "Health insurance" means the kinds of insurance specified under items (i) and (ii) of paragraph three and paragraph thirty-one of

subsection (a) of section one thousand one hundred thirteen of this chapter, and section one thousand one hundred seventeen of this chapter; medical expense indemnity, dental expense indemnity, hospital service, or health service under article forty-three of this chapter; and comprehensive health services under article forty-four of the public health law. "Health insurance" shall not include hospital, medical, surgical, prescription drug, or other health care benefits pursuant to: (1) part C of title XVIII of the social security act (42 U.S.C. § 1395w-21 et seq.) or part D of title XVIII of the social security act (42 U.S.C. § 1395w-101 et seq.), commonly known as Medicare parts C and D, or any regulations promulgated thereunder; (2) titles XIX and XXI of the social security act (42 U.S.C. § 1396 et seq.), commonly known as the Medicaid and child health insurance programs, or any regulations promulgated thereunder; (3) the basic health program under section three hundred sixty-nine-gg of the social services law; (4) chapter 55 of part II of subtitle A of title X (10 U.S.C §§ 1071-1110(b)), commonly known as TRICARE, or any regulations promulgated thereunder; or (5) subpart G of part III of title V (5 U.S.C. §§ 8101-9009), commonly known as the Federal Employees Program, or any regulations promulgated thereunder.

(f) "Impaired insurer" means a member insurer which after the effective date of this article is found to be impaired for the purposes of section one thousand three hundred ten or one thousand three hundred eleven of this chapter and is consequently placed under an order of liquidation, rehabilitation or conservation under article seventy-four of this chapter.

(g) "Insolvent insurer" means a member insurer which after the effective date of this article becomes insolvent for the purposes of section one thousand three hundred nine of this chapter and is placed under a final order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

(h) (1) "Member insurer" means:

(A) any life insurance company licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this article; provided, however, that the term "member insurer" also means any life insurance company formerly licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this

article; and

(B) an insurer licensed or formerly licensed to write accident and health insurance or salary protection insurance in this state, corporation organized pursuant to article forty-three of this chapter, reciprocal insurer organized pursuant to article sixty-one of this chapter, cooperative property/casualty insurance company operating under or subject to article sixty-six of this chapter, nonprofit property/casualty insurance company organized pursuant to article sixty-seven of this chapter, and health maintenance organization certified pursuant to article forty-four of the public health law.

(2) "Member insurer" shall not include a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an employee welfare fund registered under article forty-four of this chapter, a fraternal benefit society organized under article forty-five of this chapter, an institution of higher education with a certificate of authority under section one thousand one hundred twenty-four of this chapter, or a continuing care retirement community with a certificate of authority under article forty-six or forty-six-A of the public health law.

(i) "Premiums" means direct gross insurance premiums and annuity and funding agreement considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders or contract holders on such direct business, subject to such modifications as the superintendent may establish by regulation or order as necessary to facilitate the equitable administration of this article. Premiums do not include premiums and considerations on contracts between insurers and reinsurers. For the purposes of determining the assessment for an insurer under this article, the term "premiums", with respect to a group annuity contract (or portion of any such contract) that does not guarantee annuity benefits to any specific individual identified in the contract and with respect to any funding agreement issued to fund benefits under any employee benefit plan, means the lesser of one million dollars or the premium attributable to that portion of such group contract that does not guarantee benefits to any specific individuals or such agreements that fund benefits under any employee benefit plan.

(j) "Person" means any individual or legal entity, including a

corporation, partnership, association, limited liability company, trust, or voluntary organization.

(k) "Resident" means a person to whom a contractual obligation is owed and who either: (1) resides in this state on the date of entry of a court order of liquidation or rehabilitation with respect to a member insurer that is an impaired or insolvent insurer; or (2) resided in this state at the time a member insurer issued a covered policy to such person.

(l) "Supplemental contract" means an agreement or any other mechanism for the distribution of proceeds under a life insurance policy, health insurance policy, annuity contract, or funding agreement.

(m) "Long-term care insurance" means an insurance policy, rider, or certificate advertised, marketed, offered, or designed to provide coverage, subject to eligibility requirements, for not less than twenty-four consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides at least the benefits set forth in part fifty-two of title eleven of the official compilation of codes, rules and regulations of this state.

§ 7706. Creation of the corporation. (a) There is created a not-for-profit corporation to be known as "The Life and Health Insurance Company Guaranty Corporation of New York". To the extent that the provisions of the not-for-profit corporation law do not conflict with the provisions of this article or the plan of operation of the corporation hereunder the not-for-profit corporation law shall apply to the corporation and the corporation shall be a type C corporation pursuant to the not-for-profit corporation law. If an applicable provision of this article or the plan of operation of the corporation hereunder relates to a matter embraced in a provision of the not-for-profit corporation law but is not in conflict therewith, both provisions shall apply. All member insurers shall be and remain members of the corporation as a condition of their authority to transact insurance in this state. The corporation shall perform its functions under the plan of operation established and approved under section seven thousand seven hundred ten of this article and shall exercise its powers through a board of directors established under section seven thousand

seven hundred seven of this article. For purposes of administration and assessment the corporation shall maintain two accounts:

(1) the health insurance account; and

(2) the life insurance, annuity and funding agreement account.

(b) The corporation shall come under the immediate supervision of the superintendent and shall be subject to the applicable provisions of this article.

§ 7707. Board of directors. (a) The board of directors of the corporation shall consist of not less than five nor more than thirteen member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the superintendent. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the superintendent. To select the initial board of directors, and initially organize the corporation, the superintendent shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the superintendent may appoint the initial members of the board.

(b) In approving selections or in appointing members to the board, the superintendent shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the corporation for expenses incurred by them as members of the board of directors but shall not otherwise be compensated by the corporation for their services.

(d) The superintendent shall be ex-officio chair of the board of directors but shall not be entitled to vote.

§ 7708. Powers and duties of the corporation. In addition to the powers and duties enumerated in other sections of this article, and

subject to limitations and exclusions contained in this and other sections of this article:

(a) (1) If a domestic insurer is an impaired or insolvent insurer, the corporation shall, with the approval of the superintendent:

(A) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies, or arrange for replacement by policies found by the superintendent to be substantially similar to such covered policies;

(B) assure payment of the contractual obligations of the impaired or insolvent insurer; and

(C) provide such moneys, pledges, notes, guarantees or other means as are reasonably necessary to discharge such duties.

(2) The aggregate liability of the corporation under this subsection shall not exceed five hundred thousand dollars for all benefits, including cash values, with respect to any one life or, to the extent benefits are not allocated pursuant to a covered policy to any one life, to any one covered policy; provided, however, that (A) the foregoing limitation shall not apply to any group or blanket accident or health insurance or accident and health insurance policy; and (B) the corporation shall be liable under this subsection in an amount not to exceed one million dollars for all benefits, including cash values, with respect to any group annuity contract (or portion of any such contract) that does not guarantee annuity benefits with respect to any specific individual identified in the contract and with respect to any funding agreement issued to fund benefits under any employee benefit plan.

(b) (1) If a foreign or alien insurer is an impaired or insolvent insurer, the corporation shall, with the approval of the superintendent:

(A) guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies, or arrange for replacement by policies found by the superintendent to be substantially similar to such covered policies;

(B) assure payment of the contractual obligations of the insolvent insurer; and

(C) provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties.

(2) The aggregate liability of the corporation under this subsection shall be the excess over any amount that the superintendent determines

to be the statutory obligation of the guaranty corporation or association of the foreign or alien insurer's state of domicile or state of entry, but in no event shall the corporation's liability, when added to the amount so determined to be available from such other guaranty corporation or association, exceed five hundred thousand dollars for all benefits, including cash values, with respect to any one life, or, to the extent benefits are not allocated pursuant to a covered policy to any one life, to any one covered policy; provided, however, that the (A) foregoing five hundred thousand dollar limitation shall not apply to any group or blanket accident or health insurance or accident and health insurance policy; and (B) liability of all such guaranty corporations or associations may in the aggregate equal, but shall not exceed one million dollars for all benefits, including cash values, with respect to any group annuity contract (or portion of any such contract) that does not guarantee annuity benefits with respect to any specific individual identified in the contract and with respect to any funding agreement issued to fund benefits under any employee benefit plan.

(c) (1) The superintendent may, with the approval of the court, suspend cash surrender rights and policy loan rights under any covered policy for an initial period not to exceed one year and for additional successive periods, each not to exceed one year, all in addition to any contractual provision for deferral of cash or policy loan values, upon a finding that:

(A) The amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the impaired or insolvent insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens to be in the public interest, or

(B) Such suspension is necessary and proper to effectuate at a reasonable cost any guarantee, assumption or reinsurance agreement.

(2) The obligations of the corporation under subsection (a) or (b) of this section, whichever is applicable, with regard to maintaining in force any policy or contract of group life insurance or group health insurance shall be limited to one hundred eighty days from the date the impaired or insolvent insurer was placed under an order of liquidation, rehabilitation or conservation under article seventy-four of this

chapter, and the corporation shall have no obligation with regard to any claim incurred pursuant to any such policy or contract beyond one hundred eighty days from such date, provided (A) that the superintendent shall have discretion to extend the period of one hundred eighty days up to three hundred sixty-six days with regard to any policy or contract when he believes circumstances warrant, and

(B) that the superintendent and the corporation may make such further extensions of such period as they mutually agree are warranted.

(3) If the superintendent or the corporation shall find that at the time a covered annuity contract or funding agreement or a class thereof, other than an annuity contract, funding agreement or class thereof which funds a compromise or settlement contained in a judgment or order entered pursuant to the provisions of section twelve hundred seven of the civil practice law and rules, was issued by the impaired or insolvent insurer the interest rate guaranteed under such contract or agreement or class thereof was clearly excessive, the superintendent may petition the court having jurisdiction in this state, upon appropriate notice to and opportunity for submission of comments from the corporation and owners of contracts and agreements proposed to be affected, to limit the corporation's obligations under this article with respect to payment of interest to an interest rate which the court finds would have been appropriate and reasonable at the time the contract or agreement or class thereof was issued. Nothing in this subsection shall limit the rights of a holder of a contract or agreement so affected as against the impaired or insolvent insurer.

(4) Notwithstanding anything to the contrary in this article, under no circumstances shall the corporation have any obligation on account of an impaired or insolvent insurer either to, or which inures to the benefit of, any person or firm which at the time the policy, contract or agreement was issued or renewed or within ninety days of the date the insurer was determined to be impaired or insolvent, as the case may be, directly or indirectly owned ten percent or more of or controlled such impaired or insolvent insurer; provided, however, that nothing in this subsection shall relieve the corporation of responsibility with regard to contractual obligations of such insurer under certificates of insurance issued to, and inuring solely to the benefit of, the employees of such person or firm.

(d) If the corporation fails to act within a reasonable period of time as provided in subsection (a) or (b) of this section, whichever is applicable, the superintendent shall have the powers and duties of the corporation under this article with respect to any impaired or insolvent insurer.

(e) The corporation may render assistance and advice to the superintendent, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(f) When any person receives benefits under this article, the corporation shall possess all of the rights under the covered policy that such person had immediately before such receipt to the extent of the benefits received because of this article whether the benefits are payments of contractual obligations or continuation of coverage; provided, however, that the corporation shall not have any greater priority against the assets of an impaired or insolvent insurer by reason of this subsection than is expressly given by section seven thousand four hundred thirty-five of this chapter. The corporation may require an assignment to it, or the execution of any other instrument evidencing the corporation's possession, of such rights by any payee, policy or contract owner, beneficiary, insured or annuitant. The receipt of such assignment or other instrument, and its validity and enforceability by the corporation in accordance with its terms under the laws of the insurer's state of domicile or state of entry, shall be a condition precedent to the receipt of any rights or benefits conferred by this article upon such person.

(g) The contractual obligations of the impaired or insolvent insurer for which the corporation becomes or may become liable shall be no greater than the contractual obligations of the impaired or insolvent insurer would have been in the absence of an impairment or insolvency.

(h) The corporation may:

(1) enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section seven thousand seven hundred nine of this article;

(3) borrow money to effect the purposes of this article, provided,

however, that the corporation may agree, as a condition of any borrowing, that the lender will be subrogated to the rights of the corporation against the impaired or insolvent insurer to the extent of the amount borrowed and interest accruing thereon, and provided further that any note or other evidence of indebtedness of the corporation not in default shall be a legal investment for domestic insurers and may be carried as admitted assets;

(4) employ or retain such persons as are necessary or proper to handle the financial transactions of the corporation, and to perform such other functions as become necessary or proper under this article;

(5) with the approval of the superintendent, negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the corporation;

(6) take such legal action as may be necessary to avoid payment of improper claims;

(7) exercise, for the purposes of this article and to the extent approved by the superintendent, the powers of a domestic life, health, or property/casualty insurance company, but in no case may the corporation issue insurance policies or contracts or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer;

(8) fund a resolution facility established pursuant to section seven thousand seven hundred nineteen of this article; and

(9) exercise all powers necessary or convenient for the purposes of this article.

§ 7709. Assessments. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the corporation, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary in accordance with the provisions of paragraph three of subsection (c) of this section. Assessments shall be due on the date set by the board which shall be not less than thirty days nor more than sixty days after prior written notice to the member insurers. Assessments shall accrue interest at the maximum rate allowed by subdivision one of section 5-501 of the general obligations law on and after the due date.

(b) There shall be three classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the corporation under section seven thousand seven hundred eight of this article with regard to an impaired or insolvent domestic insurer.

(3) Class C assessments shall be made to the extent necessary to carry out the powers and duties of the corporation under section seven thousand seven hundred eight of this article with regard to an impaired or insolvent foreign or alien insurer.

(c) (1) The amount of any class A assessment shall be determined by the board and may be made on a non pro rata basis. Such assessment shall be credited against future impairment or insolvency assessments. The maximum such assessment against any member insurer in any calendar year shall be determined, in accordance with the table set forth below, on the basis of its admitted assets as shown on its annual statement required by this chapter for the year next preceding the date of such assessment:

Companies with Admitted Assets of	Maximum Assessment
Up to $50,000,000	$200
$50,000,000 to $1,000,000,000	$1000
$1,000,000,000 or more	$2000

(2) The amount of any class B or class C assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies or contracts covered by each account for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums bears to the premiums received by such insurer for such calendar year on all covered policies. The amount of any class B or class C assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the superintendent. The methodology shall provide for fifty percent of the assessment to be allocated to health insurance company member insurers and fifty percent to be allocated to life insurance company member insurers; provided,

however, that a property/casualty insurer that writes health insurance shall be considered a health insurance company member for this purpose. Class B and class C assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the three calendar years preceding the assessment bears to such premiums received on business in this state for such calendar years by all assessed member insurers. Class B and Class C assessments against member insurers for the health insurance account shall be further reduced for not-for-profit member insurers pursuant to a methodology included in the plan of operation and approved by the superintendent. Such methodology shall reduce the assessments imposed on not-for-profit member insurers in an amount that, when accounting for appropriate factors, including the value of the tax credits and a factor for the time value of money, results in a percentage of net assessments to premiums that is equivalent for not-for-profit member insurers and for-profit member insurers.

(3) Assessments for funds to meet the requirements of the corporation with respect to an impaired or insolvent insurer shall be made within a reasonable time after deemed necessary by the superintendent to implement the purposes of this article. Classification of assessment under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The corporation may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e) (1) With respect to a member insurer that is a domestic insurer and is subject to an order of rehabilitation under article seventy-four of this chapter as of March first, two thousand twelve, the total assessment against all member insurers for impairments and insolvencies,

less the amount of refunds (not including interest) to member insurers pursuant to subsection (f) of this section, shall be five hundred fifty-eight million dollars; provided, however, that such five hundred fifty-eight million dollar total shall be subject to reduction in an amount, if any, determined by the superintendent, on a date not earlier than twelve months after the entry of an order of liquidation with respect to such domestic insurer, to be not needed for the corporation to be able to pay its obligations and reasonable expenses in connection with the liquidation of such domestic insurer, but in no event shall such reduction exceed fifty-eight million dollars.

(2) The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the corporation in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the corporation, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, by retirement of certificates of contribution in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds necessary to carry out during the coming year the obligations of the corporation with regard to that account, including assets accruing from net realized capital gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the corporation and for future losses if refunds are impractical.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article with respect to insurers which have become impaired or insolvent.

(h) The corporation shall issue to each insurer paying an assessment under this article, other than a class A assessment, a certificate of contribution, in a form prescribed by the superintendent, for the amount

of the assessment so paid. All outstanding certificates shall be of equal dignity and priority irrespective of amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the superintendent may approve.

§ 7710. Plan of operation. (a) (1) The corporation shall submit to the superintendent a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the corporation. The plan of operation and any amendments thereto shall become effective upon approval in writing by the superintendent.

(2) If the corporation fails to submit a suitable plan of operation within one hundred eighty days following the effective date of this article or if at any time thereafter the corporation fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the corporation and approved by the superintendent.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall constitute the bylaws of the corporation and shall, in addition to requirements enumerated elsewhere in this article:

(1) Establish procedures for handling the assets of the corporation.

(2) Establish the amount and method of reimbursing members of the board of directors under section seven thousand seven hundred seven of this article.

(3) Establish regular places and times for meetings of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the corporation, its agents and the board of directors.

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the superintendent.

(6) Establish any additional procedures for assessments under section seven thousand seven hundred nine of this article.

(7) Contain such additional provisions as the superintendent or corporation may deem necessary or proper for the execution of the powers and duties of the corporation.

(d) The plan of operation may provide that any or all powers and duties of the corporation, except those under sections seven thousand seven hundred eight and seven thousand seven hundred nine of this article, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of the corporation, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the corporation and shall be paid for its performance of any function of the corporation. A delegation under this subsection shall take effect only with the approval of both the board of directors and the superintendent, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

§ 7711. Powers of the superintendent and the board of directors. In addition to the duties and powers enumerated elsewhere in this chapter:

(a) The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the superintendent may levy a penalty to be paid to the people of this state, after notice and hearing, on any member insurer which fails to pay an assessment when due. Such penalty shall not exceed five percent of the unpaid assessment per month, but no penalty shall be less than one hundred dollars per month.

(b) Any action of the board of directors or the corporation may be appealed to the superintendent by any member insurer if such appeal is taken within thirty days of the action being appealed. Any final action or order of the superintendent shall be subject to judicial review in a court of competent jurisdiction.

(c) Upon the request of the superintendent, the board of directors shall render advice and make recommendations to the superintendent concerning any matter affecting his duties and responsibilities

regarding the financial condition of member companies and companies seeking admission to transact insurance business in this state.

(d) The board of directors shall establish a panel of advisors, consisting of representatives of at least thirteen member insurers not serving on the board of directors, knowledgeable as to the life and health insurance business to provide it with information tending to indicate that any member insurer or company seeking to do any insurance business in this state is or may be in danger of becoming an impaired or insolvent insurer; persons serving on the panel of advisors shall be deemed agents of the corporation for purposes of section seven thousand seven hundred sixteen of this article. The board of directors may, upon majority vote, make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents. Nothing in this article shall be deemed to limit the ability of a member of the panel of advisors or any other person from reporting information germane to the solvency of a member insurer or company seeking to do an insurance business in this state to the superintendent or other lawful authority or the corporation.

(e) It shall be the duty of the board of directors, upon majority vote, to notify the superintendent of any information indicating any member insurer may be an impaired or insolvent insurer.

(f) The board of directors may, upon majority vote, make recommendations to the superintendent for the detection and prevention of insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the corporation was obligated to pay covered claims, prepare a report to the superintendent containing such information as it may have in its possession bearing on the history and causes of such insolvency. The corporation shall cooperate with the boards of directors of guaranty associations or corporations in other states in preparing a report on the history and causes for insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations or corporations.

§ 7712. Credits for assessments paid. (a) The superintendent shall annually issue a certificate of tax credit for net class A assessments paid, and a separate certificate of tax credit for total net class B and class C assessments paid, as such assessments are described in section seven thousand seven hundred nine of this article, to an insurance company that is required to file a tax return pursuant to article thirty-three of the tax law. The superintendent shall issue such certificates by March thirty-first of the year following the year in which the class A, B, and C assessments are paid or to which they are allocated pursuant to the provisions of subsection (c) of this section. For the purposes of this section, an insurance company's "net class A assessments paid" shall mean its gross class A assessments paid pursuant to the provisions of article seventy-five or section seven thousand seven hundred nine of this article, less any refunds, recoveries, or reimbursements, and an insurance company's "total net class B and class C assessments paid" shall mean its gross class B and class C assessments paid pursuant to the provisions of article seventy-five or section seven thousand seven hundred nine of this article, less any refunds, recoveries, or reimbursements.

(b) The certificates of tax credit shall set forth the amount of tax credit an insurance company may claim as follows:

(1) for net class A assessments, the eligible credit amount shall be equal to the product of eighty per centum and the company's net class A assessments paid; and

(2) for total net class B and class C assessments, the eligible credit amount shall be equal to the product of eighty per centum and the company's total net class B and class C assessments paid, subject to subsection (c) of this section.

(c)(1) The aggregate amount of tax credits pursuant to this section for total net class B and class C assessments in each calendar year shall not exceed one hundred fifty million dollars. The aggregate tax credit amount shall be allocated annually by the superintendent on a pro rata basis to each company required to file a tax return pursuant to article thirty-three of the tax law.

(2) The superintendent shall allocate any tax credit amount that exceeds the annual credit cap of one hundred fifty million dollars to

the following calendar year and include such amount within the calculation of the eligible credit amount subject to the aggregate credit amount for the succeeding calendar year by the superintendent.

(3) For companies issued a certificate of tax credit for total net class B and class C assessments, such annual certificate shall set forth an amount equal to thirty-three and one-third per centum of the amount calculated under subsection (b) of this section and allocated pursuant to paragraph one of this subsection. The amount on the certificate of tax credit shall be eligible to be claimed in the taxable year that begins in the calendar year that such certificate is issued. Thirty-three and one-third per centum of such amount shall be eligible to be claimed in each of the two taxable years following such taxable year.

(d)(1) The superintendent shall, in consultation with the commissioner of taxation and finance, develop a certificate of tax credit for net class A assessments, and a certificate of tax credit for total net class B and class C assessments. Each certificate shall contain such information as required by the commissioner of taxation and finance, including a certificate date.

(2) The superintendent shall solely determine the tax credit eligibility of any insurance company and shall revoke any certificate of tax credit issued to an insurance company that no longer qualifies for a tax credit. The superintendent shall modify the amount of the credit shown on any such certificate if the superintendent determines that the amount certified under subsection (b) of this section was not computed properly pursuant to this section.

(3) To be issued a certificate of tax credit by the superintendent, each insurance company shall:

(A) agree to allow the department of taxation and finance to share the insurance company's tax information relevant to the administration of this section with the superintendent. However, any information shared with the superintendent as a result of this section shall not be available for public disclosure or inspection under article six of the public officers law;

(B) allow the superintendent and the corporation access to any and all books and records the superintendent or corporation may require to monitor compliance with this section; and

(C) agree to provide any additional information required by the superintendent relevant to this section.

§ 7713. Miscellaneous provisions. (a) Nothing in this article shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) The corporation shall maintain records of all negotiations and meetings in which the corporation or its representatives are involved to discuss the activities of the corporation in carrying out its powers and duties under section seven thousand seven hundred eight of this article, except to the extent otherwise provided by or pursuant to the plan of operation. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the corporation to render a report of its activities under section seven thousand seven hundred fourteen of this article.

(c) (1) During an article seventy-four rehabilitation proceeding, assets of the impaired or insolvent insurer which are determined by the superintendent to be currently available may be used to continue all covered policies, and pay all contractual obligations, of the impaired or insolvent insurer that would otherwise be covered by the corporation under section seven thousand seven hundred eight of this article. The corporation shall, subsequent to the termination of the article seventy-four rehabilitation proceeding and within a reasonable time after the commencement of a liquidation proceeding under article seventy-four of this chapter reimburse the estate of the impaired or insolvent insurer for such portion of the amount of assets so used to the extent necessary to pay class one, two and three claims pursuant to paragraph one, two or three of subsection (a) of section seven thousand four hundred thirty-five of this chapter. The corporation shall have a claim against the estate of the impaired or insolvent insurer equal to the full amount of such reimbursement, consistent with the provisions of

paragraph four of subsection (a) of section seven thousand four hundred thirty-five of this chapter.

(2) During an article seventy-four rehabilitation proceeding, assets of the impaired or insolvent insurer which are determined by the superintendent to be currently available may be used to continue covered policies, and pay contractual obligations, of the impaired or insolvent insurer, other than the covered policies and contractual obligations that are covered by the corporation under section seven thousand seven hundred eight of this article, if a corporation, association or other organization which performs or will perform functions similar to those of the corporation enters into an agreement satisfactory to the superintendent prior to such use of such assets to repay the amount of such assets subsequent to the termination of the article seventy-four rehabilitation proceeding and within a reasonable time after the commencement of a liquidation proceeding under article seventy-four of this chapter.

(d) In addition to the duties and powers enumerated elsewhere in this chapter, and subject to the limitations and exclusions contained in this and other sections of this chapter, upon the commencement of a proceeding under article seventy-four of this chapter with respect to any impaired or insolvent domestic insurer, the superintendent may request and receive from the corporation, and the corporation shall lend to the superintendent upon such request, an amount not to exceed five hundred thousand dollars as determined by the superintendent to be necessary on an emergency basis for use by the superintendent, as liquidator or rehabilitator, in the administration of the affairs of such impaired or insolvent insurer. To the extent it deems necessary or appropriate to carry out its duties under this section, the corporation may borrow such amount in accordance with subsection (h) of section seven thousand seven hundred eight of this article and may assess member insurers for the purpose of repaying such borrowing. Such assessments against each member insurer shall be in the proportion that the premiums received by such insurer on business in this state in all accounts for the calendar year preceding the assessment bear to such premiums received on business in this state in all accounts for such calendar year by all assessable member insurers. The corporation shall have a claim against the estate of such impaired or insolvent insurer equal to

the amount loaned to the superintendent in accordance with this subsection, together with interest thereon at the maximum rate allowed by subdivision one of section 5-501 of the general obligations law, and such claim shall be treated as a class one claim under section seven thousand four hundred thirty-five of this chapter.

(e) The corporation shall have a claim against the impaired or insolvent insurer for all amounts expended by the corporation for the purposes of carrying out its obligations under this article.

(f) (1) Prior to the termination of any proceeding under article seventy-four of this chapter, the court may take into consideration the contributions of the respective parties, including the corporation, the shareholders and policyholders of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to shareholders, if any, of an impaired or insolvent insurer shall be made, and no rehabilitation proceeding shall be terminated (except by a final order of liquidation), until and unless the total amount of valid claims of the corporation for all funds expended in carrying out its powers and duties under section seven thousand seven hundred eight of this article with respect to such insurer, together with interest thereon, have been fully recovered by the corporation or an arrangement satisfactory to the corporation has been made for their recovery. Such interest shall be at a rate which, in the opinion of the court, fairly compensates the corporation for the use of such funds, but in no event shall such rate be in excess of the maximum rate allowed by subdivision one of section 5-501 of the general obligations law at the time such funds were expended.

(g) (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any parent corporation or holding company or person who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation, conservation or rehabilitation, as the

case may be, subject to the limitations of paragraphs two, three and four of this subsection.

(2) No such distribution shall be recoverable if the insurer shows that when paid, such distribution was reasonable and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations. Notice to the superintendent pursuant to subsection (a) of section four thousand two hundred seven of this chapter and the lack of a prior objection by the superintendent to such distributions shall not constitute evidence to support the showing of reasonableness which would prevent the recovery of such distribution.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer at the time such distributions were paid shall be liable up to the amount of distributions such persons received. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distribution, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse the corporation for such payments and for all other claims the corporation may have pursuant to subsection (c) of this section.

(5) To the extent that any person liable under paragraph three of this subsection is insolvent or otherwise fails to pay claims due from it pursuant to such paragraph, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

§ 7714. Examination of the corporation; annual report. The corporation shall be subject to examination and regulation by the superintendent.

The corporation shall submit to the superintendent, not later than May first of each year, a financial report for the preceding calendar year in a form approved by the superintendent and a report of its activities during the preceding calendar year.

§ 7715. Tax exemptions. The corporation shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

§ 7716. Immunity and indemnification. No director, officer, agent or other representative of the corporation shall be individually liable to any person, firm or corporation, including the corporation, for any act or omission to act, or for any liability incurred or assumed, on behalf of the corporation or by virtue hereof. Any such liability so incurred or assumed shall be indemnified by the corporation. The expense of such indemnification shall be assessed against member insurers in a manner consistent with the method of assessment prescribed in paragraph two of subsection (c) of section seven thousand seven hundred nine of this article; no member company shall be subject to any liability except for assessment as herein provided.

§ 7717. Stay of proceedings; reopening default judgments. All proceedings in which the impaired or insolvent insurer is a party in any court in this state shall be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the corporation on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the corporation may apply to have such judgment set aside by the same court that made such judgment and, if such application is granted in the court's discretion, the corporation shall be permitted to defend against such suit on the merits. The provisions of this section shall be in addition to any other provision provided by law.

§ 7718. Prohibited advertisement of the corporation in sale of insurance. No person, including an insurer, agent or affiliate of an insurer and no broker shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the corporation for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by this article, provided, however, that this section shall not apply to the corporation or any other entity which does not sell or solicit insurance, or to prohibit the furnishing of written information in a form prepared by the corporation and approved by the superintendent by a member insurer directly to a policyholder in response to a written request therefor.

§ 7719. Resolution facility. (a) The corporation may incorporate one or more not-for-profit corporations, known as a resolution facility, in connection with the liquidation of an insolvent domestic life insurance company, health insurance company, or property/casualty insurance company under article seventy-four of this chapter for the purpose of administering and disposing of the business of the insolvent insurance company.

(b) To the extent that the provisions of the not-for-profit corporation law do not conflict with the provisions of this section or the plan of operation of the resolution facility hereunder, the not-for-profit corporation law shall apply to the resolution facility and the resolution facility shall be a non-charitable corporation pursuant to the not-for-profit corporation law. If an applicable provision of this section or the plan of operation of the resolution facility hereunder relates to a matter embraced in a provision of the not-for-profit corporation law but is not in conflict therewith, then both provisions shall apply. The corporation shall be a member of the resolution facility, and other persons, including the life insurance guaranty corporation continued under article seventy-five of this

chapter and guaranty entities of other states, may become members of the resolution facility in accordance with the resolution facility's certificate of incorporation and plan of operation.

(c) In addition to its certificate of incorporation, a resolution facility shall submit to the superintendent a plan of operation, and amendments thereto, necessary or suitable to assure the fair, reasonable, and equitable administration of the resolution facility. The plan of operation, and any amendments thereto, shall become effective upon approval in writing by the superintendent. The plan of operation shall constitute the bylaws of the resolution facility.

(d) A resolution facility may:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies, or arrange for replacement by policies found by the superintendent to be substantially similar to the covered policies;

(2) exercise, for the purposes of this article and to the extent approved by the superintendent, the powers of a domestic life insurance company, health insurance company, or property/casualty insurance company but in no case may the resolution facility issue insurance policies, annuity contracts, funding agreements, or supplemental contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer;

(3) assure payment of the contractual obligations of the insolvent insurer; and

(4) provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge its duties.

(e) A resolution facility shall not be subject to any provisions of this chapter or the financial services law except:

(1) this section; and

(2) sections seven thousand seven hundred fourteen, seven thousand seven hundred fifteen, and seven thousand seven hundred sixteen of this article, which shall apply in the same manner as they apply to the corporation.

(f) Notwithstanding subsection (e) of this section, the superintendent may address to the resolution facility any inquiry in relation to its transactions or condition or any matter connected therewith pursuant to section three hundred eight of this chapter.

(g) (1) If the superintendent determines that the resolution facility is not administering and disposing of the business of an insolvent domestic life insurance company, health insurance company, or property/casualty insurance company consistent with the resolution facility's certificate of incorporation, plan of operation, or this section, then the superintendent shall provide notice to the resolution facility and the resolution facility shall have thirty days to respond to the superintendent and cure the defect.

(2) If, after thirty days, the superintendent continues to believe that the resolution facility is not administering and disposing of the business of an insolvent domestic life insurance company, health insurance company, or property/casualty insurance company consistent with the resolution facility's certificate of incorporation, plan of operation, or this section, then the superintendent may apply to the court for an order directing the resolution facility to correct the defect or take other appropriate actions.

§ 7720. Penalties. (a) If any member insurer fails to make any payment required by this article, or if the superintendent has cause to believe that any other statement filed is false or inaccurate in any particular, or that any payment made is incorrect, the superintendent may examine all the books and records of the member insurer to ascertain the facts and determine the correct amount to be paid. Based on such finding, the corporation may proceed in any court of competent jurisdiction to recover for the benefit of the fund any sums shown to be due upon such examination and determination.

(b) Any member insurer that fails to make any such required statement, or to make any payment to the fund when due, shall forfeit to the corporation for deposit in the fund a penalty of five percent of the amount determined to be due plus one percent of such amount for each month of delay, or fraction thereof, after the expiration of the first month of such delay. If satisfied that the delay was excusable, the corporation may remit all or any part of the penalty.

(c) The superintendent, in the superintendent's discretion, may revoke the certificate of authority to do business in this state of any foreign member insurer that fails to comply with this article or to pay any

penalty imposed hereunder.

ARTICLE 78

LIFE SETTLEMENTS

Section 7801. Short title.
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§ 7801. Short title. This article shall be known and may be cited as the "life settlements act".

§ 7802. Definitions. In this article:

(a) "Accredited investors" shall be as defined in regulation D, rule 501 of the Federal Securities Act of 1933, as amended.

(b) "Advertisement" means any written, electronic or printed communication or any communication by means of recorded telephone

messages or transmitted on radio, television, the Internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase, sell, assign, devise, bequest or transfer the death benefit or ownership of, a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

(c)(1) "Business of life settlements" means an activity involving, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking life settlement contracts.

(2) For purposes of this article, "business of life settlements" shall also include:

(A) such acts or transactions effectuated in this state by mail or otherwise from outside this state; and

(B) doing or proposing to do any business in substance equivalent to the business of life settlements in a manner designed to evade the provisions of this chapter.

(d) "Compensation" means anything of value, including money, credits, loans, interest on premium, forgiveness of principal or interest, vacations, prizes, gifts or the payment of employee salaries or expenses, whether paid as commission or otherwise.

(e) "Financing entity" means an accredited investor:

(1) whose principal activity in connection with the transaction is providing funds to effect the life settlement contract or to purchase one or more policies; and

(2) who has an agreement in writing with a life settlement provider to finance the acquisition of a life settlement contract.

(f) "Financing transaction" means a transaction in which a licensed life settlement provider obtains financing from a financing entity, including any secured or unsecured financing, any securitization transaction, or any securities offering which is registered or exempt from registration under federal and state securities laws.

(g) "Insured" means a person covered under a policy that is or may be the subject of a life settlement contract.

(h) "Insurer" means a life insurance company or a fraternal benefit

society.

(i) "Life expectancy" means the arithmetic mean of the number of months the insured can be expected to live taking into consideration medical records and appropriate experiential data.

(j) "Life settlement broker" means a person who, for compensation, solicits, negotiates or offers to negotiate a life settlement contract; except that such term shall not include a licensed life settlement provider, or representative thereof, licensed attorney at law, certified public accountant, or financial planner that is accredited by a nationally recognized accreditation agency acceptable to the superintendent, who is retained in his or her professional capacity, does not advertise as being in the business of life settlements and is compensated without regard to whether a life settlement contract is effectuated.

(k)(1) "Life settlement contract" means an agreement establishing the terms under which compensation is provided to an owner, which compensation is less than the expected death benefit of the policy, in return for the assignment, transfer, sale, release, devise or bequest of any portion of:

(A) the death benefit;

(B) the ownership of the policy; or

(C) any beneficial interest in the policy, or in a trust or any other entity that owns the policy, where a primary purpose of the transaction is to acquire the policy.

(2) "Life settlement contract" shall include an agreement, entered into after the effective date of this article, described in paragraph one of this subsection regardless of the date the compensation is provided and regardless of the date the assignment, transfer, sale, devise or bequest is effectuated.

(3) "Life settlement contract" shall not include:

(A) an assignment of a policy as collateral for a loan by any depository institution insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration;

(B) an assignment of a policy as collateral for a loan made by a licensed financial institution under which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the

transfer of the policy by the lender, provided that the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this article;

(C) an assignment of a policy as collateral for a loan made by a lender that does not violate article twelve-B of the banking law;

(D) the making of a policy loan, or the paying of surrender benefits or other benefits, by the issuer of a policy with respect to that policy;

(E) an exchange of life insurance policies in a transaction described by section 1035 of the Internal Revenue Code of 1986, as amended;

(F) an agreement made by an individual to take an assignment, purchase, or otherwise receive the death benefit or ownership of any portion of a policy or policies on the life of a single insured or lives of joint insureds; provided that, in a calendar year, the individual enters into no other agreement to take an assignment, purchase, or otherwise receive the death benefit or ownership of any portion of a policy or policies on the life of any other insured or lives of any other joint insureds;

(G) an agreement to assign, transfer or pledge a settled policy, or any interest therein, to a licensed life settlement provider, an accredited investor or qualified institutional buyer, financing entity, special purpose entity, or related provider trust;

(H) an agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(I) any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(J) a bona fide business succession planning arrangement between:

(i) one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(ii) one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(iii) one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(K) legitimate corporate or pension benefit plans, as determined by the superintendent; or

(L) any other agreement that the superintendent determines is substantially similar to any of the foregoing.

(l) "Life settlement intermediary" means a person who maintains an electronic or other facility or system, for the disclosure, through a forum of offers and counteroffers, to sell or purchase a policy pursuant to a life settlement contract; and delivers to:

(1) a life settlement provider an offer from a life settlement broker or owner to sell a policy; or

(2) an owner or life settlement broker an offer from a life settlement provider to purchase a policy.

(m) "Life settlement provider" means a person who enters, or offers to enter, into a life settlement contract with the owner.

(n) "Owner" means the owner of a policy who enters or seeks to enter into a life settlement contract.

(o) "Person" means any natural person or legal entity, including a partnership, limited liability company, association, trust or corporation.

(p) "Policy" means an individual or group life insurance policy or certificate.

(q) "Premium finance loan" means a loan made for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(r) "Qualified institutional buyer" shall be as defined in rule 144A of the Federal Securities Act of 1933, as amended.

(s) "Related provider trust" means a trust established by a licensed life settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in settled policies in connection with a financing transaction; provided that the trust has a written agreement with the licensed life settlement provider under which:

(1) the licensed life settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements; and

(2) the trust agrees to make all records and files relating to life settlement transactions available to the superintendent as if those records and files were maintained directly by the licensed life settlement provider.

(t) "Settled policy" means a policy that at any time has been acquired by a life settlement provider pursuant to a life settlement contract.

(u) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide, either directly or indirectly, access to institutional capital markets for a financing entity or licensed life settlement provider.

§ 7803. License requirements for life settlement providers. (a) No person shall engage in the business of life settlements as a life settlement provider in this state without having authority to do so by virtue of a life settlement provider license issued and in force pursuant to this article.

(b)(1) The superintendent may issue a life settlement provider license to any person who is deemed by the superintendent to be trustworthy and competent to act as a life settlement provider and who is otherwise qualified as required in this article and who has complied with the prerequisites prescribed in this article.

(2) Every license issued pursuant to this section shall expire on June thirtieth of odd-numbered years.

(c)(1) Application for a life settlement provider license shall be made to the superintendent by the applicant on a form prescribed by the superintendent, and the application shall be accompanied by a fee in an amount to be established by the superintendent.

(2) The applicant for a life settlement provider license shall:

(A) fully disclose the identity of all stockholders (except stockholders owning fewer than ten percent of the voting shares of a life settlement provider whose shares are publicly traded), partners, officers, members, directors and persons with a controlling interest. For purposes of this section, "controlling interest" means a person who directly or indirectly, has the power to cause to be directed the management, control or activities of such licensee;

(B) provide a detailed plan of operation;

(C) provide, if a legal entity, a certificate of good standing from the state of its domicile;

(D) provide an anti-fraud plan that meets the requirements of article four of this chapter;

(E) demonstrate financial accountability as evidenced by a bond or other method for financial accountability as determined by the superintendent pursuant to regulation; and

(F) provide any other information required by the superintendent.

(d) The superintendent may require an applicant for such license to submit a set of fingerprints. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check. All such criminal history records sent to the superintendent pursuant to this paragraph shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall not be published or in any way disclosed to persons other than the superintendent, unless otherwise authorized by law. The superintendent shall provide such applicant with a copy of his or her criminal history record, if any, together with a copy of article twenty-three-A of the correction law, and inform such applicant of his or her right to seek correction of any incorrect information contained in such record pursuant to regulations and procedures established by the division of criminal justice services. All determinations to grant or deny clearance for licensure pursuant to this section shall be in accordance with subdivision sixteen of section two hundred ninety-six of the executive law and article twenty-three-A of the correction law. When the superintendent denies an application, written notice of such determination shall be given to the prospective applicant who shall be afforded notice and the right to be heard and offer proof in opposition to such determination.

(e)(1) As part of the application, the applicant shall submit a power of attorney designating the superintendent as agent for the purpose of receiving service of legal documents or process.

(2) The power of attorney shall include the name and address of the officer, agent, or other person to whom such legal documents or process shall be forwarded by the superintendent or his or her deputy on behalf

of such life settlement provider.

(3) Service of legal documents or process upon a life settlement provider pursuant to this subsection shall be made by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose with two copies thereof and the payment of a fee of forty dollars. The superintendent shall forward a copy of such legal documents or process by registered or certified mail to the life settlement provider at the address given in its written certificate of registration, and shall keep a record of all legal documents or process so served. Service of legal documents or process so made shall be deemed made within the territorial jurisdiction of any court in this state.

(f) The superintendent, in the exercise of the superintendent's discretion, may refuse to issue a life settlement provider license in the name of any person if not satisfied that any officer, employee, stockholder, partner, director, member, agent, or responsible person thereof, who may materially influence the applicant's conduct, meets the standards of this article.

(g) Every license issued pursuant to this section may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this section.

(h)(1) Before the renewal of any life settlement provider license shall be issued, an application for renewal of the license shall be made to the superintendent by the applicant on a form prescribed by the superintendent and containing such information as the superintendent may prescribe. The application shall be accompanied by a fee in an amount to be established by the superintendent.

(2) If an application for a renewal license shall have been filed with the superintendent before the expiration of the license, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and shall have given notice of such refusal to the applicant. Before refusing to renew any such license, the superintendent shall notify the applicant of the superintendent's intention to do so and shall give such applicant a hearing.

(3) An application for the renewal of a license shall be filed with the superintendent not less than sixty days prior to the date the license expires or the applicant may be subject to a further fee for late filing, as prescribed by the superintendent.

(i) A life settlement provider licensee shall provide to the superintendent new or revised information about stockholders (except stockholders owning fewer than ten percent of the voting shares of a life settlement provider whose shares are publicly traded), partners, officers, members, directors, designated employees or persons with a controlling interest within thirty days of the change.

(j) Every individual applicant for a license under this section shall be eighteen years of age or older at the time of the issuance of such license.

§ 7804. Registration requirements for life settlement intermediaries. (a) No person shall act as a life settlement intermediary in this state without having authority to do so by virtue of a registration issued and in force pursuant to this article.

(b)(1) The superintendent may issue a life settlement intermediary registration to any person who:

(A) is deemed by the superintendent to be trustworthy and competent to act as a life settlement intermediary;

(B) is otherwise qualified as required in this article; and

(C) has complied with the prerequisites prescribed in this article.

(2) Every registration issued pursuant to this section shall expire on June thirtieth of odd-numbered years.

(c)(1) Application for a life settlement intermediary registration shall be made to the superintendent by the applicant on a form prescribed by the superintendent, and the application shall be accompanied by a fee in an amount established by the superintendent.

(2) The applicant for a life settlement intermediary registration shall provide:

(A) the state in which the life settlement intermediary is domiciled or resident;

(B) the principal place of business of the life settlement intermediary;

(C) all other states in which the life settlement intermediary is doing or intends to do business;

(D) a detailed plan of operation; and

(E) the identities of the life settlement intermediary executive officer or officers directly responsible for such business, and all stockholders (except stockholders owning fewer than ten percent of the voting shares of a life settlement intermediary whose shares are publicly traded), partners, officers, members, directors and persons with a controlling interest. For purposes of this section, "controlling interest" means a person who directly or indirectly, has the power to cause to be directed the management, control or activities of such registrant.

(d) Each life settlement intermediary that is required to register pursuant to this section shall also furnish such information as may be required by the superintendent to:

(1) verify that the person or persons qualify as a life settlement intermediary; and

(2) determine compliance with any applicable state law.

(e)(1) As part of the application, the applicant shall submit a power of attorney designating the superintendent as agent for the purpose of receiving service of legal documents or process.

(2) The power of attorney shall include the name and address of the officer, agent, or other person to whom such legal documents or process shall be forwarded by the superintendent or his or her deputy on behalf of such life settlement provider.

(3) Service of legal documents or process upon a life settlement provider pursuant to this subsection shall be made by serving the superintendent, any deputy superintendent or any salaried employee of the department whom the superintendent designates for such purpose with two copies thereof and the payment of a fee of forty dollars. The superintendent shall forward a copy of such legal documents or process by registered or certified mail to the life settlement provider at the address given in its written certificate of registration, and shall keep a record of all legal documents or process so served. Service of legal documents or process so made shall be deemed made within the territorial jurisdiction of any court in this state.

(f) The superintendent may require an applicant for such registration

to submit a set of fingerprints. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check. All such criminal history records sent to the superintendent pursuant to this paragraph shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall not be published or in any way disclosed to persons other than the superintendent, unless otherwise authorized by law. The superintendent shall provide such applicant with a copy of his or her criminal history record, if any, together with a copy of article twenty-three-A of the correction law, and inform such applicant of his or her right to seek correction of any incorrect information contained in such record pursuant to regulations and procedures established by the division of criminal justice services. All determinations to grant or deny clearance for registration pursuant to this section shall be in accordance with subdivision sixteen of section two hundred ninety-six of the executive law and article twenty-three-A of the correction law. When the superintendent denies an application, written notice of such determination shall be given to the prospective applicant who shall be afforded notice and the right to be heard and offer proof in opposition to such determination.

(g) The superintendent, in the exercise of the superintendent's discretion, may refuse to issue a life settlement intermediary registration in the name of any person if not satisfied that any officer, employee, stockholder, partner, director, member, agent, or responsible person thereof who may materially influence the applicant's conduct meets the standards of this article.

(h) Every registration issued pursuant to this section may be renewed for the ensuing period of twenty-four months upon the filing of an application in conformity with this section.

(i)(1) Before the renewal of any life settlement intermediary registration shall be issued, an application for renewal of the registration shall be made to the superintendent by the applicant on a form prescribed by the superintendent and containing such information as the superintendent may prescribe, and the application shall be accompanied by a fee in an amount to be established by the

superintendent.

(2) If an application for renewal registration shall have been filed with the superintendent before the expiration of the registration, the registration sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal registration applied for or until five days after the superintendent shall have refused to issue such renewal registration and shall have given notice of such refusal to the applicant. Before refusing to renew any such registration, the superintendent shall notify the applicant of the superintendent's intention to do so and shall give such applicant a hearing.

(3) An application for the renewal of a registration shall be filed with the superintendent not less than sixty days prior to the date the registration expires or the applicant may be subject to a further fee for late filing, as prescribed by the superintendent.

(j) A life settlement intermediary shall, as to any subsequent changes in any of the items set forth in paragraph two of subsection (c) and paragraph one of subsection (d) of this section, notify the superintendent in writing within thirty days of any such change.

(k) Every individual applicant for registration under this section shall be eighteen years of age or older at the time of the issuance of such registration.

§ 7805. License and registration revocation. (a) The superintendent may suspend, revoke or refuse to renew the license of any life settlement provider or the registration of any life settlement intermediary, if, after notice and hearing, the superintendent determines that the life settlement provider or life settlement intermediary, or any officer, partner, member, or key management personnel thereof, has:

(1) violated any insurance laws or any regulation promulgated thereunder, any subpoena or order of the superintendent or of another state's insurance commissioner, or any other law in the course of the licensee's dealings in such capacity;

(2) provided materially incorrect, materially misleading, materially incomplete or materially untrue information in the license or

registration application;

(3) obtained or attempted to obtain a license or registration through misrepresentation or fraud;

(4)(A) used fraudulent, coercive or dishonest practices;

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

(D) demonstrated financial irresponsibility in the conduct of business in this state or elsewhere;

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

(6) intentionally misrepresented the terms of any insurance contract or life settlement contract or any application therefor;

(7) been convicted of a felony, or has been guilty of fraudulent or dishonest practices or other misconduct or malfeasance;

(8) admitted or been found to have committed any insurance unfair trade practice or fraud;

(9) had a life settlement provider license or life settlement intermediary registration, or an equivalent denied, suspended or revoked in any other state, province, district or territory;

(10) forged another person's name to an application for insurance or life settlement contract or to any document related to an insurance or life settlement transaction;

(11) knowingly conducted the business of life settlements with a person who is not licensed or registered unless such person is not required to be licensed or registered;

(12) demonstrated a pattern of unreasonable payments to owners or insureds;

(13) failed to honor contractual obligations set out in a life settlement contract;

(14) sold, assigned, pledged or otherwise transferred the ownership of a settled policy to a person other than as provided in this article; or

(15) failed to protect the privacy of the insured or owner or other person for whom the licensee or registrant was required to provide protection pursuant to this article.

(b)(1) Before the superintendent suspends, revokes or refuses to renew the license of a life settlement provider or the registration of a life

settlement intermediary, the superintendent shall give notice to the licensee or registrant and shall hold, or cause to be held, a hearing not less than ten days after the giving of such notice, except that where, in the judgment of the superintendent, the public health, safety or welfare so requires, a license or registration may be suspended for up to ten days prior to a hearing.

(2) In lieu of revoking or suspending the license or registration for any of the causes enumerated in subsection (a) of this section, the superintendent may impose a civil penalty not to exceed ten thousand dollars for each violation.

(3) Upon the failure of such licensee or registrant to pay such penalty ordered pursuant to paragraph two of this subsection within twenty days after the mailing of such order, postage prepaid, registered, and addressed to the last known place of business of such licensee or registrant, unless such order is stayed by a court of competent jurisdiction, the superintendent may revoke the license of such licensee or the registration of such registrant, or may suspend the same for such period as the superintendent determines.

§ 7806. Life settlement contract forms. (a) No licensed life settlement provider shall enter into a life settlement contract subject to this chapter unless the life settlement contract form, application form, and any other form as may be prescribed by regulation, has been filed with and approved by the superintendent. The superintendent may disapprove any such form if the superintendent finds the form or any provisions contained therein to be unreasonable, contrary to law or the interests of the people of this state, or otherwise misleading or unfair.

(b) Whenever, by the provisions of this chapter, the superintendent has approved any life settlement contract form, application form, or any other form, the superintendent may, after notice and hearing given to the life settlement provider that submitted the form for approval, withdraw an approval previously given if:

(1) the use of the form is contrary to the requirements applicable to the form at the time of such withdrawal, or

(2) it contains provisions that are unjust, unfair or inequitable.

Any withdrawal of approval shall be effective at the expiration of such period, at least ninety days after the giving of notice of withdrawal or as the superintendent shall in such notice prescribe.

§ 7807. Reporting requirements. (a)(1) Every licensed life settlement provider shall file in the office of the superintendent, annually on or before the first day of March, a statement, to be known as its annual statement, verified by the oath of at least two of its principal officers, showing its condition at the end of the preceding calendar year. The statement shall be in such form and shall contain such other matters as the superintendent shall prescribe. In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The information shall not include individual transaction data regarding the business of life settlements or information if there is a reasonable basis to believe the information could be used to identify the owner or the insured.

(2) Every life settlement provider that willfully fails to file an annual statement as required in this section, or willfully fails to reply within thirty days to a written inquiry by the superintendent in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty not to exceed five hundred dollars per day of delay, not to exceed fifty thousand dollars in the aggregate, for each such failure.

§ 7808. Examinations or investigations. The superintendent may make an examination or investigation into the affairs of any life settlement provider, life settlement broker, life settlement intermediary, applicant for licensure as a life settlement provider or life settlement broker, or applicant for registration as a life settlement intermediary as prescribed under article three of this chapter.

§ 7809. Advertising. (a) A life settlement provider, life settlement intermediary or life settlement broker licensed pursuant to this article may conduct or participate in advertisements within this state. The advertisements shall comply with all advertising and marketing laws or rules and regulations as may be promulgated by the superintendent.

(b) Advertisements shall be accurate, truthful and not misleading in fact or by implication.

(c) No life settlement provider, life settlement intermediary, life settlement broker, or any person acting on behalf thereof shall:

(1) directly or indirectly, market, advertise, solicit or otherwise promote the purchase of a policy for the primary purpose of, or with an emphasis on, settling the policy; or

(2) use the words "free", "no cost" or words of similar import in the marketing, advertising, soliciting or otherwise promoting of the purchase of a policy.

(d) The failure to follow the provisions of this section shall be a defined violation under article twenty-four of this chapter.

§ 7810. Privacy. (a) Except as otherwise permitted or required by law, no life settlement provider, life settlement broker, or life settlement intermediary, or any authorized representative thereof, insurer, information bureau, rating agency or company, or any other person with actual knowledge of an insured or owner's identity, shall disclose the identity of the insured or owner, or any information that there is a reasonable basis to believe could be used to identify the insured or owner, or the insured's financial or medical information, to any person unless the disclosure is:

(1) necessary to effect a life settlement contract between the owner and a life settlement provider and the owner and insured have provided prior written consent to the disclosure;

(2) necessary to effectuate the sale or transfer of a life settlement contract or a settled policy, or interest therein, provided that every sale is conducted in accordance with applicable state and federal law and provided further that the owner and the insured have both provided prior written consent to the disclosure;

(3) provided in response to an investigation or examination by the

superintendent, any other governmental officer or agency, or a self-regulating entity established pursuant to federal securities law;

(4) a term or condition to the transfer of a policy by one licensed life settlement provider to another licensed life settlement provider, in which case the receiving life settlement provider shall be required to comply with the confidentiality requirements of this section;

(5) necessary to allow the life settlement provider or life settlement broker, or any authorized representative thereof to administer the insurance policy, or to make contacts for the purpose of determining health status as authorized by subsection (k) of section seven thousand eight hundred thirteen of this article. For the purposes of this article, the term "authorized representative" shall not include any person who has or may have any financial interest in the life settlement contract other than a licensed life settlement provider, licensed life settlement broker, financing entity, related provider trust or special purpose entity; further, a life settlement provider or life settlement broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this article;

(6) required to purchase insurance; or

(7) otherwise permitted by regulation promulgated by the superintendent.

(b) Any person who obtains or may obtain a settled policy, or any interest therein, pursuant to a transfer, sale, conveyance or assignment of a settled policy, or any interest therein, shall:

(1) comply with the provisions of this chapter and regulations promulgated thereunder and all other applicable laws, governing the protection of the identity and privacy of the insured or owner; and

(2) protect against the unlawful release of all information concerning the identity of any insured or owner, which information would or could reasonably be expected to be used to identify or contact such insured or owner, including the name, address (except the state of residence) or social security number of the insured or the owner, or representative thereof, the related insurance policy number or the insured's medical information.

(c) Non-public personal information solicited or obtained in connection with a proposed or executed life settlement contract shall be subject to the provisions applicable to financial institutions under the

Gramm Leach Bliley Act, P.L. 106-102 (1999), and all other applicable laws relating to confidentiality of non-public personal information.

(d) The failure to follow the provisions of this section shall be a defined violation under article twenty-four of this chapter.

§ 7811. Disclosures to owners and insureds. (a) The life settlement provider or life settlement broker shall provide the owner with a separate written document conspicuously displaying the information and disclosures required by this subsection. The separate document shall be signed by the owner and life settlement provider, no later than the date the life settlement contract is signed by all parties. At a minimum, the document shall state:

(1) that there are possible alternatives to life settlement contracts, including accelerated benefits offered by the issuer of the policy;

(2) that some or all of the proceeds of a life settlement contract may be taxable and that advice should be sought from a professional tax advisor;

(3) that the proceeds from a life settlement contract could be subject to the claims of creditors;

(4) that receipt of proceeds from a life settlement contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5) that the owner has a right to rescind a life settlement contract from the time of execution of the contract until fifteen days after the receipt of the life settlement proceeds by the owner;

(6) that proceeds will be sent to the owner within three business days after the life settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(7) that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits, that may exist under the policy or certificate of a group policy to be forfeited by the owner and that assistance should be sought from a professional financial advisor;

(8) the gross offer or bid that the life settlement provider shall pay pursuant to the life settlement contract; the net amount to be paid to the owner pursuant to the life settlement contract; the name of each life settlement broker, life settlement intermediary, insurance producer or insurance consultant that will be compensated by the life settlement provider, or any affiliate, parent corporation, or subsidiary of the life settlement provider; and the amount of compensation that the life settlement provider, or any affiliate, parent corporation or subsidiary of the life settlement provider, shall provide to a life settlement broker, life settlement intermediary, insurance producer or insurance consultant, or any affiliate, parent corporation or subsidiary of such broker, intermediary, producer, or consultant, pursuant to the life settlement contract. For the purposes of this paragraph, "gross offer or bid" means the total amount or value offered by the life settlement provider for the purchase of one or more life insurance policies, inclusive of commissions and fees;

(9) the date by which the funds will be available to the owner and the transmitter of the funds;

(10) that the life settlement provider or life settlement broker is required to provide an owner during the solicitation process with a consumer information booklet in a form prescribed by the superintendent, or other similar material, subject to the approval of the superintendent;

(11) that the insured may be contacted by either the life settlement provider or life settlement broker, or any authorized representative thereof, for the purpose of determining the insured's health status or to verify the insured's address, and that the contact shall be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;

(12) any affiliations or contractual arrangements between the life settlement provider and the issuer of the policy to be settled;

(13) any affiliations or contractual arrangements with any other life settlement provider, life settlement broker, life settlement intermediary or party financing the transaction;

(14) that a life settlement broker represents exclusively the owner, and not the insurer or the life settlement provider or any other person,

and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;

(15) the name, business address, telephone number and e-mail address of the independent, third party escrow agent and that the owner has the right to inspect or receive copies of the relevant escrow or trust agreements or documents;

(16) that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life; and

(17) the name, business address, telephone number and e-mail address of the life settlement provider.

(b) The life settlement provider or life settlement broker shall provide to the insured in a separate written document conspicuously displaying the information and disclosures required by this subsection. The separate document shall be signed by the insured no later than the date the life settlement contract is signed by all parties. The document shall:

(1) state that the insured may be contacted by either the life settlement provider or life settlement broker or any authorized representative thereof, for the purpose of determining the insured's health status or to verify the insured's address, and that the contact shall be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;

(2) state that a change of ownership could in the future limit the insured's ability to purchase additional insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life; and

(3) contain the following language, or such other language required by the superintendent by regulation: "All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information,

you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years".

(c) The life settlement broker shall provide the owner with a separate written document conspicuously displaying the information and disclosures required by this subsection. The separate document shall be signed by the owner and life settlement broker, no later than the date the life settlement contract is signed by all parties. At a minimum, the document shall state:

(1) the name, business address, telephone number and e-mail address of the life settlement broker;

(2) a full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed life settlement contract;

(3) any affiliations or contractual arrangements with any life settlement provider, other life settlement broker, life settlement intermediary or any financing entity;

(4) the gross amount to be paid pursuant to the life settlement contract, the net amount of the proceeds to be paid to the owner pursuant to the life settlement contract, the amount of compensation to be paid to the life settlement broker pursuant to the life settlement contract, and the name of such life settlement broker. For purposes of this paragraph, "gross amount to be paid" means the total amount or value to be paid by the life settlement provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and

(5) a complete reconciliation of the gross offer or bid by the life settlement provider to the net amount of proceeds or value to be received by the owner, provided that for the purpose of this section, "gross offer or bid" shall mean the total amount or value offered by the life settlement provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

§ 7812. Life insurance applications. (a) Without limiting the ability of an insurer to assess the insurability of a policy applicant and to determine whether or not to issue the policy, and in addition to other

questions an insurer may lawfully pose to a life insurance applicant, insurers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(b) The insurer may include the following notice to the applicant and the insured, or other notice acceptable to the superintendent, on the application or as an amendment thereto: "If you enter into a loan arrangement where the policy is used as collateral, and the policy changes ownership at some point in the future in satisfaction of the loan, then the following may be true:

(1) a change of ownership may lead to a person unknown to you owning an interest in the insured's life;

(2) a change of ownership may limit your ability to purchase insurance in the future on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(3) if ownership of the life insurance policy changes, and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, and/or other factors may reduce the ability to obtain coverage and/or may result in significantly higher premiums; and

(4) you should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner."

§ 7813. General rules. (a) A life settlement provider entering into a life settlement contract shall first obtain a written consent from the insured to the release of the insured's medical records subject to the limitations contained in section seven thousand eight hundred ten of this article.

(b) The insurer shall respond to a request for verification of coverage submitted by a life settlement provider, life settlement broker or life settlement intermediary within fifteen days after the date the request is received. The insurer shall complete and issue the verification of coverage or indicate the specific reasons why it is unable to respond. In its response, the insurer shall indicate whether,

based on the medical evidence and documents provided, the insurer is pursuing or intends to pursue an investigation regarding the validity of the policy.

(c) The life settlement provider shall give written notice to the insurer that issued the policy within ten days after the life settlement contract is executed by all parties.

(d) Unless the insurer is pursuing or intends to pursue an investigation, the insurer shall, within fifteen days of receipt of a request for a change of ownership or assignment used to effectuate the transfer or assignment of the owner's rights or benefits under a policy to a life settlement provider, process the change of ownership or assignment and notify the life settlement provider and the owner that the transfer or assignment has been effectuated.

(e) If a life settlement broker performs any activity required of the life settlement provider in this section or provides any disclosures required by section seven thousand eight hundred eleven of this article, then the life settlement provider is deemed to have performed that activity or provided that disclosure.

(f) All medical information solicited or obtained by any licensee or any other person shall be subject to the provisions applicable to health care providers under the public health law and all applicable laws relating to confidentiality of medical information, provided that, to the extent that this chapter provides for greater confidentiality of medical information, this chapter shall govern.

(g)(1) Every life settlement contract shall provide that the owner has an unconditional right to rescind the life settlement contract from the time of execution of the contract until fifteen days after the receipt of the life settlement proceeds by the owner by giving notice of rescission to the life settlement provider by midnight of the fifteenth day.

(2) Within five days after receipt of the notice of rescission, the life settlement provider shall provide a written statement to the owner itemizing the amount of all life settlement proceeds and any premiums, loans and loan interest paid or to be paid as of a date certain as may be requested by the owner.

(3) Within fifteen days after the receipt of the written, itemized statement by the owner, the owner must repay all such life settlement

proceeds and any premiums, loans and loan interest paid by the life settlement provider.

(4) If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment of all life settlement proceeds and any premiums, loans and loan interest paid by the life settlement provider.

(5) Within five days after receipt of notice of the insured's death during the rescission period, the life settlement provider shall provide a written statement to the owner or, if the owner is deceased, to the legal representative of the owner's estate, itemizing the amount of all life settlement proceeds and any premiums, loans and loan interest paid or to be paid as of a date certain as may be requested by the owner or the legal representative of the owner's estate. As soon as practicable, the owner or the owner's estate shall repay all such proceeds and any premiums, loans and loan interest paid by the life settlement provider.

(h) Within three business days after receipt from the owner of documents to effect the transfer of the policy that is the subject of a life settlement contract, the life settlement provider shall deposit the proceeds of the life settlement contract into an escrow or trust account in a state or federally chartered financial institution. The escrow agent or trustee shall be required to transfer the proceeds due to the owner within three business days of acknowledgement of the transfer from the insurer.

(i) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner shall render the life settlement contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until thirty days after the written notice of the right of rescission has been given.

(j)(1) No person, at any time prior to, or at the time of, the application for, or issuance of, a policy, or during the two-year period commencing with the date of issuance of the policy, shall enter into a life settlement contract, regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise or bequest of the policy is to occur. This prohibition shall not apply if the owner certifies to the life settlement provider that:

(A) the policy was issued upon the owner's exercise of conversion rights arising out of a policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy shall be calculated without regard to a change in insurers, provided the coverage has been continuous and under the same group sponsorship; or

(B) one or more of the following conditions, for which the owner submits independent evidence to the life settlement provider, have been met within the two-year period:

(i) the owner or insured is terminally or chronically ill;

(ii) the owner or insured disposes of ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

(iii) the owner's spouse dies;

(iv) the owner divorces his or her spouse;

(v) the owner retires from full-time employment or involuntarily ceases employment;

(vi) the owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment;

(vii) a final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee or liquidator to all or a substantial part of the owner's assets; or

(viii) any other condition that the superintendent may determine by regulation to be an extraordinary circumstance for the owner or the insured.

(2) Copies of the independent evidence required by subparagraph (B) of paragraph one of this subsection shall be submitted to the insurer when the life settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the life settlement provider that the copies are true and correct copies of the documents received by the life settlement provider. Nothing in this section shall prohibit an insurer from exercising its right to contest the validity of any policy.

(3) For the purposes of this section a person is:

(A) terminally ill if the individual has an illness, sickness or physical condition that can reasonably be expected to result in death in twenty-four months or less; or

(B) chronically ill if that individual has been certified by a licensed health care practitioner as:

(i) being unable to perform without substantial assistance from another individual at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence) for a period of at least ninety days, due to a loss of functional capacity;

(ii) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment for a period of at least ninety days, due to a loss of functional capacity; or

(iii) having a level of disability similar to that described in clause (i) of this subparagraph, as determined by the United States Secretary of Health and Human Services.

(k) Contacts with the insured for the purpose of determining the health status of the insured by a licensed life settlement provider after the life settlement contract has been executed shall be made only by the licensed life settlement provider or licensed life settlement broker, or any authorized representative thereof, and shall be limited to once every three months for an insured with a life expectancy of more than one year, and to no more than once per month for an insured with a life expectancy of one year or less.

(l) The life settlement broker shall represent only the owner and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

(m) A life settlement provider, life settlement broker, or life settlement intermediary shall be responsible for the actions of its authorized representative.

(n)(1) A life settlement intermediary's services shall not be limited to life settlement providers or life settlement brokers that are affiliates, parents, or subsidiaries of the life settlement intermediary.

(2) A life settlement intermediary shall establish and maintain systems, practices and procedures to ensure that:

(A) every transaction with an affiliate, parent or subsidiary of the

life settlement intermediary is fair and equitable and conducted on an arms-length basis; and

(B) an affiliate, parent or subsidiary of the life settlement intermediary is not granted or provided with preferential treatment or access to information or services that are not granted or provided to an unaffiliated life settlement provider or life settlement broker that conducts business with the life settlement intermediary.

(o) A life settlement provider may sell, assign, pledge or otherwise transfer the ownership of a settled policy only to a licensed life settlement provider, an accredited investor or qualified institutional buyer, financing entity, special purpose entity, or related provider trust; provided, however, a life settlement provider may sell, assign, pledge or otherwise transfer a beneficial interest in a settled policy to someone other than a life settlement provider licensed in this state, an accredited investor or qualified institutional buyer, financing entity, special purpose entity, or related provider trust if a licensed life settlement provider continues to administer and service the settled policy and protects the privacy of the insured and owner pursuant to section seven thousand eight hundred ten of this article.

(p) The failure to follow the provisions of this section shall be a defined violation under article twenty-four of this chapter.

§ 7814. Prohibited practices. (a) No person shall:

(1) enter into a life settlement contract if the person knows or reasonably should have known that the policy was obtained in a false, deceptive or misleading way;

(2) engage in any transaction, practice or course of business if the person knows or reasonably should have known that the intent was to avoid the disclosure or other notice requirements of this article;

(3) engage in any fraudulent act or practice in connection with any transaction relating to any life settlement;

(4)(A) enter into a premium finance loan with an applicant for a new policy or an owner, pursuant to which the person providing premium financing, or any affiliate, parent corporation or subsidiary of the person, shall receive any proceeds, fees or other consideration, directly or indirectly, from the policy or owner of the policy or any

other person, other than commissions earned by a licensed insurance producer on the policy, with respect to the premium finance loan, that are in addition to the amounts required to pay the principal, interest and any reasonable costs, fees or expenses incurred by the lender or borrower related to the premium finance loan or subsequent sale of such loan; provided, further, that any payments, charges, fees or other amounts in addition to the amounts required to pay the principal, interest and any reasonable costs or expenses incurred by the lender or borrower related to the premium finance loan shall be remitted to the original owner of the policy or to the original owner's estate if the original owner is not living at the time of the determination of the overpayment. For purposes of this paragraph, "owner" means the owner of a policy whether or not entering into, or offering to enter into, a life settlement contract;

(B) If, at any time, a policy that is the subject of a premium finance loan specified in subparagraph (A) of this paragraph is sold, assigned, transferred, devised or bequeathed pursuant to the terms of a premium finance loan, any proceeds or other consideration received other than the amounts specified in subparagraph (A) of this paragraph shall be remitted to the original owner of the policy or to the original owner's estate if the original owner is not then living;

(5) with respect to any life settlement contract, knowingly fail to disclose any affiliation or contractual arrangement as required by this article;

(6) directly or indirectly, purchase or obtain an interest in any policy that is the subject of a life settlement contract where the person has acted as a life settlement broker or life settlement intermediary with respect to the policy, unless such affiliation has been disclosed to the owner pursuant to paragraph three of subsection (c) of section seven thousand eight hundred eleven of this article; and (A) if a life settlement broker, the broker has provided all offers and counter offers pursuant to paragraph two of subsection (c) of section seven thousand eight hundred eleven of this article, and has conducted the transaction on a fair and equitable arm-length basis; or (B) with respect to a life settlement intermediary, the intermediary complies with subsection (o) of section seven thousand eight hundred thirteen of this article;

(7) directly or indirectly provide any compensation to any person acting in this state as a life settlement broker, and no person shall accept any such compensation, unless the person is a licensed life settlement broker pursuant to the provisions of section two thousand one hundred thirty-seven of this chapter;

(8) directly or indirectly pay any referral or finder's fee or provide any other compensation to any owner's physician, attorney, accountant, insurance producer, insurance consultant, or other person providing medical, legal or financial planning services to the owner, or to any other person, other than a life settlement broker, representing the owner with respect to the life settlement contract, and no person shall accept any such fee or compensation;

(9) directly or indirectly provide compensation to a life settlement broker, except where the compensation is for a specific life settlement contract and is clearly disclosed to the owner as required in this article;

(10) directly or indirectly engage in any act determined by the superintendent to be an unfair or deceptive act or practice pursuant to this chapter;

(11) remove, conceal, alter, destroy or sequester from the superintendent the assets or records of a life settlement provider, life settlement broker, life settlement intermediary or other person engaged in the business of life settlements;

(12) misrepresent or conceal the financial condition of a life settlement provider; or

(13) in relation to the business of life settlements, file with the superintendent a document containing materially false information concerning any fact material thereto or otherwise conceal information about a fact material thereto from the superintendent.

(b) No life settlement provider, life settlement broker, life settlement intermediary, owner or any other person, as a condition of entering into a life settlement contract, shall request or require an insured to submit to a medical examination at any time subsequent to the settlement of the policy.

(c) No life settlement provider shall enter into any life settlement contract in which payments of proceeds are made in installments.

(d) No life settlement provider, life settlement broker or life

settlement intermediary shall directly or indirectly:

(1) be a party to or enter into an agreement or understanding limiting or restricting an owner's or life settlement broker's ability to seek competitive bids on policies to the extent that the agreement or understanding unlawfully restrains trade or constitutes anti-competitive behavior;

(2) monopolize or attempt to monopolize, or combine or conspire with any other person or persons to monopolize, in this state, the business of life settlements;

(3) be a party to or enter into an agreement with a life settlement provider, life settlement broker or life settlement intermediary to the extent that the agreement fixes or limits the value paid to owners;

(4) be a party to or enter into any agreement or communication with a life settlement provider or life settlement intermediary with respect to the terms to be offered to an owner to the extent that the agreement or understanding unlawfully restrains trade or constitutes anti-competitive behavior;

(5) be a party to or enter into any agreement with a life settlement provider, life settlement broker, life settlement intermediary or other person to restrain trade or engage in any other anti-competitive behavior;

(6) be party to or enter into any agreement with a life settlement provider, life settlement broker, life settlement intermediary or other person the effect of which may be substantially to lessen competition in the business of life settlements subject to this chapter; or

(7) be a party to or enter into any agreement with a life settlement provider, life settlement broker, life settlement intermediary or other person to refuse to conduct business with any person in the business of life settlements.

(e) No life settlement intermediary shall:

(1) represent, solicit, negotiate or act on behalf of, an owner, a life settlement provider, or a life settlement broker; or

(2) act as a life settlement provider or life settlement broker.

(f) No insurer shall prohibit an insurance agent from disclosing to a client the availability of a life settlement contract.

(g) The failure to follow the provisions of this section shall be a defined violation under article twenty-four of this chapter.

§ 7815. Stranger-originated life insurance. (a) In this chapter, "stranger-originated life insurance" means any act, practice or arrangement, at or prior to policy issuance, to initiate or facilitate the issuance of a policy for the intended benefit of a person who, at the time of policy origination, has no insurable interest in the life of the insured under the laws of this state, including:

(1) the purchase of life insurance with resources or guarantees from or through a person that, at the time of policy initiation, could not lawfully initiate the policy;

(2) an arrangement or other agreement to transfer the ownership of the policy or the policy benefits to another person; or

(3) a trust or similar arrangement that is used, directly or indirectly, for the purpose of purchasing one or more policies for the intended benefit of another person in a manner that violates the insurable interest laws of this state.

(b) Stranger-originated life insurance arrangements do not include lawful life settlement contracts as permitted by this article or those practices set forth in paragraph three of subsection (k) of section seven thousand eight hundred two of this article, provided that such contracts or practices are not for the purpose of evading regulation under this article.

(c) No person shall directly or indirectly engage in any act, practice or arrangement that constitutes stranger-originated life insurance.

(d) The failure to follow the provision of subsection (c) of this section shall be a defined violation under article twenty-four of this chapter.

§ 7816. Penalties and civil remedies. (a)(1) If, after notice and hearing, the superintendent determines that any information required by subsection (a) or (c) of section seven thousand eight hundred eleven of this article knowingly was not provided or knowingly was delayed in being provided by the life settlement broker to the material detriment of the owner, then the superintendent, in addition to any other penalty prescribed by law, may require the life settlement broker to pay to the

people of this state an amount not to exceed the compensation due or provided to the life settlement broker.

(2) If, after notice and hearing, the superintendent determines that any information required by subsection (a) of section seven thousand eight hundred eleven of this article knowingly was not provided or knowingly was delayed in being provided by the life settlement provider to the material detriment of the owner, then the superintendent, in addition to any other penalty prescribed by law, may require the life settlement provider to pay to the people of this state an amount not to exceed forty-five thousand dollars.

(b) If, after notice and hearing, the superintendent determines any person knowingly violated subsection (c) of section seven thousand eight hundred fifteen of this article, then the superintendent, in addition to any other penalty prescribed by law, may require the person to pay to the people of this state an amount not to exceed one hundred thousand dollars.

(c) If, after notice and hearing, the superintendent determines that any person knowingly violated section seven thousand eight hundred ten of this article, then the superintendent, in addition to any other penalty prescribed by law, may require the person to pay the insured or owner an amount not to exceed twenty thousand dollars.

(d)(1) If, after notice and hearing, the superintendent determines that any person knowingly and willfully acted as a life settlement provider without a license in violation of subsection (a) of section seven thousand eight hundred three of this article, then the superintendent may impose a civil penalty payable to the people of this state not to exceed one hundred thousand dollars for each policy settled in violation thereof.

(2) If, after notice and hearing, the superintendent determines that any person knowingly and willfully acted as a life settlement broker without a license in violation of subsection (a) of section two thousand one hundred thirty-seven of this chapter, then the superintendent may impose a civil penalty payable to the people of this state not to exceed fifty thousand dollars for each policy settled in violation thereof.

(3) If, after notice and hearing, the superintendent determines that any person knowingly and willfully acted as a life settlement intermediary without a registration in violation of subsection (a) of

section seven thousand eight hundred four of this article, then the superintendent may impose a civil penalty payable to the people of this state not to exceed fifty thousand dollars for each transaction.

(e) Any person who has been injured by reason of a violation of subsection (a), (b) or (c) of this section may bring an action to recover damages suffered by reason of such violation. In any action brought under this section, the court may award reasonable attorney's fees to a prevailing plaintiff.

(f) Nothing provided in this article shall limit or restrict any common law, contractual or other right of action.

§ 7817. Authority to promulgate regulations. The superintendent may promulgate regulations implementing this article.

§ 7818. Nonconforming contracts. (a) Except as otherwise specifically provided in this chapter, any life settlement contract subject to this chapter that is in violation of any of the provisions of this chapter shall be valid and binding upon the life settlement provider, but in all respects in which the contract's provisions are in violation of the requirements or prohibitions of this chapter it shall be enforceable as if it conformed with such requirements or prohibitions.

(b) In any action to recover under the provisions of any life settlement contract that the superintendent is authorized by this chapter to approve, if in the superintendent's opinion the provisions of this chapter are more favorable to owners, the court shall enforce such contract as if its provisions were the same as those specified in this chapter unless the court finds that the actual provisions of the contract were more favorable to owners at the date when the contract was entered into.

§ 7819. Applicability and choice of law. (a) The provisions of this article shall apply to any life settlement contract made, proposed to be made, or solicited with a resident of this state or any owner physically in this state.

(b)(1) If there is more than one owner on a single policy, and the owners are residents of different states, then the state of residency shall be the state in which the owner having the largest percentage of ownership resides or, if the owners hold equal ownership, the state of residence of one owner, agreed upon in writing by all of the owners.

(2) A life settlement contract entered into with an owner who is a resident of another state may be governed by the laws of the other state provided that the owner elects in writing to be governed by the laws of the other state, and if the owner is also a resident of this state, the life settlement contract is made, proposed to be made and solicited outside this state.

(c) For the purposes of this section, with respect to any person other than a natural person, the state of residence shall be:

(1) the state in which the person maintains its principal place of business; or

(2) with respect to a trust, a state in which the grantor resides.

§ 7820. Severability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid and after exhaustion of all further judicial review, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this article directly involved in the controversy in which the judgment shall have been rendered.

ARTICLE 79
SERVICE CONTRACTS

Section 7901. Scope and purposes.
7902. Definitions.
7903. Requirements for doing business.
7904. Required disclosures; service contract reimbursement insurance policy.
7905. Required disclosures; service contract.
7906. Prohibited acts.
7907. Registration of providers.

7908. Recordkeeping requirements.
7909. Termination of service contract reimbursement insurance policy.
7910. Enforcement provisions.
7911. Authority to develop regulations.
7912. Transition.
7913. Separability provision.

§ 7901. Scope and purposes. (a) The purposes of this article are to:

(1) create a legal framework within which service contracts may be sold in this state;

(2) encourage the marketing and developing of more economical and effective means of providing services under service contracts; and

(3) permit and encourage fair and effective competition among different systems of providing and paying for these services.

(b) This article shall not apply to:

(1) Express or implied warranties;

(2) Maintenance agreements;

(3) Warranties, service contracts or maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by the public service commission; and

(4) Warranties, service contracts and maintenance agreements that are conditioned upon or otherwise associated with the sale or supply of heating fuel.

§ 7902. Definitions. As used in this article:

(a) "Appliances" may include but are not limited to electrical or mechanical appliances sold separately or included with the sale of residential real property such as refrigerators, stoves, ovens, clothes washers and dryers and dishwashers.

(b) "Administrator" means any person designated by a provider to be responsible for administration of service contracts, including servicing, claims management and processing, recordkeeping, customer service and collection of fees.

(c) "Incidental damages" has the meaning as set forth in subdivision

one of section 2-715 of the uniform commercial code, as such definition may be amended from time to time.

(d) "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance of property, other than contracts providing for the repair or replacement of such property due to a defect in materials or workmanship or wear and tear.

(e) "Non-original manufacturers' parts" means replacement parts not made for or by the original manufacturer of the property, commonly referred to as "after market parts".

(f) "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal, syndicate or any similar entity or combination of entities acting in concert.

(g) "Premium" means the consideration paid to an insurer for a service contract reimbursement insurance policy.

(h) "Provider" means a person who markets, sells, offers for sale, issues, makes or proposes to make or administers a service contract, and who is contractually obligated to provide service under a service contract.

(i) "Provider fee" means the total purchase price or consideration paid for a service contract.

(j) "Qualified United States financial institution" has the meaning set forth in the regulations as promulgated from time to time by the superintendent.

(k) "Service contract" means a contract or agreement, for a separate or additional consideration, for a specific duration to perform the repair, replacement or maintenance of property, or indemnification for repair, replacement or maintenance, due to a defect in materials or workmanship or wear and tear, with or without additional provision for indemnity payments for incidental damages, provided any such indemnity payment per incident shall not exceed the purchase price of the property serviced. Service contracts may include towing, rental and emergency road service, and may also provide for the repair, replacement or maintenance of property for damage resulting from power surges and accidental damage from handling. Service contracts may also include contracts to repair, replace or maintain residential appliances and systems. Such term shall also mean a contract or agreement made (1) by

or for the manufacturer or seller of a motor vehicle tire for repair or replacement of the tire or wheel as the result of damage arising from a road hazard, (2) by or for the supplier or seller of a service for repair of chips or cracks in a motor vehicle windshield, but not including services that involve the replacement of the entire windshield, (3) by or for the supplier or seller of a service for repair or removal of dents, dings or creases from a motor vehicle without affecting the existing paint finish using paintless dent repair techniques, but not including services that involve the replacement of vehicle body panels, or sanding, bonding or painting; and (4) by or for the supplier or seller of a service for repair or replacement of a motor vehicle key or key fob in the event that the key or key fob becomes inoperable, lost or stolen. In conjunction with a motor vehicle leased for personal use, such term shall also mean a contract to perform the repair, replacement or maintenance of property, or to provide indemnification for repair, replacement or maintenance, due to excess wear and use or damage for interior stains, rips or scratches or missing interior parts that result in a lease-end charge not otherwise covered by a service agreement or warranty, provided any such payment shall not exceed the purchase price of the vehicle.

(l) "Systems" means plumbing, electrical, heating, cooling, ventilation, and other systems used in residential real property, including without limitation:

(A) plumbing systems which include gas supply lines and fittings, water supply, waste and vent pipes and their fittings, septic tanks and their drain fields, water, gas and sewer service piping, and their extensions to the tie-in of a public utility connection, or on-site well and sewage disposal system;

(B) electrical systems which include all wiring, electrical boxes, switches, outlets, and connections up to the public utility connection; and

(C) heating, cooling and ventilation systems which include all duct work, steam, water and refrigerant lines, registers, convectors, radiation elements and dampers.

(m) "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a service contract.

(n) "Service contract reimbursement insurance policy" means a policy

of service contract reimbursement insurance.

§ 7903. Requirements for doing business. (a) Notwithstanding any other provision of this chapter to the contrary, the marketing, sale, offering for sale, issuance, making, proposing to make and administration of service contracts by any provider, administrator or other person, shall be exempt from all other provisions of this chapter. A provider may, but is not required to, appoint an administrator or other designee to be responsible for any or all of the administration of service contracts and compliance with this article. Notwithstanding any other provision of this article, a provider of a service contract, as defined in paragraphs two and three of subsection (k) of section seven thousand nine hundred two of this article, shall, at least thirty days prior to the effective date of an initial provider fee, or a change in a provider fee, file the amount of the provider fee with the superintendent and such filing shall be open to public inspection; and provided further that the provider fee shall not exceed the amount filed. The requirement to file the amount of the provider fee with the superintendent in this subsection shall not apply to fees set forth in any agreement to which an authorized insurer is a party.

(b) Service contracts shall not be issued, sold or offered for sale in this state unless the provider:

(1) provides a receipt for, or other written evidence of, the purchase of the service contract and a copy of the terms and conditions of the service contract to the service contract holder where the sale takes place in a retail store or other place of business. A copy of the service contract in all cases shall be provided to the service contract holder within a reasonable period of time after the date of purchase of the service contract; and

(2) otherwise complies with this article.

(c) In order to assure the faithful performance of a provider's obligations to its contract holders, each provider who is contractually obligated to provide service under a service contract shall comply with one of the following three paragraphs of this subsection:

(1) insure the performance of its obligations under all service contracts pursuant to a service contract reimbursement insurance policy

issued by an insurer authorized to issue service contract reimbursement insurance in this state or procured by an excess line licensee pursuant to section two thousand one hundred eighteen of this chapter. Each provider may maintain a maximum of five service contract reimbursement insurance policies insuring its service contracts actively offered. In the event the provider fails to insure its obligations pursuant to this paragraph or in the event that such insurance shall lapse or be terminated, the provider shall comply with either paragraph two or three of this subsection within forty-five days of the insurance lapse or termination;

(2) (A) maintain a funded reserve account for its obligations under its service contracts issued and outstanding in this state, which reserve account (i) contains reserves in an amount not less than forty percent of the gross consideration received upon the sale of, less claims paid under, all its service contracts then in force, but not less than zero, and (ii) shall be subject to examination and review by the superintendent; and

(B) place in trust with the superintendent a financial security deposit, having a value of not less than five percent of the gross consideration received upon the sale of, less claims paid under, all service contracts issued and then in force, but not less than fifty thousand dollars, consisting of one or more of the following:

(i) a surety bond issued by an authorized surety;

(ii) securities of the type eligible for deposit by authorized insurers in this state;

(iii) cash; or

(iv) a letter of credit issued by a qualified United States financial institution; or

(3) (A) maintain a net worth or stockholders' equity of at least one hundred million dollars; and

(B) provide the superintendent with a copy of the financial statements of the provider, either on a stand alone basis or consolidated with its consolidated affiliates, included in its or its direct or indirect parent company's most recent annual report on form 10-K or form 20-F filed with the securities and exchange commission within the last calendar year, or if the provider or its direct or indirect parent company is not required to file such reports with the securities and

exchange commission, a copy of the audited financial statements of the provider, either on a stand alone basis or consolidated with its consolidated affiliates. If the net worth or stockholders' equity of the provider, either on a stand alone basis or consolidated with its consolidated affiliates, as shown in the foregoing financial statements is at least one hundred million dollars, the provider shall be deemed to meet the requirements of this paragraph and there shall be no requirement of a guarantee, reimbursement insurance, or other form of financial stability arrangement. In the event the net worth or stockholders' equity of the provider, either on a stand alone basis or consolidated with its consolidated affiliates, is not at least one hundred million dollars, or the net worth or stockholders' equity of the provider, as aforesaid, is not determinable from the foregoing audited financial statements, the provider shall comply with paragraph one or two of this subsection within forty-five days of becoming aware of such deficiency. If the provider's direct or indirect parent company's form 10-K, form 20-F, or audited financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state.

(d) Premium taxes. (1) Provider fees shall not be subject to premium taxes.

(2) Premiums collected on service contract reimbursement insurance policies shall be subject to applicable premium taxes.

(e) Service contracts shall require every provider to permit the service contract holder to return the contract within at least twenty days of the date of mailing of the service contract or within at least ten days if the service contract is delivered at the time of the sale or within a longer time period permitted under the contract. If no claim has been made under the contract, the contract shall be void and the provider shall refund to the contract holder the full purchase price of the contract. A ten percent penalty per month shall be added to a refund that is not made within thirty days of return of the contract to the provider. The provisions of this subsection only apply to the original purchaser of the service contract.

§ 7904. Required disclosures; service contract reimbursement insurance policy. Service contract reimbursement insurance policies insuring service contracts issued, sold or offered for sale in this state shall state that, upon failure of the provider to perform under the service contract, including failure to return the unearned provider fee thereunder, the insurer that issued the service contract reimbursement insurance policy shall pay on behalf of the provider any sums the provider is legally obligated to pay under the service contract or shall perform the service which the provider is legally obligated to perform according to the provider's contractual obligations under the service contracts issued or sold by the provider.

§ 7905. Required disclosures; service contract. (a) Service contracts marketed, sold or offered for sale, issued, made, proposed to be made or administered in this state shall be dated and written in clear, understandable language and the entire service contract shall be printed or typed in easy to read type and disclose the requirements of this section, as applicable. The date the service contract is issued is not required to be preprinted on the service contract and may be added or attached to the service contract at the time of sale.

(b) Service contracts insured under a service contract reimbursement insurance policy pursuant to paragarph one of subsection (c) of section seven thousand nine hundred three of this article shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement insurance policy. If the provider fails to pay or provide service on a claim within sixty days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the insurer under the service contract reimbursement insurance policy." The service contract shall also state the name and address and a toll-free telephone number of the insurer under the related service contract reimbursement insurance policy.

(c) Service contracts not insured under a service contract reimbursement insurance policy pursuant to paragraph one of subsection (c) of section seven thousand nine hundred three of this article shall contain a statement substantially to the following effect: "Obligations

of the provider under this service contract are backed by the full faith and credit of the provider." The service contract shall also state the name and address of the provider thereunder.

(d) Service contracts shall identify any administrator if different from the provider or seller, the provider, and the service contract seller. The identities of such parties are not required to be preprinted on the service contract and may be added to the service contract at the time of sale. Service contracts shall clearly state the procedure that the service contract holder must take to obtain service under the terms and conditions of the service contract.

(e) Service contracts shall state the total purchase price and the terms and conditions under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

(f) If prior approval of repair work is required, the service contracts shall state the procedure for obtaining prior approval and for making a claim, including a toll free telephone number for claim service and if the service contracts provide services essential to public health, safety or welfare, the service contracts shall either provide for twenty-four hour telephone assistance or state the procedure for obtaining emergency repairs performed outside of normal business hours. The superintendent may promulgate regulations necessary to effectuate this subsection as authorized by section seven thousand nine hundred eleven of this article.

(g) Service contracts shall state the existence of any deductible amount thereunder if applicable.

(h) Service contracts shall specify the merchandise and services to be provided and any limitations, exceptions or exclusions from coverage thereunder if applicable.

(i) Service contracts covering motor vehicles shall state whether the use of non-original manufacturers' parts may be allowed. Conditions stated shall comply with applicable state and federal laws.

(j) Service contracts shall state any terms, restrictions or conditions governing the transferability of such service contracts.

(k) Service contracts shall state the terms, restrictions or conditions governing termination of the service contract by the parties

to the service contract. The provider of the service contract shall mail a written notice to the service contract holder at the last known address of the service contract holder contained in the records of the provider at least fifteen days prior to cancellation by the provider. The notice shall state the effective date of the cancellation and the reason for the cancellation. Written notice is not required if the reason for cancellation is nonpayment of the provider fee, a material misrepresentation, or a substantial breach of duties by the service contract holder relating to the covered property or its use.

(l) Service contracts shall set forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage and any requirement to follow owner's manual instructions.

(m) Service contracts shall clearly state whether or not the service contract provides for or excludes preexisting conditions.

(n) Service contracts shall contain a statement of the service contract holder's right to return the contract within at least twenty days of the date of mailing of the service contract or within at least ten days if the service contract is delivered at the time of the sale or within a longer time period permitted under the contract. If no claim has been made under the contract, the contract shall be void and the provider shall refund to the contract holder the full purchase price of the contract. The service contract shall also contain a statement that a ten percent penalty per month shall be added to a refund that is not made within thirty days of return of the contract to the provider.

§ 7906. Prohibited acts. (a) A provider shall not use in its name the words insurance, casualty, guaranty, surety, mutual or any other words descriptive of the insurance, casualty, guaranty or surety business, or a name deceptively similar to the name or description of any insurance or surety corporation or any other provider.

(b) A provider shall not in its service contracts or literature make, permit or cause to be made any false or misleading statement, or deliberately omit any material statement that would make the service contracts or literature misleading if omitted, in connection with the sale, offer to sell, or advertisement of a service contract.

(c) A person, including a bank, savings and loan association, lending institution, manufacturer or seller of any product, shall not require the purchase of a service contract as a condition of a loan or other extension of credit or a condition for the sale or other disposition of any property. The superintendent may promulgate regulations necessary to effectuate this subsection as authorized by section seven thousand nine hundred eleven of this article.

§ 7907. Registration of providers. (a) No person shall act as a provider pursuant to this article without having first obtained an approval of a registration to do so from the superintendent. The application for approval of registration shall contain the following information;

(1) the name and address of the principal office of the provider;

(2) the name and address of the providers' agent for service of process in this state, if other than the provider;

(3) the identities of the provider's executive officer or officers directly responsible for such provider's service contract business, and, if more than fifty percent of the provider's revenue is derived from the sale of service contracts, the identities of the provider's directors and stockholders having beneficial ownership of five percent or more of any class of securities registered under the federal securities law;

(4) the name, location and telephone number of any administrators designated by the provider to be responsible for the administration of service contracts in this state, together with an acknowledgment by each such administrator (who is not employed by the provider) of such administrator's obligations under this article;

(5) a statement indicating under subsection (c) of section seven thousand nine hundred three of this article the provider qualifies to do business as a service contract provider in this state.

(b) The registration application shall be accompanied by a fee of two hundred fifty dollars for each year or fraction of a year in which the registration shall be in effect.

(c) A provider shall keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the

month in which the provider learns of such change or addition.

(d) The superintendent shall render a determination on the application for registration within forty-five days of the date of filing. The superintendent may not approve the application for registration if the provider is not trustworthy or has otherwise given cause that the superintendent determines that to approve such registration would not promote the health, safety and welfare of the public. In the event the registration application is disapproved, the superintendent shall state the reason or reasons therefor. In the event the application was incomplete, the applicant may file an amended registration application. The superintendent shall render a decision on the amended application within thirty days of receipt thereof.

(e) The registration shall continue in force until suspended or revoked by the superintendent on the grounds that the provider is not trustworthy or has violated any provision of this chapter or has given cause for the revocation or suspension of such registration or the provider has failed to comply with any prerequisite for the issuance of such registration approved, or terminated at the request of the provider, subject, however, to the biennial renewal of the registration, by filing a renewal application and payment, prior to March first of each odd numbered year following that in which its original registration application is filed, of a fee of five hundred dollars.

(f) Except for the registration requirement in this section, providers and administrators of service contracts are exempt from any licensing requirements.

(g) The biennial renewal application shall contain such information as required by the superintendent including, but not limited to information to demonstrate that the applicant continues to satisfy all requirements of section seven thousand nine hundred three of this article.

§ 7908. Recordkeeping requirements. (a) Books and records. (1) A provider or its administrator shall keep accurate accounts, books and records concerning transactions regulated under this article.

(2) A provider's or its administrator's accounts, books and records shall include:

(A) copies of each type of service contract issued;

(B) the name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder to the provider;

(C) a list of the provider locations where service contracts are marketed, sold, offered for sale, issued, made or proposed to be made or administered; and

(D) written claims filed which shall contain at least the dates and description of all claims related to the service contracts.

(3) Except as provided in subsection (b) of this section, a provider or its administrator shall retain all of the service contract records required under paragraph two of this subsection pertaining to each service contract holder for at least three years after the specified period of coverage thereunder has expired.

(4) A provider may keep all records required under this article on a computer disk or other similar technology. If the records are maintained in other than hard copy, the records shall be capable of duplication to legible hard copy at the request of the superintendent.

(b) A provider discontinuing business in this state shall maintain its records until it furnishes to the superintendent satisfactory proof that it has discharged all obligations to service contract holders in this state.

§ 7909. Termination of service contract reimbursement insurance policy. An insurer that issues a service contract reimbursement insurance policy shall not terminate the policy except in accordance with section three thousand four hundred twenty-six of this chapter and upon notice to the superintendent. The termination of a service contract reimbursement insurance policy shall not reduce the issuer's responsibility for service contracts issued in this state by providers prior to the date of the termination.

§ 7910. Enforcement provisions. (a) The superintendent may conduct investigations or examinations of providers, administrators, insurers or other persons to enforce the provisions of this article and protect service contract holders in this state. Upon request of the

superintendent, the provider shall make all accounts, books and records concerning service contracts sold in this state by the provider available to the superintendent which are necessary to enable the superintendent to reasonably determine compliance or noncompliance with this article.

(b) The superintendent may take action which is necessary or appropriate to enforce the provisions of this article and the superintendent's regulations and orders, and to protect service contract holders in this state.

(1) If the provider has violated this article or the superintendent's regulations or orders, the superintendent may order a service contract provider to cease and desist from committing violations of this article or the superintendent's regulations or orders, may issue an order suspending a provider's registration under this article or prohibiting a service contract provider from marketing, selling, offering for sale, issuing, making or proposing to make service contracts, or may issue an order imposing a civil penalty, or any combination of these. An order issued under this paragraph may be delivered to the provider at its principal office or to the provider's designated agent for service of process indicated in the provider's registration materials pursuant to paragraph two of subsection (a) of section seven thousand nine hundred seven of this article.

(A) A person aggrieved by an order issued under this paragraph may request a hearing before the superintendent. The hearing request shall be filed with the superintendent within twenty days of the date the superintendent's order is effective;

(B) If a hearing is requested, an order issued under this paragraph shall be suspended from the original effective date of the order until completion of the hearing and delivery of the final decision thereon by the superintendent, except that where the provider has demonstrated a consistent pattern or practice of gross misconduct in connection with the marketing, sale, offering for sale, issuance, making or proposing to make of service contracts, the effective date of the order shall not be suspended pending the hearing and decision by the superintendent; and

(C) At the hearing, the burden shall be on the superintendent to show why the order issued pursuant to this paragraph is justified. The provisions of section three hundred five of the financial services law

shall apply to a hearing requested under this paragraph.

(2) The superintendent may bring an action in any court of competent jurisdiction for an injunction or other appropriate relief to enjoin threatened or existing violations of this article or of the superintendent's orders or regulations. An action filed under this paragraph may also seek restitution on behalf of persons aggrieved by a violation of this article or orders or regulations of the superintendent.

(3) A person in violation of this article may be subject to a monetary penalty of not more than five hundred dollars per violation. If the violation is not willful, such person may in lieu of paying such monetary penalty, provide restitution to the persons aggrieved by the violation or otherwise remedy the violation within sixty days after becoming aware of the violation.

(c) The authority of the superintendent under this section is in addition to any other authority of the superintendent.

§ 7911. Authority to develop regulations. The superintendent may promulgate regulations necessary to effectuate this article.

§ 7912. Transition. Providers who have submitted an application for approval of registration pursuant to section seven thousand nine hundred seven of this article who have been previously engaged in New York state, for not less than two years immediately prior to the effective date of this section in the business of marketing, selling, offering for sale, issuing, making, proposing or administering a service contract which otherwise was in compliance with all applicable laws of the state of New York immediately prior to the effective date of this section, may engage in such business in the state of New York until such time as the superintendent has issued a determination on such application for approval of registration provided that such application is received by the superintendent within sixty days of the effective date of this section.

§ 7913. Separability provision. If any provision of this article, or the application of any such provision to any person or circumstances, shall be held invalid, the remainder of this article, and the application of the provision to any person or circumstances other than those as to which it is held invalid, shall not be affected.

ARTICLE 80
MUTUAL HOLDING COMPANY

Section 8001. Definitions.
8002. Reorganization of mutual life insurer through formation of a mutual holding company; contents of plan.
8003. Dividend practices.
8004. Adoption of plan; submission of plan to the superintendent.
8005. Amendment or withdrawal of plan.
8006. Consultants.
8007. Approval of plan by superintendent; hearing.
8008. Approval of plan by policyholders.
8009. Filing of plan; effective date of reorganization.
8010. Effect of reorganization.
8011. Corporate existence.
8012. Directors and officers.
8013. Notice of proposed reorganization.
8014. Failure to give notice.
8015. Limitations of actions; security.
8016. Prohibited transactions by officers, directors and employees.
8017. Requirements applicable to a mutual holding company.
8018. Other requirements applicable to a stock holding company and a mutual holding company.
8019. Conversion of mutual holding company.
8020. Transfers of subsidiaries.
8021. Limitations on accumulation of surplus of mutual holding companies.

§ 8001. Definitions. As used in this article, the following terms shall have the following meanings:

(a) "Adoption date" means the date the board of directors of the mutual life insurer adopts the plan of reorganization.

(b) "Beneficial ownership" with respect to any security, means the sole or shared power to vote or direct the voting of, such security and/or the sole or shared power to dispose or direct the disposition of such security.

(c) "Effective date" means, in the case of the reorganization of a mutual life insurer, the date upon which the reorganization of the mutual life insurer shall be effective in accordance with section eight thousand nine of this article as a result of reorganization proceedings pursuant to this article.

(d) "Member" with reference to a mutual life insurer, means a person who, by the records of the mutual life insurer, is deemed to be the "policyholder" of a policy or annuity contract which is of a type described in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter for purposes of paragraph three of subsection (a) of section four thousand two hundred ten of this chapter. On and after the effective date of a plan of reorganization that creates a mutual holding company, the term "member" means a member of such mutual holding company as provided in subsection (c) of section eight thousand seventeen of this article.

(e) "Membership interests" means, with reference to an institution that is a mutual life insurer or a mutual holding company, the rights as members arising under the charter of such institution or this chapter or otherwise by law including the rights to vote and to participate in any distribution of the surplus of such institution, whether or not incident to a liquidation thereof. The term "membership interests" does not include rights expressly conferred upon the policyholders by their policies or contracts (including the right to participate in the distribution of surplus) other than the right to vote.

(f) "Mutual holding company" means a corporation organized under section eight thousand seventeen of this article.

(g) "Mutual life insurer" means a domestic mutual life insurer.

(h) "Offer" includes every offer to buy or acquire, solicitation of an offer to sell, tender offer for, or request or invitation for tenders of

a security or interest in a security for value.

(i) "Outside director" means a director:

(1) who is not an officer, employee or consultant of the mutual holding company, any stock holding company, the reorganized insurer or any other subsidiary of the mutual holding company or any stock holding company;

(2) who does not directly or indirectly own, control or hold one percent or greater of the voting securities of any stock holding company, the reorganized insurer or any other subsidiary of the mutual holding company or any stock holding company; and

(3) who is not a director, officer or employee of any person except the mutual holding company or any stock holding company that directly or indirectly owns, controls or holds such percentage of such voting security.

Lesser amounts of ownership of voting securities other than those provided for in this subsection may be approved by the superintendent as a component of the mutual holding company's plan of reorganization pursuant to this article.

(j) "Person" means an individual, partnership, firm, association, corporation, joint-stock company, limited liability company, limited liability partnership, trust, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, estate, trustee or fiduciary, any similar entity or any combination of the foregoing acting in concert.

(k) "Plan of reorganization" or "plan" means a plan adopted by a mutual life insurer in compliance with this article.

(l) "Policyholder" means a person, as determined by the records of the reorganizing insurer or reorganized insurer, who is deemed to be the "policyholder" of a policy or annuity contract which is of a type described in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter for purposes of paragraph three of subsection (a) of section four thousand two hundred ten of this chapter.

(m) "Public offering" means a stock offering required to be registered pursuant to the Securities Act of 1933, United States Code, Title 15, Section 77e.

(n) "Reorganized insurer" means the stock life insurer into which a mutual life insurer has been reorganized in accordance with the provisions of this article.

(o) "Reorganizing insurer" means, in the case of a plan of reorganization of a mutual life insurer under this article, the mutual life insurer that is reorganizing pursuant to such plan.

(p) "Stock holding company" means a corporation incorporated under the laws of any jurisdiction in the United States, at least fifty-one percent of the voting stock of which is owned, directly or through another stock holding company, by a mutual holding company and which holds, directly or indirectly, voting stock in at least one reorganized insurer.

(q) "Voting security" includes voting securities as defined in paragraph forty-five of subsection (a) of section one hundred seven of this chapter, any reorganization certificate or subscription (including subscription rights issued pursuant to a plan of reorganization), or any security convertible (with or without consideration) into any such security, or carrying any warrant or right to subscribe for or purchase any such security, or any such warrant or right.

(r) "Voting stock" means capital stock that constitutes voting securities as defined in paragraph forty-five of subsection (a) of section one hundred seven of this chapter. All references in this article to a specified percentage of the voting stock of any person shall mean securities having the specified percentage of the voting power in such person for the election of directors, trustees or management of such person other than securities having such power only by reason of the happening of a contingency.

§ 8002. Reorganization of mutual life insurer through formation of a mutual holding company; contents of plan. (a) A mutual life insurer having on the adoption date admitted assets of less than ten billion dollars may be reorganized as a domestic stock life insurer with a mutual holding company by complying with the requirements of this article.

(b) The plan of reorganization shall contain provisions for:

(1) the reorganizing insurer becoming a domestic stock life insurer;

(2) the formation of a mutual holding company;

(3) the members of the reorganizing insurer becoming members of the mutual holding company with membership interests therein, and the membership interests in the reorganizing insurer being extinguished; and

(4) at least fifty-one percent of the voting stock issued by the reorganized insurer being acquired and held, directly or through one or more stock holding companies, by the mutual holding company.

(5) the general terms for the establishment of the closed block or an alternative provision under subsection (b) of section eight thousand three of this article and the proposed dividend policy under subsection (a) of section eight thousand three of this article; and

(6) a plan of operation for the reorganized insurer including financial projections for a three-year period and a statement indicating its intentions with regard to issuing any nonparticipating business.

(c) The plan of reorganization shall provide that the reorganization will not change premiums or reduce policy benefits, values or guarantees or other policy obligations of the mutual life insurer, provided that the plan of reorganization may provide that the reorganized insurer will be able to make such changes and reductions as would be permitted under this chapter if the mutual life insurer were not a reorganizing insurer under this article.

(d) The plan may provide for the formation of one or more stock holding companies.

(e) The plan shall include the following as exhibits:

(1) the proposed charters or certificates of incorporation of the reorganized insurer, the mutual holding company and any stock holding company or companies; and

(2) the proposed by-laws of the reorganized insurer, the mutual holding company and any stock holding company or companies.

§ 8003. Dividend practices. (a) Following the effective date of the plan, the reorganized insurer may, with respect to its participating individual policies and contracts, either:

(1) continue the dividend practices of the reorganizing insurer;

(2) continue the dividend practices of the reorganizing insurer and adopt such other dividend practices as, at the effective date or at any

time thereafter, may be permitted under applicable law or regulation or approved by the superintendent; or

(3) adopt such other alternative with respect to dividend practices as the superintendent may approve.

(b) Following the effective date of the plan, the reorganized insurer shall, on or before the date on which the mutual holding company holds, directly or indirectly through one or more stock holding companies, less than seventy-five percent of the issued and outstanding voting stock of the reorganized insurer, either:

(1) (A) establish a closed block, for policyholder dividend purposes only, consisting of all of the participating individual policies and contracts of the mutual life insurer or the reorganized insurer, as the case may be, in force on the effective date and for which the insurer had an experience-based dividend scale payable in the year of the implementation date, to which closed block, on or before the implementation date, shall be allocated assets of the insurer in an amount that produces cash flows, together with anticipated revenues from the closed block business, expected to be sufficient to support the closed block business including provision for payment of claims and those expenses and taxes specified in the terms for the establishment of the closed block and to provide for continuation of the dividend practices in effect on the effective date if the closed block is established on or before the one hundred eightieth day after the effective date, or otherwise the dividend practices in effect on the implementation date, provided, however, that no policies or contracts entering into force after the implementation date will be included in the closed block, and provided, further, that, in determining dividend practices of the reorganizing insurer, the superintendent shall review dividend scales in effect for at least two years prior to the filing of the reorganization plan; and

(B) the terms for the establishment of the closed block may provide for conditions under which, with the approval of the superintendent, the reorganized insurer may cease to maintain the closed block and allocation of assets thereto, but regardless of such a cessation the policies and contracts constituting closed block business shall remain obligations of the reorganized insurer and any dividends on such policies and contracts shall be determined and apportioned by the board

of directors of the reorganized insurer in accordance with the terms of such policies and contracts and applicable provisions of this chapter; or

(2) provide as to participating individual policies and contracts of the reorganizing or reorganized insurer in such manner as the superintendent may approve.

(c) The general terms for the establishment of the closed block or such alternative provision under subsection (b) of this section and the proposed dividend policy shall be included in the plan under section eight thousand two of this article.

(d) The superintendent may appoint one or more consultants as the superintendent shall reasonably deem necessary to advise the superintendent regarding the proposed terms for the establishment of the closed block or the alternative provision under subsection (a) or (b) of this section; and the reorganizing insurer shall be responsible for the reasonable fees and expenses of any such consultants.

(e) For purposes of this section, "implementation date" means the date as of which the closed block is established, as specified in the terms for the establishment of the closed block.

§ 8004. Adoption of plan; submission of plan to the superintendent. (a) A mutual life insurer seeking to reorganize under this article shall, by action of three-fourths of its entire board of directors, adopt a plan consistent with the provisions of sections eight thousand two and eight thousand three of this article which is fair and equitable to the policyholders. The resolution shall specify the reasons for and the purposes of the proposed reorganization.

(b) The plan shall be submitted to the superintendent, together with the resolution of the board of directors of the reorganizing insurer, certified by the secretary thereof, adopting the plan pursuant to this article.

§ 8005. Amendment or withdrawal of plan. At any time before the plan of reorganization becomes effective as provided in section eight thousand nine of this article, the reorganizing insurer may, by

resolution of a three-fourths majority of its entire board of directors, amend the plan of reorganization or withdraw the plan of reorganization. In the case of a plan amendment, all references in this article to the plan of reorganization shall be deemed to refer to the plan as amended, but no amendment shall be deemed to change the adoption date of the plan of reorganization. A further public hearing is not necessary unless the superintendent determines that amendments submitted after the original hearing required under section eight thousand seven of this article will substantially alter the plan. In the event that the superintendent determines that the amendment substantially alters the plan, the plan as amended must be submitted for reconsideration by the policyholders entitled to vote on the plan as provided in section eight thousand eight of this article.

§ 8006. Consultants. The superintendent may appoint one or more consultants as the superintendent shall reasonably deem necessary to advise the superintendent in making the determination whether the proposed plan of reorganization meets the applicable requirements of this article. The reorganizing insurer shall be responsible for the reasonable fees and expenses of any such consultants. This expenditure shall not constitute an expenditure of public funds pursuant to the state finance law.

§ 8007. Approval of plan by superintendent; hearing. The superintendent shall order a public hearing on the plan to be held prior to the plan being submitted to the policyholders for their approval. The reorganizing insurer shall give written notice of the hearing to policyholders whose policies or contracts are in force on the adoption date, sent by mail or electronic transmission to the last known mailing or electronic addresses of such policyholders as shown on the records of the reorganizing insurer. Such summary notice shall be subject to the approval of the superintendent, shall include the date, time and place of the hearing, and shall include both a website address and a toll-free telephone number through which members may obtain, if not included in the summary notice, a full notice of the hearing and either a true and

correct copy of the plan, or a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require. The reorganizing insurer shall also post a copy of such notice on its website. Such notice shall be sent at least thirty days before the date specified for the hearing. The hearing shall be held at a time and location in this state deemed by the superintendent to be most convenient to the greatest number of persons affected by such plan. At such hearing any person may be heard in favor of, or against, the terms of the plan. The plan of reorganization shall be made available for public inspection at one office of the department in each city in this state where the department maintains an office and at the principal office of the reorganizing insurer. The superintendent shall approve the plan if the superintendent finds that:

(a) the plan is fair and equitable to policyholders;

(b) the plan does not violate this article; and

(c) after giving effect to the reorganization, the reorganized insurer will have an amount of capital and surplus the superintendent deems to be reasonably necessary for its future solvency.

§ 8008. Approval of plan by policyholders. (a) A proposal to approve the plan of reorganization shall be submitted to policyholders for approval. The policyholders entitled to notice of and to vote upon the proposal shall be the holders of policies or contracts which are in force on the adoption date. The reorganizing insurer shall give written notice stating the date, time and place for voting on such proposal to policyholders entitled to notice of and to vote on the proposal in accordance with this section, sent by mail or electronic transmission to the last known mailing or electronic addresses of such policyholders as shown on the records of the reorganizing insurer. Such notice shall be sent at least thirty days before the date of the proposed vote to approve the plan of reorganization. Such notice may be combined with the summary notice of the hearing required by section eight thousand seven of this article. Such notice shall be subject to the approval of the superintendent and shall include both a website address and a toll-free telephone number through which members may obtain either a true and correct copy of the plan, or a summary thereof approved by the

superintendent, and such other explanatory information as the superintendent shall approve or require.

(b) Each policyholder entitled to vote on the proposal shall be entitled to cast one vote, unless otherwise provided in the charter or by-laws of the reorganizing insurer, on the proposal, either in person or by mail or by proxy, irrespective of the number or amount of the policies or contracts he or she holds. Each proxy shall be revocable at any time, except to the extent that, at the time of attempted revocation, the power conferred thereby has already been properly exercised. All votes shall be by written ballot cast in person or by mail or by electronic means by policyholders entitled to vote or by proxy agents duly appointed by policyholders entitled to vote. The voting on the proposal shall be held at the home office of the reorganizing insurer. The polls shall be opened at ten o'clock in the forenoon and remain open until four o'clock in the afternoon of the day fixed for such voting, at which time they shall be closed.

(c) The proposal to approve the plan of reorganization shall be adopted by the affirmative vote of at least two-thirds of all votes cast by policyholders entitled to vote.

(d) The superintendent shall have power to prescribe rules governing the procedures for conduct of the voting on the proposal.

(e) The provisions of section four thousand two hundred ten of this chapter shall not apply to the action by policyholders pursuant to this section.

(f) Upon the conclusion of the vote, the reorganizing insurer shall submit to the superintendent:

(1) a certified copy of the plan of reorganization, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or an assistant secretary of the reorganizing insurer;

(2) a certificate, subscribed by the chairman of the board, the president or any vice president and attested by the secretary or assistant secretary of the reorganizing insurer, or subscribed by the person or persons, if any, designated by the superintendent to supervise the giving of notice of the date for action on the proposal, to the effect that such notice was given in accordance with this section to all policyholders entitled to such notice; and

(3) a certificate subscribed by an officer of the reorganizing insurer

of the results of the vote, as evidenced by valid ballots received before the polls were closed.

Each such certificate shall be affirmed as true under the penalties of perjury by the person or persons subscribing the same and, in the case of a certificate signed by officers of the reorganizing insurer, shall be affirmed under the corporate seal of the reorganizing insurer.

§ 8009. Filing of plan; effective date of reorganization. (a) When the superintendent has given his or her approval of the plan of reorganization as provided in section eight thousand seven of this article, and certification of approval of the plan by policyholders entitled to vote on the plan has been made to the superintendent as provided in section eight thousand eight of this article, a copy of the plan of reorganization, with the superintendent's approval endorsed thereon, shall be filed in the office of the superintendent. A copy of such plan certified by the superintendent shall also be filed by the reorganizing insurer in the office of the clerk of the county where the principal office of the reorganizing insurer is located within thirty days after the superintendent's approval.

(b) The plan of reorganization shall take effect in accordance with its terms on the date and at the time when the filing in the office of the superintendent required by this section has been made or on such later date or at such later time, if any, as may have been specified in or determined in accordance with the plan or pursuant thereto.

(c) As of the effective date, the superintendent shall issue an amended certificate of authority to the reorganized insurer, and, if the plan of reorganization specifies that the reorganized insurer proposes to continue to issue for delivery in this state participating policies or contracts, the superintendent shall, in accordance with subsection (f) of section four thousand two hundred thirty-one of this chapter, issue a permit authorizing it to do so.

§ 8010. Effect of reorganization. Upon the effective date of a plan of reorganization in accordance with section eight thousand nine of this

article:

(a) the reorganizing insurer shall immediately become a domestic stock life insurer;

(b) the members of the reorganizing insurer on the effective date shall immediately become members of the mutual holding company with membership interests therein, and all membership interests in the reorganizing insurer shall be extinguished;

(c) persons becoming policyholders of the reorganized insurer after the effective date of the plan shall become members of the mutual holding company immediately upon issuance of the policy or contract;

(d) one hundred percent of the voting stock issued by the reorganized insurer shall be owned, directly or through one or more stock holding companies, by the mutual holding company, and at no time subsequent shall such mutual holding company own less than fifty-one percent of such voting stock; and

(e) any other reorganization of the reorganizing insurer and its subsidiaries specified in the plan shall become effective in accordance with the terms of the plan. Except for the right to vote, the rights of all policyholders with respect to the reorganized insurer thereafter shall be as specified in their policies or contracts, in the charter of the reorganized insurer and in the plan of reorganization.

§ 8011. Corporate existence. (a) The reorganized insurer shall be a continuation of the reorganizing insurer, and the reorganization shall in no way annul, modify or change any of such insurer's existing suits, rights, contracts or liabilities except as provided in the approved plan of reorganization. All rights, franchises and interests of the reorganizing insurer in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be vested in the continuing company, without any deed or transfer, and simultaneously therewith such continuing company shall be subject to all of the obligations and liabilities of the reorganizing insurer, other than obligations and liabilities with respect to the policyholders' membership interests extinguished by the plan of reorganization.

(b) No action or proceeding pending at the time of the reorganization to which the reorganizing insurer may be a party shall be abated or

discontinued by reason of such reorganization, but the same may be prosecuted to final judgment in the same manner as if the reorganization had not taken place, or the reorganized insurer may be substituted in place of such reorganizing insurer by order of the court in which the action or proceeding may be pending.

§ 8012. Directors and officers. Except as otherwise provided in the plan of reorganization and subject to subsection (d) of section eight thousand seventeen of this article, the directors and officers of the reorganizing insurer shall serve as directors and officers of the reorganized insurer, any stock holding company and the mutual holding company until new directors and officers have been duly elected and qualified pursuant to the charter or certificate of incorporation and the by-laws of the respective companies.

§ 8013. Notice of proposed reorganization. (a) In addition to the notices given pursuant to section eight thousand eight of this article, the reorganizing insurer shall give written notice of the pendency of the proposed reorganization and of the effect thereof to all persons to whom the reorganizing insurer delivers policies or contracts which are issued after the adoption date and before the plan takes effect or is withdrawn, sent by mail or electronic transmission to the last known mailing or electronic addresses of such policyholders as shown on the records of the reorganizing insurer. Except as otherwise provided in this section, such persons shall have the right, unless the laws of their domiciliary state provide otherwise, to rescind such policies or contracts, and to be refunded any amounts paid with respect thereto, by written notice to such insurer or its agent given within ten days of their receipt of the aforesaid notice given by such insurer.

(b) Neither the receipt of such policy or contract nor the right to receive such notice shall entitle such persons to vote on the proposed plan of reorganization pursuant to section eight thousand eight of this article or vest such persons with any other rights or entitlements except as provided for in this article.

(c) Where, prior to the issuance of a policy or contract, the

reorganizing insurer provides the prospective policyholders with notice of the pendency of the proposed reorganization and of the effect thereof, which notice has been approved for such purpose by the superintendent, then, unless the laws of the policyholder's domiciliary state otherwise require, such policyholders shall not have the foregoing rights of rescission and refund.

§ 8014. Failure to give notice. If the reorganizing insurer complies substantially and in good faith with the requirements of this article with respect to the giving of any required notice to policyholders, its failure in any case to give such notice to any person or persons entitled thereto shall not impair the validity of the actions and proceedings taken under this article or entitle such person to any injunctive or other equitable relief with respect thereto, but this section shall not impair any claim for damages such person or persons would otherwise have due to such failure.

§ 8015. Limitations of actions; security. (a) Notwithstanding any other provision of law to the contrary and except as otherwise provided in subsection (c) or (d) of this section, actions concerning or arising out of any plan of reorganization, proposed plan of reorganization, plan amendment or proposed plan amendment under this article or any acts taken or proposed to be taken under this article must be commenced within eighteen months after the plan of reorganization or plan amendment is filed pursuant to subsection (a) of section eight thousand nine of this article or the charter is filed pursuant to subsection (c) of section eight thousand seventeen of this article, as the case may be, in the office of the superintendent or one year from the effective date of the plan of reorganization, whichever is later, or if the plan of reorganization or plan amendment is withdrawn, within one year from the date the board of directors approves a resolution to withdraw the plan. Where an action concerns or arises out of a plan amendment or proposed plan amendment made under section eight thousand five of this article, the applicable time period is measured from the filing, effective date or approval of withdrawal of the plan amendment, as the case may be.

Where the action arises out of either a transfer of subsidiaries pursuant to section eight thousand twenty of this article or a sale of securities of the reorganized insurer or any stock holding company pursuant to section eight thousand eighteen of this article, which transfer or sale is not contemplated by the plan, then the applicable time period shall be measured from the effective date of such transfer or sale, as the case may be. Where the action arises out of the terms or proposed terms for the establishment of the closed block or such alternative provision pursuant to subsection (b) of section eight thousand three of this article, then the applicable time period shall be measured from the implementation date as defined in subsection (e) of section eight thousand three of this article. Where the action concerns or arises out of a plan of reorganization adopted pursuant to section eight thousand nineteen of this article, then the applicable time period shall be measured from the effective date of the plan of reorganization.

(b) In any action referred to in subsection (a) of this section, the plaintiff or plaintiffs shall be required, upon a motion of the mutual holding company, reorganizing insurer or reorganized insurer or any stock holding company which establishes to the satisfaction of the court, that a substantial likelihood exists that such action is brought without merit and with an intention to delay or harass, to give adequate security for the damages and reasonable expenses, including attorneys' fees, which may be incurred as a result of, or in connection with, such action by such company and by any other defendants in such action or for which such company may become liable, to which security the mutual holding company, reorganizing insurer or reorganized insurer or any stock holding company shall have recourse in such amount as the court determines upon the termination of such action. The amount of security may from time to time be increased or decreased in the discretion of the court upon a showing that the security provided has or may become inadequate or excessive.

(c) Notwithstanding any other provision of law to the contrary, any action seeking a stay, restraining order, injunction or similar remedy to prevent or delay the closing of any transaction pursuant to this article or of any transaction described in the plan of reorganization must be commenced within one hundred twenty days after, as applicable: (1) the approval of a plan of reorganization by the superintendent

pursuant to section eight thousand seven or eight thousand nineteen of this article, as the case may be; or (2) the approval of the superintendent pursuant to section eight thousand twenty of this article.

(d) Any action or proceeding against the superintendent or any other governmental body or officer in connection with any act taken or order, regulation or rule issued pursuant to this article must be commenced within one hundred twenty days from the date of such act or signing of such order, regulation or rule.

(e) Any person aggrieved by any act taken or order, regulation or rule issued pursuant to this article may petition for judicial review in the manner provided by article seventy-eight of the civil practice law and rules, pursuant to the limitations period prescribed in subsection (d) of this section. The petition shall be brought in the judicial department embracing the county wherein the act was taken or the order, regulation or rule was issued. All such proceedings shall be heard and determined as expeditiously as possible and with lawful precedence over other matters. Acts taken or orders, regulations or rules issued pursuant to this article shall not be stayed or enjoined except upon application after notice to the superintendent and to the attorney general and upon a showing that the petitioner has a substantial likelihood of success and will suffer irreparable harm if the stay or injunction is not granted.

§ 8016. Prohibited transactions by officers, directors and employees. No director, officer, agent or employee of the reorganizing insurer shall receive any fee, commission or other valuable consideration whatsoever, other than regular salary and compensation, for in any manner aiding, promoting or assisting in the reorganization except as set forth in the plan approved by the superintendent.

§ 8017. Requirements applicable to a mutual holding company. (a) The following provisions of this article are applicable to a mutual holding company:

(1) the following provisions of article twelve of this chapter shall

apply to a mutual holding company as though it were a domestic mutual insurer: section one thousand two hundred one of this chapter to the extent provided in subsection (c) of this section and sections one thousand two hundred two, one thousand two hundred six, one thousand two hundred eight, one thousand two hundred nine, one thousand two hundred twelve and one thousand two hundred fifteen through one thousand two hundred nineteen of this chapter;

(2) the provisions of the business corporation law that are applicable to a domestic mutual life insurer shall apply to a mutual holding company as though it were a domestic mutual insurer; and

(3) the provisions of section four thousand two hundred ten of this chapter applicable to a domestic mutual life insurer shall be applied to a mutual holding company as though its members were voting policyholders of a mutual life insurer.

(b) A mutual holding company shall not dissolve, liquidate or wind up and dissolve except through proceedings under section eight thousand nineteen of this article, article seventy-four of this chapter for the liquidation or dissolution of the reorganized insurer or as the superintendent may otherwise approve. In the event any proceedings are instituted under article seventy-four of this chapter for the complete liquidation of reorganized insurer pursuant to this article:

(1) the mutual holding company formed as part of such reorganization shall automatically become a party to such proceedings;

(2) all of the mutual holding company's assets (including its holdings of shares in the reorganized insurer or any stock holding company) shall be deemed assets of the estate of the domestic stock life insurer to the extent necessary to satisfy claims of persons who have class one, class two, class three or class four claims under subsection (a) of section seven thousand four hundred thirty-five of this chapter with respect to such domestic stock life insurer; and

(3) members of the mutual holding company shall be deemed to hold class eight claims with respect to the mutual holding company under subsection (a) of section seven thousand four hundred thirty-five of this chapter.

(c) The charter of the mutual holding company shall be filed with the superintendent and shall contain the matters required to be contained in the charter of a domestic mutual life insurer by section one thousand

two hundred one of this chapter, except that the name of the mutual holding company shall contain the word "mutual" and shall not contain the word "insurance," "assurance" or "annuity" and the company's powers shall not include doing an insurance business. The charter shall contain provisions stating that:

(1) it is a mutual holding company organized under this article;

(2) a purpose shall be to hold, directly or through one or more stock holding companies, not less than fifty-one percent of the voting stock of a reorganized insurer;

(3) it shall not be authorized to issue voting stock;

(4) it shall not be authorized to conduct any business other than that of a holding company, except for the acquisition, ownership, management and disposition of its assets and all actions reasonably incident thereto; and

(5) it shall have members having the rights specified in this section and section eight thousand ten of this article and in its charter and by-laws. The charter shall also contain provisions setting forth any rights of members of the mutual holding company in the surplus of the mutual holding company.

(d) At least two-thirds of the directors of the mutual holding company and of any stock holding company, all of the members of the compensation committee of the board of directors of the mutual holding company and of any stock holding company, at least two-thirds of the members of any committee responsible for making decisions affecting the capital structure or mergers and acquisitions, and a majority of the directors on each other committee of the board of directors of the mutual holding company and any stock holding company shall be outside directors. The aggregate percentage of voting securities of the reorganized insurer directly or indirectly owned, controlled or held with the power to vote, either personally or by persons (other than the mutual holding company and any stock holding company) of which they are directors, officers or employees, by outside directors, shall not exceed three percent or such lesser percentage as may be determined by the superintendent in his or her approval of the mutual holding company's plan of reorganization pursuant to this article. The by-laws of the mutual holding company and any stock holding company shall provide that the affirmative vote of at least two-thirds of the board of directors of such company shall be

required for any action by such company to adopt a plan of conversion pursuant to section eight thousand nineteen of this article, enter into a merger, conduct a public offering or authorize the issuance of any voting stock or security convertible into voting stock of the reorganized insurer or the stock holding company to any person other than the mutual holding company or the stock holding company.

(e) The superintendent may, by regulation, require a mutual holding company to file annual statements with the superintendent in such form as the superintendent shall prescribe.

(f) With the written approval of the superintendent, and subject to the conditions that the superintendent may impose, a mutual holding company or stock company may:

(1) merge or consolidate with, or acquire the assets of, a mutual holding company organized pursuant to this article or pursuant to the laws of another state;

(2) either alone or together with one or more of the reorganized insurer, any stock holding companies or any subsidiaries of any of them, merge or consolidate with or acquire the assets of a mutual life insurer;

(3) merge or consolidate with any other person.

(g) A mutual holding company may also acquire the capital stock or assets of other persons.

(h) A member of a mutual holding company is not, as a member, personally liable for the acts, debts, liabilities or obligations of the company. No assessment of any kind may be imposed upon the members of a mutual holding company by the board of directors, members or creditors of the mutual holding company or because of any liability of any company owned or controlled, in whole or in part, directly or indirectly, by the mutual holding company or because of any act, debt or liability of the mutual holding company.

(i) A membership interest in a mutual holding company shall not constitute a security under the laws of this state.

(j) The superintendent shall retain jurisdiction over any mutual holding company organized pursuant to this article.

(k) Directors of the mutual holding company shall be elected by a majority vote of all members who vote in such election in person or by proxy. If the reorganized insurer takes any action (other than election

of its directors) that would require a vote of policyholders if the reorganized insurer were a mutual life insurer, then such action shall require a vote of members of the mutual holding company.

§ 8018. Other requirements applicable to a stock holding company and a mutual holding company. (a) From and after the effective date of the plan, the mutual holding company shall hold, directly or through one or more stock holding companies, at least fifty-one percent of the issued and outstanding voting stock of the reorganized insurer. The reorganized insurer and any stock holding company may issue to the mutual holding company and to other persons securities, including voting stock, non-voting stock and securities convertible into voting or non-voting stock, provided that, such issuance and the terms of such issuance shall have received the prior approval of the superintendent, who shall consider the interests of the mutual holding company and its members and who may require that, at the time of such issuance, consideration be distributed to members. For purposes of the fifty-one percent limitation, any issued and outstanding securities of the reorganized insurer or any stock holding company that are convertible into voting stock shall be considered issued and outstanding voting stock.

(b) A mutual holding company and any stock holding company shall each be deemed to be a "holding company" of the reorganized insurer within the meaning of article fifteen of this chapter, and all provisions of article fifteen of this chapter shall apply to transactions occurring between the mutual holding company, the stock holding company and the reorganized insurer. Approval of the plan of reorganization by the superintendent pursuant to this article shall constitute approval of the acquisition of control by a mutual holding company and any stock holding company under section one thousand five hundred six of this chapter, the registration by the reorganized insurer as a controlled insurer under section one thousand five hundred three of this chapter and notice of the acquisition of shares of the reorganized insurer under section four thousand two hundred three of this chapter.

(c) Outside directors of the mutual holding company, a stock holding company or the reorganized insurer shall not own beneficially, in the aggregate, more than three percent of the voting stock of the stock

holding company or the reorganized insurer.

(d) In no event shall any person, directly or indirectly, offer to acquire or acquire in any manner beneficial ownership of more than fifteen percent of any class of voting securities of the reorganized insurer, any stock holding company or any other institution which owns directly or indirectly a majority or all of the voting securities of the reorganized insurer without the prior approval of the superintendent.

(e) Any issuance of voting stock or securities convertible into voting stock or options for the purchase of voting stock of the reorganized insurer or the stock holding company prior to an initial public offering, private equity placement, or the issuance of public or private voting stock or securities convertible into voting stock of the reorganized insurer or stock holding company or any other type of capital raised shall be subject to the approval of the superintendent as to the proposed valuation of such stock or securities, the superintendent may impose conditions upon such approval, and all expenses of the superintendent's review, including without limitation those of outside consultants in reviewing such proposed valuation, shall be borne by the issuing company.

(f) In the event of an initial public offering, a stock holding company or reorganized insurer may not repurchase capital stock within one year following the date of such initial public offering, except that repurchases of no greater than five percent of the outstanding stock may be repurchased during this one year period without the approval of the superintendent.

(g) In the event of any violation of this section, or of any action which, if consummated, might constitute such a violation:

(l) all voting stock of the reorganized insurer, any stock holding company, or the reorganized mutual holding company, acquired by any person in excess of the maximum amount permitted to be acquired by such person pursuant to this subsection shall be deemed to be non-voting stock; and

(2) in addition to any other enforcement powers of the superintendent, under this chapter, such violation or action may be enforced or enjoined, as the case may be, by appropriate proceeding commenced on behalf of the reorganized insurer, any stock holding company or, if applicable, a reorganized mutual holding company, by the reorganized

insurer, the stock holding company, the mutual holding company or the superintendent, the attorney general, any member of the mutual holding company or, if applicable, a reorganized mutual holding company, or any stockholder of the reorganized insurer, any stock holding company or the reorganized mutual holding company in the supreme court in the judicial district in which the reorganized insurer has its home office or in any other court having jurisdiction, and such court may issue any order, injunctive or otherwise, it finds necessary to cure such violation or to prevent such action.

§ 8019. Conversion of mutual holding company. (a) A mutual holding company may reorganize in accordance with a plan of reorganization which is fair and equitable to the company's members and is:

(1) adopted by action of three-fourths of its entire board of directors;

(2) approved by the superintendent if found by the superintendent to be fair and equitable to the company's members after a hearing held upon notice to the company's members; and, thereafter,

(3) adopted by the affirmative vote of two-thirds of all votes cast by members of the company entitled to vote, after notice being given to all members entitled to vote. The mutual holding company shall give written notice stating the date, time and place for voting on such proposal to members entitled to notice of and to vote on the proposal in accordance with this section, sent by mail or electronic transmission to the last known mailing or electronic addresses of such policyholders as shown on the records of the mutual holding company. Such notice shall be sent at least thirty days before the date of the proposed vote to approve the plan of reorganization. Such notice may be combined with notice of the hearing required by paragraph two of this subsection. Such notice shall be preceded or accompanied by a true and correct copy of the plan, or by a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require.

(b) A plan of reorganization pursuant to subsection (a) of this section shall provide for the membership interests in the mutual holding company being extinguished and may provide either for:

(1) the conversion of the mutual holding company into a stock

corporation, in which event consideration distributed shall be equal to that required under section seven thousand three hundred twelve of this chapter or such other law governing the demutualization of mutual life insurers as may then be in effect; or

(2) the distribution to eligible members of the mutual holding company of consideration consisting of all assets of the mutual holding company including all stock of the reorganized insurer or any stock holding company owned by the mutual holding company, or other consideration having equivalent aggregate value, which may be in the form of cash, securities of any institution, additional insurance or annuity benefits or policy credits, increased dividends or other consideration, all such consideration being allocated among eligible members of the mutual holding company in a manner that is fair and equitable to the company's members.

(c) If no closed block of participating policies and contracts was established or alternative provision was approved pursuant to section eight thousand three of this article when the mutual holding company was established or thereafter, then the plan of reorganization of the mutual holding company pursuant to subsection (a) of this section shall provide for the establishment of such a closed block or alternative provision upon a reorganization of the mutual holding company under this section. Any such closed block or alternative provisions shall be subject to subsection (b) of section eight thousand three of this article. However, if a closed block of participating policies and contracts was established or alternative provision was approved pursuant to subsection (b) of section eight thousand three of this article when the mutual holding company was established or thereafter, then no such closed block or alternative provision shall be required upon a reorganization of the mutual holding company under this section.

§ 8020. Transfers of subsidiaries. A reorganizing or reorganized insurer may transfer any one or more of its subsidiaries to the mutual holding company or to one or more persons owned or controlled by the mutual holding company, provided the reorganizing or reorganized insurer obtains the prior approval of the superintendent. Any such transfer may be made without consideration as a dividend or for consideration that

may include obligations of the mutual holding company or obligations or preferred shares of a person owned or controlled by the mutual holding company. The superintendent shall approve each such proposed transfer if the superintendent finds it is fair and equitable. For a reorganizing insurer, the plan may provide for such transfer, in which case approval of the plan shall constitute approval by the superintendent pursuant to this section. The provisions of sections one thousand five hundred five and four thousand two hundred seven of this chapter shall not apply to any transfer of subsidiaries effected pursuant to this section but shall otherwise apply to the reorganized insurer and its affiliates in accordance with their terms. The provision of subparagraph (ii) of paragraph two of subsection (a) of section one thousand four hundred five of this chapter limiting the aggregate amount of investments in preferred shares of American institutions shall not apply to an investment by a reorganizing or reorganized insurer in such preferred shares received by it in consideration for a transfer pursuant to this section. For a reorganized insurer, the other provisions of this article, including, without limitation, the requirement of filing a plan of reorganization, shall not apply to the transfer of subsidiaries pursuant to this section.

§ 8021. Limitations on accumulation of surplus of mutual holding companies. (a) A mutual holding company may maintain (1) a non-insurance surplus not exceeding the aggregate capital and surplus of its insurance subsidiaries and (2) aggregate capital and surplus of its insurance subsidiaries not exceeding the surplus limit of its insurance subsidiaries, unless otherwise approved by the superintendent.

(b) As used in this section, the following terms shall have the following meanings:

(1) "Non-insurance surplus" means the mutual holding company's net worth, determined in accordance with generally accepted accounting principles on a consolidated basis, excluding the portion thereof derived from its interest in its insurance subsidiaries.

(2) "Insurance subsidiary" means a subsidiary of the mutual holding company that is a domestic insurer, a foreign insurer, an alien insurer or (notwithstanding its exemption from this chapter) a health

maintenance organization.

(3) "Aggregate capital and surplus" of a mutual holding company's insurance subsidiaries means the sum of:

(A) for each subsidiary that is a life insurance company and is not a subsidiary of another life insurance company, its statutory capital and surplus;

(B) for each subsidiary that is an insurance company other than a life insurance company, a health maintenance organization or a subsidiary of another insurance subsidiary, its statutory capital and surplus; and

(C) for each subsidiary that is a health maintenance organization and is not a subsidiary of an insurance subsidiary, thirty-five percent of its net premium written in the preceding calendar year.

(4) "Surplus limit" of a mutual holding company's insurance subsidiaries means the aggregate of:

(A) for each subsidiary that is a life insurance company and is not a subsidiary of another life insurance company, the greater of (i) eight hundred fifty thousand dollars, or (ii) ten percent of its policy reserves and policy liabilities, or (iii) ten percent of the policy reserves and policy liabilities of such life insurance company and of all subsidiaries of such company that are insurance companies, plus (x) the product of three and the authorized control level RBC of such life insurance company as determined in accordance with section one thousand three hundred twenty-two of this chapter or corresponding provisions of the law of its state of domicile, plus (y) for each subsidiary of such domestic life insurance company that is a health maintenance organization, thirty-five percent of its net premium written in the preceding calendar year, minus (z) the asset valuation reserves of such life insurance company and of all subsidiaries of such company that are life insurance companies, or (iv) the minimum amount of capital and surplus required by the law of another state in which such life insurance company is authorized to do business, all as determined in accordance with accounting practices prescribed or permitted by the superintendent, in the case of domestic insurers, or the principal regulator of any insurance subsidiary that is not a domestic insurer;

(B) for each subsidiary that is an insurance company other than a life insurance company, a health maintenance organization or a subsidiary of another insurance subsidiary, its statutory capital and surplus; and

(C) for each subsidiary that is a health maintenance organization and is not a subsidiary of an insurance subsidiary, thirty-five percent of its net premium written in the preceding calendar year;

(D) The superintendent may, for good cause shown, by order, permit such mutual holding company to maintain a surplus in excess of the maximum prescribed by subsection (a) of this section, for a specified period, not exceeding one year under any one order. The superintendent shall state in such order the reasons therefor and shall cause a statement of such order and such reasons to be published in the next annual report of the superintendent to the legislature.

ARTICLE 91

TAXES AND FEES

Section 9101. Definitions.
9102. Allocation of premiums.
9103. Tax return to be filed with superintendent; audit; examination.
9104. Fire insurance premium tax on foreign and alien insurers.
9105. Fire insurance premium tax; foreign mutual fire insurance companies.
9106. Exemptions from taxation.
9107. Fees.
9108. Fire insurance fee.
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9110. Motor vehicle law enforcement fee.
9110*2. Temporary franchise tax on certain insurance companies.
9111. Temporary franchise tax on certain insurance companies.
9111-a. Temporary franchise tax on certain insurance companies.
9111-b. Temporary franchise tax on certain insurance companies.
9111-c. Temporary franchise tax on certain insurance companies.

§ 9101. Definitions. In this article:

(a) "Insurer" includes every corporation, firm, association, individual or aggregation of individuals, by whatever name known, doing

an insurance business in this state; and every such insurer shall be an "insurance corporation" within the meaning of the tax laws of this state.

(b) "Premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and includes premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract.

§ 9102. Allocation of premiums. In determining the amount of direct premiums taxable in this state, all such premiums written, procured, or received in this state shall be deemed written on property or risks located or resident in this state except such premiums properly allocated and reported as taxable premiums of any other state or states.

§ 9103. Tax return to be filed with superintendent; audit; examination. (a) (1) Whenever this article requires an insurer to file a tax return, such return shall be subscribed by a responsible officer of such insurer and affirmed by such officer as true under the penalties of perjury.

(2) The return shall be upon a form prescribed and furnished by the superintendent, and shall be filed with the superintendent. Such form shall be arranged for the convenient determination of the amount of taxes due pursuant to this article and reconciliation of the net taxable premiums shown in such return with the amounts of total gross and net premiums shown in the annual statement of the insurer.

(b) The superintendent shall require, as a part of every tax return of taxes payable under section one thousand five hundred ten of the tax law, supplemental schedules showing:

(1) Premiums on reinsurance assumed, covering property or risks located or resident in this state, and the insurers from whom assumed; and

(2) Direct premiums, less returns, on which the tax provided for in section nine thousand one hundred four of this article or in the charters of the cities of New York and Buffalo, has been paid.

(c) In every such return the reporting of premiums for tax purposes

shall be on a written basis or on a paid for basis, consistent with the basis required by the annual statement of the insurer filed with the superintendent pursuant to section three hundred seven of this chapter.

(d) Every such return shall be subject to audit by the superintendent at any time, and for such purpose he may make such examination or investigation as he deems expedient.

§ 9104. Fire insurance premium tax on foreign and alien insurers. (a) Except in the cities of New York and Buffalo, there shall be paid by every foreign and alien fire insurance corporation, association or individuals which insure property against loss or damage by fire, except foreign mutual fire insurance companies, on or before the first day of March the sum of one dollar and eighty cents upon the hundred dollars, and at that rate, upon the amount of all premiums which during the year, or part of a year, ending on the last preceding thirty-first day of December, shall have been received by any such insurer for any insurance against loss or damage by fire written by it upon property situated within each city, village, fire district, or fire alarm district, or fire protection district to:

(1) the treasurer or other fiscal officer of the fire department affording fire protection in such city, village, fire district, fire alarm district, or fire protection district, or

(2) if any such fire department does not have a treasurer or other fiscal officer then to the fiscal officer of the authorities having jurisdiction and control of such fire department, or

(3) to such other person or entity as shall be designated in any special law to receive the premium tax, and

(4) if such payment is made to the treasurer or other fiscal officer of a fire department or fiscal officer of authorities having jurisdiction and control of such fire department, such treasurer or fiscal officer shall on or before the fifteenth day of March in each year distribute the amount so received to the fire companies constituting the fire department if such fire department is constituted of more than one fire company.

(b) There shall also be paid to the treasurer of the Firemen's Association of the State of New York, on or before the first day of

March in each year, by each such insurer, for the support and maintenance of the firemen's home at Hudson, New York, the sum of twenty cents upon the hundred dollars, and at that rate, upon the amount of all premiums upon which a fire insurance premium tax is payable as aforesaid.

(c) Each insurer required to pay a tax pursuant to this section shall, at the time of paying such tax, file with the person to whom the tax is required to be paid a report, subscribed and affirmed by the person making it as true under the penalties of perjury, setting forth the aggregate amount of premiums upon which the tax is payable.

(d) Corporations, associations or individuals required to pay a fire insurance premium tax by this section may elect to pay such tax to the superintendent, which shall be distributed by him as prescribed in this section, except that such distribution shall be made with the distribution required by section nine thousand one hundred five of this article after adding any earnings and deducting the expenses as specified in such section.

(e) Every agent for any such insurer writing a policy of fire insurance upon property in this state shall report to the insurer the name of the city, village, fire district or fire alarm district or fire protection district in which the property insured is situated, and, if the property insured is situated in territory not protected by any fire department or fire company, that fact shall be reported.

(f) Except as otherwise provided in any special law, and except as to the Firemen's Association of the State of New York, such tax shall be used for the benefit of, as determined by the members thereof:

(1) the fire company receiving the same, but this shall not preclude the payment by a fire company of all or a part of such tax so received to the fire department of which it is a part, or

(2) the fire department when such tax is not required under paragraph four of subsection (a) of this section to be distributed to fire companies.

(g) The provisions of this section shall not be changed, modified or amended by any charter, local law, ordinance, resolution or regulation.

(h) Those provisions of subsections (a) and (e) of this section which require the determination of the city, village, fire district, fire alarm district or fire protection district within which an insured

property is located shall not apply to policies which insure motor vehicles, provided that:

(1) the insurer allocates the tax to be paid on fire premiums received from such policies by city, village, fire district, fire alarm district or fire protection district using a percentage of allocation which is based upon the amounts of tax to be paid on all other fire premiums; and

(2) the insurer has received the approval of the superintendent to use this percentage of allocation.

§ 9105. Fire insurance premium tax; foreign mutual fire insurance companies. (a) (1) Every mutual fire insurance company or association authorized to do business in this state pursuant to section four thousand one hundred eight of this chapter shall pay to the superintendent on or before the fifteenth day of February of each year a tax of two per centum on all gross premiums collected or received by it or them for direct insurance against loss or injury upon property situated within this state during the preceding year ending the thirty-first day of December.

(2) The tax shall be determined after deducting from such gross premiums, premiums upon policies not taken; premiums returned on cancelled policies; and any dividends or refunds or returns paid to policyholders or applied in part payment of any renewal premium during such year.

(b) (1) Every such mutual fire insurance company or association whose business is confined chiefly to the insurance of sprinklered risks and which is conducted solely for the benefit and protection of its members and which pays no commissions or brokerages for the acquirement of its business, in lieu of all other taxes on premiums, shall pay to the superintendent on or before the fifteenth day of February of each year a tax at the rate of two per centum on all gross premiums upon policies on risks located in this state in force on the thirty-first day of December next preceding.

(2) The tax shall be determined after deducting from such gross premiums the dividends and returns and the unused or unabsorbed portion of such gross premiums computed at the average rate of such dividends and returns and the unused or unabsorbed portion of such gross premiums

actually paid to policyholders or applied in part payment of any renewal premiums on its annual policy expiring during such year.

(c) (1) On or before the fifteenth day of February of each year every mutual fire insurance company or association shall file with the superintendent a statement showing the aggregate amount of gross premiums collected for insurance against loss or injury and the several items of deduction referred to under paragraph two of subsection (a) hereof, and specifying the aggregate amounts of such gross premiums so collected and the deductions therefrom by city, village, fire district, fire alarm district, or fire protection district in which the property covered by such insurance is located.

(2) In the case of a mutual fire insurance company or association whose business is confined chiefly to the insurance of sprinklered risks and which is conducted solely for the benefit and protection of its members and which pays no commissions or brokerages for the acquirement of its business, such statement shall, in lieu of the information required pursuant to paragraph one hereof, specify by city, village, fire district, fire alarm district, or fire protection district:

(A) the aggregate amount of such gross premiums upon policies on risks located in this state in force at last year-end; and

(B) the dividends and returns and the unused or unabsorbed portion of such aggregate amount of gross premiums, computed at the average rate of such dividends and returns and the unused or unabsorbed portion of such gross premiums, actually paid or applied in part payment of any renewal premiums on its annual policies expiring during such year.

(3) Those provisions of this subsection which would require the determination of the city, village, fire district, fire alarm district or fire protection district in which an insured property is located shall not apply to policies which insure motor vehicles provided that:

(A) the mutual fire insurance company or association allocates the gross premiums and deductions, subject to the tax required by this section, received from such policies by city, village, fire district, fire alarm district or fire protection district using a percentage of allocation which is based upon the amounts of all other premiums required to be reported by this section; and

(B) the mutual fire insurance company or association has received the approval of the superintendent to use this percentage of allocation.

(d) (1) The amount of all monies which were received by the superintendent on or before the first day of April in each year under the provisions of this section or section nine thousand one hundred four of this article shall be distributed by him not later than the first day of July in such year, after adding any earnings resulting from the investment of such monies and deducting the expenses of collection and distribution. Ten percent of such remaining monies received under this section shall be paid to the treasurer of the Firemen's Association of the State of New York for the support and maintenance of the firemen's home at Hudson, New York, and the balance shall be paid as specified in paragraph two hereof, in amounts which will be that proportion of the balance so to be distributed which the total amount of fire insurance business written by foreign mutual fire insurance companies on property situated in such locality bears to the total amount of fire insurance business written by foreign mutual fire insurance companies on property situated in any and all of the protected localities in the state having treasurers or other fiscal officers as designated in paragraph two hereof afforded fire protection by a fire department or fire company and upon which the tax provided in this section has been paid.

(2) Such payment shall be made (A) in the city of New York to the fire commissioner as treasurer of the fire department of the city of New York, and

(B) to the treasurer or other fiscal officer of the fire department affording fire protection in each city, village, fire district, fire alarm district, or fire protection district, or

(C) if any such fire department does not have a treasurer or other fiscal officer then to the fiscal officer of the authorities having jurisdiction and control of such fire department, or

(D) to such other person or entity as shall be designated in any special law to receive such tax, and

(E) if such payment is received by the treasurer or other fiscal officer of a fire department or fiscal officer of authorities having jurisdiction and control of such fire department, such treasurer or fiscal officer shall on or before the fifteenth day of July in each year distribute the amount so received to the fire companies constituting the fire department if such fire department is constituted of more than one fire company.

(3) Except as otherwise provided in any special law, and except as to the Firemen's Association of the State of New York, such tax shall be used for the benefit of, as determined by the members thereof:

(A) the fire company receiving the tax, but this shall not preclude the payment by a fire company of all or a part of such tax to the fire department of which it is a part, or

(B) the fire department when such tax is not required under subparagraph (E) of paragraph two of this subsection to be distributed to fire companies.

(e) The provisions of this section shall not be changed, modified or amended by any charter, local law, ordinance, resolution or regulation.

§ 9106. Exemptions from taxation. The following shall be exempt from the payment of any taxes imposed under the provisions of this article:

(a) the government of the United States, or of any state or municipality thereof, or any instrumentality of any such government which is not subject to taxation by this state;

(b) the persons, firms, associations or corporations which are exempted from the requirement that they obtain a license to do business in this state, under the provisions of section one thousand one hundred eight of this chapter;

(c) any foreign or alien fraternal benefit society; and

(d) any corporation otherwise subject to the provisions of this article which as a health maintenance organization offers a comprehensive health services plan pursuant to the provisions of article forty-four of the public health law to subscribers. Such exemption shall be limited to that income derived from subscriber prepayments to such plan.

§ 9107. Fees. (a) In addition to any other fees provided for by law, the following shall be due and payable to the superintendent:

(1) for the initial filing by a domestic corporation of its declaration and charter, thirty dollars;

(2) for filing by a foreign or alien insurer of a certified copy of its charter incident to the issuance of a license, thirty dollars;

(3) for initial issuance of a license or filing amendments to charter of domestic insurance corporations, ten dollars;

(4) for each certificate of deposit, valuation, compliance, or other certificate, five dollars;

(5) for copying official records other than annual statements of authorized insurers, ten cents per hundred words; and

(6) for copying annual statements compiled by authorized insurers, fifty cents per page.

(b) The superintendent may in cases he deems proper remit by official order any of the fees provided for in paragraphs four, five and six of subsection (a) hereof.

§ 9108. Fire insurance fee. (a) Every insurance company authorized to do business in this state shall collect, in addition to the applicable premium charge, a fire insurance fee, separately identified and charged to each policyholder, from each such holder of a policy issued in the state or for delivery in the state for coverage of peril of fire, excluding a policy for protection of household furnishings and/or policies issued to protect one or two-family residential structures, schools, churches and hospitals.

(b) (1) The fee is hereby imposed at the rate of one and one-quarter per centum on the gross direct premium written on property or risks located in this state, provided, however, no fee shall be imposed on a policy to insure against peril of inland marine, ocean marine, automobile, or aircraft physical damage. Such fees shall be paid quarterly by insurance companies to the superintendent, after deducting from such gross premiums, (i) premiums upon policies not taken and (ii) premiums returned on cancelled policies, as follows: April fifteenth, July fifteenth, October fifteenth, and January fifteenth to reflect the net collections for the quarters ending March thirty-first, June thirtieth, September thirtieth, and December thirty-first, respectively.

(2) On or before the fifteenth day of February of each year, every insurance company required to collect the fee imposed by this section shall file with said superintendent an annual statement in a manner the superintendent shall prescribe, which statement shall show the aggregate amount of gross premiums and premium deposits and assessments collected

during the immediately preceding year for insurance against loss or injury and the several items of deduction referred to under items (i) and (ii) of paragraph one of this subsection.

(c) In case any such company shall neglect or refuse to make and file such statement or pay over moneys collected from the fee imposed by this section, the provisions of section nine thousand one hundred nine of this article shall apply.

(d) All moneys received by the superintendent shall be paid into the code enforcement account by the tenth day of the month following receipt of such moneys.

(e) The fees imposed by this section shall be applicable to said policies issued or renewed on or after July first, nineteen hundred eighty-two.

§ 9109. Refunds and penalties. (a) (1) Whenever the superintendent is satisfied that because of cancellations, some mistake of fact, error in calculation, or erroneous interpretation of a statute of this or any other state, any authorized insurer or excess line broker has paid to him pursuant to any provision of law, taxes, fees or other charges in excess of the amount legally chargeable against it during the three year period immediately preceding the cancellations or the discovery of such overpayment, he shall refund to such insurer or excess line broker the amount of such excess by applying the amount toward the payment of taxes, fees or other charges already due or which may become due from such insurer until such excess has been fully refunded or at his discretion make a cash refund. The excess line broker shall pay the insured any refund of premium tax returned to such excess line broker if such taxes were originally collected from the insured. Such cash refund may be paid from any moneys not turned over to the department of taxation and finance pursuant to the provisions of the state finance law.

(2) The superintendent shall retain from the taxes collected pursuant to this article an amount sufficient to provide at all times a fund not to exceed ten thousand dollars out of which he shall pay any refunds to which taxpayers shall be entitled under this article.

(b) (1) If a company, association or person fails within the

prescribed time to file any report or statement required by this article or by section two thousand one hundred eighteen of this chapter, or to make any payment due under the provisions of this article or sections three hundred thirty-three, one thousand one hundred twelve, two thousand one hundred five, two thousand one hundred eighteen or four thousand four hundred seven of this chapter or section two hundred six of the financial services law, the superintendent may order such company, association or person to pay to the people of this state the following penalties:

(A) not less than one hundred nor more than five hundred dollars for each and every failure to file a report or statement within the time prescribed;

(B) five percent of the principal amount of any payment due plus an additional one percent of said sum for the second and subsequent months or fractions thereof during which payment has not been made.

(2) The superintendent may, in his discretion, waive or remit all or any part of such penalties if he finds that delay was excusable.

*** § 9110. Motor vehicle law enforcement fee.** (a) Every insurance company authorized to do business in this state shall annually collect, in addition to the applicable premium charge, a motor vehicle law enforcement fee charged to each holder of a policy issued in the state or for delivery in the state for motor vehicle liability insurance coverage.

(b) The annual fee is hereby imposed at the rate of ten dollars per insured motor vehicle registered pursuant to the provisions of paragraph b of subdivision one of section four hundred one of the vehicle and traffic law. Provided, however, that such fee shall be reduced by fifty percent per insured motor vehicle registered pursuant to the provisions of paragraph b of subdivision one of section four hundred one of the vehicle and traffic law where a policy issued in the state or for delivery in the state for motor vehicle liability insurance coverage is for a term of six months or less. Such fee will be paid monthly by insurance companies to the superintendent on or before the fifteenth of the month next succeeding the month in which such collections are received.

(c) On or before the fifteenth day of February of each year, every insurance company required to collect a fee imposed by this section shall file with the superintendent an annual statement in a manner the superintendent shall prescribe reporting the number and type of insured motor vehicles and the aggregate fees collected during the immediately preceding year.

(d) In case any such company shall neglect or refuse to make and file such statement or pay over moneys collected from the fee imposed by this section the provisions of section nine thousand one hundred nine of this article shall apply.

(e) All moneys received by the superintendent which are collected from policyholders of insurance on motor vehicles shall be paid by the tenth day of the month following receipt of such collections in the following manner:

(1) Each fiscal year, the first four million seven hundred thousand dollars shall be paid to the motor vehicle theft and insurance fraud prevention fund established pursuant to section eighty-nine-d of the state finance law.

(2) All remaining moneys shall be paid to the state police motor vehicle law enforcement account established pursuant to section ninety-seven-mm of the state finance law.

(g) The fees imposed by this section shall be applicable to motor vehicles insured under policies issued or renewed on or after July first, nineteen hundred ninety-two.

* NB There are 2 § 9110's

*** § 9110. Temporary franchise tax on certain insurance companies.** 1. Imposition. (a) For the privilege of conducting business in this state and in addition to any other requirements therefor, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of thirty-five hundredths of one-percent on all gross direct premiums, less return premiums thereon, written during calendar year nineteen hundred ninety-two on risks located or resident in this state.

(b) Determination of direct premiums--general provisions. (1) The term "premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the amount of total gross premiums or deposit premiums or assessments, less return thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax on business of any other state or states. Provided however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or residents in this state. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement filed with the superintendent of financial services pursuant to section three hundred seven of this chapter.

(2) The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section four thousand two hundred thirty-six of this chapter and premiums for insurance upon hulls, freights, or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in the course of exportation from, importation into any country, or transportation coastwide, including transportation by land or water from point of origin to final destination in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for, and while awaiting shipment, and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

(3) After determining the amount of total gross premiums, less returns thereon, as hereinbefore provided, there shall be deducted the following

items:

(A) Such premiums, less return premiums thereon, which have been received by way of reinsurance from corporations or other insurers authorized to transact business in this state;

(B) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

(4) In determining the amount of direct premiums taxable in this state, all such premiums written, procured or received in this state shall be deemed written on property or risks located or residents in this state except such premiums as are properly allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax of any other state or states, provided however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located on resident in this state.

2. Payment. Taxes due under this section shall be paid to the superintendent of financial services in such manner as the superintendent shall prescribe. The tax shall be paid in two installments. The first installment shall be due December fifteenth, nineteen hundred ninety-two and shall be no less than ninety percent of the tax ultimately determined to be due under this section. The balance of any tax due shall be paid on March fifteenth, nineteen hundred ninety-three.

3. Returns and reports. A return, in a form prescribed by the superintendent, shall accompany the tax payment due March fifteenth, nineteen hundred ninety-three. In addition, the superintendent may prescribe a return to accompany the first installment of tax due December fifteenth, nineteen hundred ninety-two.

4. Interest and penalties. (a) Interest. If any amount of tax is not paid on or before the date prescribed for payment thereof in subsection two of this section, interest on such amount of tax at the underpayment rate set by the commissioner of taxation and finance pursuant to section

one thousand ninety-six of the tax law, plus one percentage point, shall be paid to the superintendent for the period from the date prescribed for payment until the date paid.

(b) Underpayment penalty. If the amount of tax paid by March fifteenth, nineteen hundred ninety-three is less than ninety-five percent of the tax ultimately determined to be due pursuant to this section, a penalty is hereby imposed equal to one hundred percent of the difference between the amount of tax actually paid and ninety-five percent of the tax ultimately determined to be due. In addition, this penalty shall bear interest at the rate set forth in paragraph (a) of this subsection for the period from March fifteenth, nineteen hundred ninety-three until the date the penalty is paid.

5. Coordination with other laws. Notwithstanding the provisions of section one thousand one hundred twelve of this chapter, taxes paid pursuant to this section shall not be considered in the calculation of reciprocal taxes due this state pursuant to section one thousand one hundred twelve of this chapter. Notwithstanding the provisions of subdivision (c) of section fifteen hundred eleven of the tax law, taxes paid to other states on account of the imposition of the tax imposed by this section shall not be included in the calculation of the tax credit provided for by subdivision (c) of section fifteen hundred eleven of the tax law.

* NB There are 2 § 9110's

*** § 9111. Temporary franchise tax on certain insurance companies.** 1. Imposition. (a) For the privilege of conducting business in this state and in addition to any other requirements therefore, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of nine-tenths of one percent of all gross direct premiums, less return premiums thereon, written during calendar year nineteen hundred ninety-two on risks located or residing in this state.

(b) Determination of direct premiums--general provisions. (1) The term

"premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the amount of total gross premiums or deposit premiums or assessments, less return thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax on business of any other state or states. Provided however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement filed with the superintendent of financial services pursuant to section three hundred seven of this chapter.

(2) The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section four thousand two hundred thirty-six of this chapter and premiums for insurance upon hulls, freights, or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in the course of exportation from, importation into any county, or transportation coastwide, including transportation by land or water from point of origin to final destination in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for, and while awaiting shipment and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

(3) After determining the amount of total gross premiums, less returns thereon, as hereinbefore provided, there shall be deducted the following items:

(A) Such premiums, less return premiums thereon, which have been received by way of reinsurance from corporations or other insurers authorized to transact business in this state;

(B) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

(4) In determining the amount of direct premiums taxable in this state, all such premiums written, procured or received in this state shall be deemed written on property or risks located or resident in this state except such premiums as are properly allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax of any other state or states, provided however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state.

2. Payment. Taxes due under this section shall be paid to the superintendent in such manner as the superintendent shall prescribe. The tax shall be paid in two installments. The first installment shall be due March first, nineteen hundred ninety-three and shall be no less than ninety percent of the tax ultimately determined to be due under this section. The balance of any tax due shall be paid on June fifteenth, nineteen hundred ninety-three.

3. Returns and reports. A return, in a form prescribed by the superintendent, shall accompany the tax payment due June fifteenth, nineteen hundred ninety-three. In addition, the superintendent may prescribe a return to accompany the first installment of tax due March first, nineteen hundred ninety-three.

4. Interest and penalties. (a) Interest. If any amount of tax is not paid on or before the date prescribed for payment thereof in subsection two of this section, interest on such amount of tax at the underpayment rate set by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, plus one percentage point, shall be paid to the superintendent for the period from the date prescribed

for payment until the date paid.

(b) Underpayment penalty. If the amount of tax paid by June first, nineteen hundred ninety-three is less than ninety-five percent of the tax ultimately determined to be due pursuant to this section, a penalty is hereby imposed equal to one hundred percent of the difference between the amount of tax actually paid and ninety-five percent of the tax ultimately determined to be due. In addition, this penalty shall bear interest at the rate set forth in paragraph (a) of this subsection for the period from June first, nineteen hundred ninety-three until the date the penalty is paid.

5. Coordination with other laws. Notwithstanding the provisions of section one thousand one hundred twelve of this chapter, taxes paid pursuant to this section shall not be considered in the calculation of reciprocal taxes due this state pursuant to section one thousand one hundred twelve of this chapter. Notwithstanding the provisions of subdivision (c) of section fifteen hundred eleven of the tax law, taxes paid to other states on account of the imposition of the tax imposed by this section shall not be included in the calculation of the tax credit provided for by subdivision (c) of section fifteen hundred eleven of the tax law.

* NB Null & void February 1, 1993 --See chap. 1/93 § 11

*** § 9111-a. Temporary franchise tax on certain insurance companies.** (a) Imposition. (1) For the privilege of conducting business in this state and in addition to any other requirements therefor, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of two percent of all gross direct premiums, less return premiums thereon, written during the "event year", as such term is defined in the following sentence, on risks located or residing in this state. For the purposes of this section, "event year" shall mean (A) the calendar year preceding the February fifth on which the budget director fails to provide a certification to the superintendent that the transfers to the

general fund that have been authorized by section five thousand five hundred sixteen-e of this chapter have been made or (B) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred sixteen-e requires a return from the general fund of any or all of the amounts transferred to such fund pursuant to such section five thousand five hundred sixteen-e.

(2) Determination of direct premiums-general provisions. (A) The term "premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the amount of total gross premiums or deposit premiums or assessments, less return thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax on business of any other state or states. Provided, however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement filed with the superintendent of financial services pursuant to section three hundred seven of this chapter.

(B) The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section four thousand two hundred thirty-six of this chapter and premiums for insurance upon hulls, freights, or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in the course of exportation from, importation into any county, or transportation coastwide, including transportation by land or water from

point of origin to final destination in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for, and while awaiting shipment and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

(C) After determining the amount of total gross premiums, less returns thereon, as hereinbefore provided, there shall be deducted the following items:

(i) Such premiums, less return premiums thereon, which have been received by way of reinsurance from corporations or other insurers authorized to transact business in this state;

(ii) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

(D) In determining the amount of direct premiums taxable in this state, all such premiums written, procured or received in this state shall be deemed written on property or risks located or resident in this state except such premiums as are properly allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax of any other state or states, provided, however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state.

(b) Payment. Taxes due under this section shall be paid to the superintendent in such manner as the superintendent shall prescribe. The tax shall be paid in two installments. The first installment shall be due within thirty days of the time at which the superintendent determines such tax is to be paid and shall be no less than ninety percent of the tax ultimately determined to be due under this section. The balance of any tax due shall be paid on the next succeeding March twenty-fifth.

(c) Returns and reports. A return, in a form prescribed by the superintendent, shall accompany the tax payment due March twenty-fifth. In addition, the superintendent may prescribe a return to accompany the first installment.

(d) Interest and penalties. (1) Interest. If any amount of tax is not

paid on or before the date prescribed for payment thereof in paragraph two of this subsection, interest on such amount of tax at the underpayment rate set by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, plus one percentage point, shall be paid to the superintendent for the period from the date prescribed for payment until the date paid.

(2) Underpayment penalty. If the amount of tax paid by March twenty-fifth is less than ninety-five percent of the tax ultimately determined to be due pursuant to this section, a penalty is hereby imposed equal to one hundred percent of the difference between the amount of tax actually paid and ninety-five percent of the tax ultimately determined to be due. In addition, this penalty shall bear interest at the rate set forth in paragraph one of this subsection for the period from the due date until the date the penalty is paid.

(e) Coordination with other laws. Notwithstanding the provisions of section one thousand one hundred twelve of this chapter, taxes paid pursuant to this section shall not be considered in the calculation of reciprocal taxes due this state pursuant to section one thousand one hundred twelve of this chapter. Notwithstanding the provisions of subdivision (c) of section fifteen hundred eleven of the tax law, taxes paid to other states on account of the imposition of the tax imposed by this section shall not be included in the calculation of the tax credit provided for by subdivision (c) of section fifteen hundred eleven of the tax law.

* NB Section null and void if schedule is submitted as provided for in § 5516-e of the insurance law.

§ 9111-b. Temporary franchise tax on certain insurance companies. (a) Imposition. (1) For the privilege of conducting business in this state and in addition to any other requirements therefor, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of one percent of all gross direct premiums, less return premiums thereon, written during the "event year", as such term is defined in the

following sentence, on risks located or residing in this state. For the purposes of this section, "event year" shall mean (A) the calendar year preceding the February fifth on which the superintendent fails to provide a certification to the state commissioner of taxation and finance that the return of premium amounts to the hospital excess liability pool that has been authorized by subsection (a) of section five thousand five hundred seventeen-a of this chapter has been made or (B) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred seventeen-a requires a return from the hospital excess liability pool of any or all of the premium amounts returned to such pool pursuant to such section five thousand five hundred seventeen-a or (C) calendar year nineteen hundred ninety-nine if the superintendent directs and the association fails to make the transfer and deposit to the hospital excess liability pool pursuant to subsection (d) of section five thousand five hundred nine of this chapter or (D) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred nine requires a return from the hospital excess liability pool of any or all of the amounts transferred and deposited to such pool pursuant to subsection (d) of section five thousand five hundred nine.

(2) Determination of direct premiums-general provisions. (A) The term "premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the amount of total gross premiums or deposit premiums or assessments, less return thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax on business of any other state or

states. Provided, however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement filed with the superintendent of financial services pursuant to section three hundred seven of this chapter.

(B) The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section four thousand two hundred thirty-six of this chapter and premiums for insurance upon hulls, freights, or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in the course of exportation from, importation into any county, or transportation coastwide, including transportation by land or water from point of origin to final destination in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for, and while awaiting shipment and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

(C) After determining the amount of total gross premiums, less returns thereon, as hereinbefore provided, there shall be deducted the following items:

(i) Such premiums, less return premiums thereon, which have been received by way of reinsurance from corporations or other insurers authorized to transact business in this state;

(ii) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

(D) In determining the amount of direct premiums taxable in this state, all such premiums written, procured or received in this state shall be deemed written on property or risks located or resident in this state except such premiums as are properly allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax of any other state or states, provided, however, in the case of special risk premiums, direct premiums shall include only those premiums

written, procured or received in this state on property or risks located or resident in this state.

(b) Payment. Taxes due under this section shall be paid to the superintendent in such manner as the superintendent shall prescribe. The tax shall be paid in two installments. The first installment shall be due within thirty days of the time at which the superintendent determines such tax is to be paid and shall be no less than ninety percent of the tax ultimately determined to be due under this section. The balance of any tax due shall be paid on the next succeeding March twenty-fifth. The superintendent is hereby authorized and directed to deposit payments made under this section, and any interest and penalties thereon, into the hospital excess liability pool created pursuant to subdivision five of section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, as amended.

(c) Returns and reports. A return, in a form prescribed by the superintendent, shall accompany the tax payment due March twenty-fifth. In addition, the superintendent may prescribe a return to accompany the first installment.

(d) Interest and penalties. (1) Interest. If any amount of tax is not paid on or before the date prescribed for payment thereof in paragraph two of this subsection, interest on such amount of tax at the underpayment rate set by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, plus one percentage point, shall be paid to the superintendent for the period from the date prescribed for payment until the date paid.

(2) Underpayment penalty. If the amount of tax paid by March twenty-fifth is less than ninety-five percent of the tax ultimately determined to be due pursuant to this section, a penalty is hereby imposed equal to one hundred percent of the difference between the amount of tax actually paid and ninety-five percent of the tax ultimately determined to be due. In addition, this penalty shall bear interest at the rate set forth in paragraph one of this subsection for the period from the due date until the date the penalty is paid.

(e) Coordination with other laws. Notwithstanding the provisions of section one thousand one hundred twelve of this chapter, taxes paid pursuant to this section shall not be considered in the calculation of reciprocal taxes due this state pursuant to section one thousand one

hundred twelve of this chapter. Notwithstanding the provisions of subdivision (c) of section fifteen hundred eleven of the tax law, taxes paid to other states on account of the imposition of the tax imposed by this section shall not be included in the calculation of the tax credit provided for by subdivision (c) of section fifteen hundred eleven of the tax law.

(f) Return of excess collections. In the event that total collections from the assessment levied pursuant to this section shall exceed the amount required to purchase policies of excess or equivalent excess coverage for eligible participating physicians and dentists for the policy year July first, nineteen hundred ninety-seven to June thirtieth, nineteen hundred ninety-eight or for the policy year July first, nineteen hundred ninety-eight to June thirtieth, nineteen hundred ninety-nine or for the policy year July first, nineteen hundred ninety-nine to June thirtieth, two thousand or for the policy year July first, two thousand to June thirtieth, two thousand one and the cost of administering the hospital excess liability pool for such applicable policy year, amounts in excess of such amount shall be returned to the companies that paid such assessment on a pro rata basis. Provided, further, that the amount required to purchase policies of excess or equivalent excess coverage for eligible participating physicians and dentists for the policy year July first, nineteen hundred ninety-seven to June thirtieth, nineteen hundred ninety-eight, or for the policy year July first, nineteen hundred ninety-eight to June thirtieth, nineteen hundred ninety-nine, or for the policy year July first, nineteen hundred ninety-nine to June thirtieth, two thousand, or for the policy year July first, two thousand to June thirtieth, two thousand one, used in the preceding sentence shall be reduced by the "retained amount", if any, as such term is defined in the following sentence. For the purposes of this section, the term "retained amount" shall mean any amount paid into the hospital excess liability pool in accordance with the provisions of section five thousand five hundred seventeen-a of this chapter which has not been returned to the medical malpractice insurance association and which is not the subject of any state or federal judicial challenge at the time the calculation of amounts to be returned to insurers pursuant to this subsection is to be made.

(g) Conditional application of tax. The provisions of subsections (a)

through (e) of this section shall apply to all premiums written during the "event year" as such term is defined in paragraph one of subsection (a) of this section. Provided, however, that if the portion of premium amounts refunded to and received by the hospital excess liability pool from the medical malpractice insurance association pursuant to the requirements of subsection (a) of section five thousand five hundred seventeen-a of this chapter is not less than the estimated cost of all premiums necessary for the purchase of excess or equivalent excess coverage for eligible participating physicians and dentists for the policy year July first, nineteen hundred ninety-seven to June thirtieth, nineteen hundred ninety-eight or for the policy year July first, nineteen hundred ninety-eight to June thirtieth, nineteen hundred ninety-nine or for the policy year July first, nineteen hundred ninety-nine to June thirtieth, two thousand or for the policy year July first, two thousand to June thirtieth, two thousand one and the cost of administering the hospital excess liability pool for such applicable policy year, as certified by the superintendent and submitted by the superintendent to the medical malpractice insurance association, then the superintendent shall certify to the state commissioner of taxation and finance no later than February fifth following the calendar year in which such return of premiums is required to be made by the medical malpractice insurance association that the required minimum return of premium amounts has been made to and received by the pool and in such event the tax otherwise imposed by subsections (a) through (e) of this section shall not be imposed and the provisions of such subsections (a) through (e) shall in such event not be applied. Provided further, however, that if there is a final judicial determination invalidating some or all of the provisions of section five thousand five hundred seventeen-a of this chapter and requiring a return from the hospital excess liability pool of any or all of the amounts transferred to it pursuant to such section five thousand five hundred seventeen-a, then the tax imposed pursuant to the provisions of subsections (a) through (e) of this section shall be reinstated and the provisions of such subsections (a) through (e) shall in such event be applied. In such event, the superintendent shall notify the state commissioner of taxation and finance that such amounts have been returned from the hospital excess liability pool and the taxes imposed pursuant to

subsections (a) through (e) of this section as modified by subsection (f) of this section shall be due and payable within thirty days of such notification.

(h) Judicial review. Notwithstanding any other law:

(1) Application for judicial review of final determination; time limitation; deposit; undertaking. Any final determination of the amount of any tax payable under subsections (a) through (e) of this section shall be reviewable for error, illegality or unconstitutionality or any other reason whatsoever by a proceeding under article seventy-eight of the civil practice law and rules if application therefor is made to the supreme court within four months after the giving of the notice of such final determination, provided, however, that any such proceeding under article seventy-eight of the civil practice law and rules shall not be instituted unless (A) the amount of any tax sought to be reviewed, with such interest and penalties thereon as may be provided for by such law, shall be first deposited with the superintendent and there is filed an undertaking, issued by a surety company authorized to transact business in this state and approved by the superintendent as to solvency and responsibility, in such amount as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed or the tax confirmed the petitioner will pay all costs and charges which may accrue in the prosecution of such proceeding or (B) at the option of the petitioner, such undertaking may be in sum sufficient to cover the taxes, interest and penalties stated in such determination, plus the costs and charges which may accrue against it in the prosecution of the proceeding, in which event the petitioner shall not be required to deposit such taxes, interest or penalties as a condition precedent to the application.

(2) Judicial review of superintendent's denial of timely application for refund or revision; time limitation; undertaking. Where any tax imposed under such subsections (a) through (e) of this section is asserted to have been erroneously, illegally or unconstitutionally assessed or collected and application for the refund or revision thereof timely made to the superintendent, and the superintendent shall have made a determination denying such refund or revision, such determination shall be reviewable by a proceeding under article seventy-eight of the civil practice law and rules, provided (A) that such proceeding is

instituted within four months after giving of the notice of such denial, (B) that a final determination of tax due was not previously made, and (C) that an undertaking is filed with the superintendent in such amount and with such sureties as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed or the tax confirmed, the petitioner will pay all costs and charges that may accrue in the prosecution of such proceeding.

(3) Exception; action for declaratory judgment; time limitation; deposit; undertaking. Except as provided in paragraphs one and two of this subsection, no determination or proposed determination of tax imposed under subsections (a) through (e) of this section shall be enjoined or reviewed by an action for declaratory judgment, an action for money had and received or by any action or proceeding under article seventy-eight of the civil practice law and rules, provided, however, that a taxpayer may proceed by declaratory judgment, if suit is instituted within thirty days after issuance of a notice of tax due and the amount of the tax in controversy, with such interest and penalties thereon as may be provided for by such law, shall be deposited with the superintendent and there is filed an undertaking, issued by a surety company authorized to transact business in this state and approved by the superintendent as to solvency and responsibility, in such amount as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed or the tax confirmed the petitioner will pay all costs and charges which may accrue in the prosecution of such proceeding or at the option of the petitioner, such undertaking may be in a sum sufficient to cover the taxes, interest and penalties stated in such notice, plus the costs and charges which may accrue against it in the prosecution of the proceeding, in which event the petitioner shall not be required to deposit such taxes, interest or penalties as a condition precedent to the application.

(4) Venue for any action or proceeding. Venue for any declaratory judgment action, article seventy-eight proceeding or any other action or proceeding in relation to this section shall be in the supreme court, Albany county, and any such action or proceeding shall be entitled to a preference both at trial and in any appeal.

§ 9111-c. Temporary franchise tax on certain insurance companies. (a) Imposition. (1) For the privilege of conducting business in this state and in addition to any other requirements therefor, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of two percent of all gross direct premiums, less return premiums thereon, written during the "event year" as such term is defined in the following sentence on risk located or residing in this state. For the purposes of this section, "event year" shall mean (A) the calendar year preceding any calendar year in which the association fails to make transfers and deposits to the miscellaneous special revenue fund that have been authorized by subsections (a) and (b) of section five thousand five hundred sixteen-f of this chapter or (B) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred sixteen-f requires a return from the miscellaneous special revenue fund of any or all of the amounts transferred and deposited in such miscellaneous special revenue fund pursuant to such section five thousand five hundred sixteen-f.

(2) Determination of direct premiums general provisions. (A) The term "premium" includes all amounts received as consideration for insurance contracts or reinsurance contracts, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, and every other compensation for such contract. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the amount of total gross premiums or deposit premiums or assessments, less return thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax on business of any other state or states. Provided, however, in the case of special risk premiums, direct

premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement filed with the superintendent pursuant to section three hundred seven of this chapter.

(B) The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section four thousand two hundred thirty-six of this chapter and premiums for insurance upon hulls, freights, or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in the course of exportation from, importation into any county, or transportation coastwide, including transportation by land or water from point of origin to final destination in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for, and while awaiting shipment and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

(C) After determining the amount of total gross premiums, less returns thereon, as provided in this subsection, there shall be deducted the following items:

(i) Such premiums, less return premiums thereon, which have been received by way of reinsurance from corporations or other insurers authorized to transact business in this state;

(ii) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

(D) In determining the amount of direct premiums taxable in this state, all such premiums written, procured, or received in this state shall be deemed written on property or risks located or resident in this state except such premiums as are properly allocated or apportioned and reported as taxable premiums or which have been used as a measure of a tax of any other state or states, provided, however, in the case of special risk premiums, direct premiums shall include only those premiums written, procured or received in this state on property or risks located or resident in this state.

(b) Payment. Taxes due under this section shall be paid to the superintendent in such manner as the superintendent shall prescribe. The tax shall be paid in two installments. The first installment shall be due in thirty days of the time at which the superintendent determines such tax is to be paid and shall be no less than ninety percent of the tax ultimately determined to be due under this section. The balance of any tax due shall be paid on the next succeeding March twenty-fifth. The superintendent is hereby authorized and directed to deposit payments made under this section, and any interest and penalties thereon, into the miscellaneous special revenue fund.

(c) Returns and reports. A return, in a form prescribed by the superintendent, shall accompany the tax payment due March twenty-fifth. In addition, the superintendent may prescribe a return to accompany the first installment.

(d) Interest and penalties. (1) Interest. If any amount of tax is not paid on or before the date prescribed for payment thereof in paragraph two of this subsection, interest on such amount of tax at the underpayment rate set by the commissioner of taxation and finance pursuant to section one thousand ninety-six of the tax law, plus one percentage point, shall be paid to the superintendent for the period from the date prescribed for payment until the date paid.

(2) Underpayment penalty. If the amount of tax paid by March twenty-fifth is less than ninety-five percent of the tax ultimately determined to be due pursuant to this section, a penalty is hereby imposed equal to one hundred percent of the difference between the amount of tax actually paid and ninety-five percent of the tax ultimately determined to be due. In addition, this penalty shall bear interest at the rate set forth in paragraph one of this subsection for the period from the due date until the date the penalty is paid.

(e) Coordination with other laws. Notwithstanding the provisions of section one thousand one hundred twelve of this chapter, taxes paid pursuant to this section shall not be considered in the calculation of reciprocal taxes due this state pursuant to section one thousand one hundred twelve of this chapter. Notwithstanding the provisions of subdivision (c) of section fifteen hundred eleven of the tax law, taxes paid to other states on account of the imposition of the tax imposed by this section shall not be included in the calculation of the tax credit

provided for by subdivision (c) of section fifteen hundred eleven of the tax law.

(f) Return of excess collections. In the event that total collections from the assessment levied pursuant to this section shall exceed the amount required to be transferred and deposited by the medical malpractice insurance association into the miscellaneous special revenue fund pursuant to section five thousand five hundred sixteen-f of this chapter, amounts in excess of such amount shall be returned to the companies that paid such assessment on a pro rata basis. Provided, further, that the amount required to be so transferred and deposited as used in the preceding sentence shall be reduced by the "retained amount", if any, as such term is defined in the following sentence. For the purposes of this section, the term "retained amount", shall mean any amount paid into the miscellaneous special revenue fund in accordance with the provisions of section five thousand five hundred sixteen-f of this chapter which is not the subject of any state or federal judicial challenge at the time the calculation of amounts to be returned to insurers pursuant to this subsection is to be made.

(g) Conditional application of tax. The provisions of subsections (a) through (e) of this section shall apply to all premiums written during the "event year" as such term is defined in paragraph one of subsection (a) of this section. Provided, however, that if the portion of amounts received by the miscellaneous special revenue fund from the medical malpractice insurance association pursuant to the requirements of section five thousand five hundred sixteen-f of this chapter is not less than the amount required to be transferred and deposited to the miscellaneous special revenue fund pursuant to section five thousand five hundred sixteen-f of this chapter then the superintendent shall certify to the commissioner of taxation and finance no later than February fifth following the calendar year in which transfer and deposit is required to be made by the medical malpractice insurance association that the required transfer and deposit of such amounts has been made to and received by the miscellaneous special revenue fund and in such event the tax otherwise imposed by subsections (a) through (e) of this section shall not be imposed and the provisions of such subsections (a) through (e) shall in such event not be applied. Provided further, however, that if there is a final judicial determination invalidating some or all of

the provisions of section five thousand five hundred sixteen-f of this chapter and requiring a return from the miscellaneous special revenue fund of any or all of the amounts transferred and deposited to it pursuant to such section five thousand five hundred sixteen-f, then the tax imposed pursuant to the provisions of subsections (a) through (e) of this section shall be reinstated and the provisions of such subsections (a) through (e) shall in such event be applied. In such event, the superintendent shall notify the commissioner of taxation and finance that such amounts have been returned from the miscellaneous special revenue fund and the taxes imposed pursuant to subsections (a) through (e) of this section as modified by subsection (f) of this section shall be due and payable within thirty days of such notification.

(h) Judicial review. Notwithstanding any other law:

(1) Application for judicial review of final determination time limitation; deposit; undertaking. Any final determination of the amount of any tax payable under subsections (a) through (e) of this section shall be reviewable for error, illegality or unconstitutionality or any other reason whatsoever by a proceeding under article seventy-eight of the civil practice law and rules if application therefor is made to the supreme court within four months after the giving of the notice of such final determination, provided, however, that any such proceeding under article seventy-eight of the civil practice law and rules shall not be instituted unless (A) the amount of any tax sought to be reviewed, with such interest and penalties thereon as may be provided for by such law, shall be first deposited with the superintendent and there is filed an undertaking, issued by a surety company authorized to transact business in this state and approved by the superintendent as to solvency and responsibility, in such amount as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed or the tax confirmed the petitioner will pay all costs and charges which may accrue in the prosecution of such proceeding or (B) at the option of the petitioner, such undertaking may be in sum sufficient to cover the taxes, interest and penalties stated in such determination, plus the costs and charges which may accrue against it in the prosecution of the proceeding, in which event the petitioner shall not be required to deposit such taxes, interest or penalties as a condition precedent to the application.

(2) Judicial review of superintendent's denial of timely application for refund or revision, time limitation; undertaking. Where any tax imposed under such subsections (a) through (e) of this section is asserted to have been erroneously, illegally or unconstitutionally assessed or collected and application for the refund or revision thereof timely made to the superintendent, and the superintendent shall have made a determination denying such refund or revision, such determination shall be reviewable by a proceeding under article seventy-eight of the civil practice law and rules, provided (A) that such proceeding is instituted within four months after giving of the notice of such denial, (B) that a final determination of tax due was not previously made, and (C) that an undertaking is filed with the superintendent in such amount and with such sureties as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed, or the tax confirmed, the petitioner will pay all costs and charges which may accrue in the prosecution of such proceeding.

(3) Exception. Action for declaratory judgment; time limitation; deposit; undertaking. Except as provided in paragraphs one and two of this subsection, no determination or proposed determination of tax imposed under subsections (a) through (e) of this section shall be enjoined or reviewed by an action for declaratory judgment, an action for money had and received or by any action or proceeding under article seventy-eight of the civil practice law and rules, provided, however, that a taxpayer may proceed by declaratory judgment, if suit is instituted within thirty days after issuance of a notice of tax due and the amount of the tax in controversy, with such interest and penalties thereon as may be provided by such law, shall be deposited with the superintendent and there is filed an undertaking, issued by a surety company authorized to transact business in this state and approved by the superintendent as to solvency and responsibility, in such amount as a justice of the supreme court shall approve to the effect that if such proceeding be dismissed or the tax confirmed the petitioner will pay all costs and charges which may accrue in the prosecution of such proceeding or at the option of the petitioner, such undertaking may be in a sum sufficient to cover the taxes, interest and penalties stated in such notice, plus the costs and charges which may accrue against it in the prosecution of the proceeding, in which event the petitioner shall not

be required to deposit such taxes, interest or penalties as a condition precedent to the application.

(4) Venue for any action or proceeding. Venue for any declaratory judgment action, article seventy-eight proceeding or any other action or proceeding in relation to this section shall be in the supreme court, Albany county, and any such action or proceeding shall be entitled to a preference both at trial and in any appeal.

ARTICLE 99

TIME OF TAKING EFFECT

Section 9901. Time of taking effect.

§ 9901. Time of taking effect. This chapter shall take effect on the first day of September next succeeding the date on which it shall have become a law.