§ 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.