§ 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.