§ 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.