§ 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.