

§ 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

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* (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;

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* (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.

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* (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;

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* (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;

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* (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.

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(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

(1-1) * (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 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 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 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 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.

(1-2) 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 tomosynthesis,

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 tomosynthesis.

(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 verify 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