§ 4321. Standardization of individual enrollee direct payment contracts offered by health maintenance organizations prior to October first, two thousand thirteen. (a) On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer a standardized individual enrollee contract on an open enrollment basis as prescribed by section forty-three hundred seventeen of this article and section forty-four hundred six of the public health law, and regulations promulgated thereunder, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act. On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen, the enrollee contracts issued pursuant to this section and section four thousand three hundred twenty-two of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-two of this article shall also be the only contracts issued by health maintenance organizations for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prevent health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

(b) The standardized individual enrollee direct payment contract shall provide coverage for all health services which an enrolled population in a health maintenance organization might require in order to be maintained in good health, rendered without limitation as to time and cost, except to the extent permitted by this chapter; provided however that no individual enrollee and no family unit enrolled in such

organization shall incur out-of-pocket costs in excess of fifteen hundred dollars and three thousand dollars, respectively, in any calendar year. Such covered services shall be identical to the in-plan covered benefits of the standardized individual direct payment enrollee contract described in section four thousand three hundred twenty-two of this article, except as otherwise provided in subsections (c), (d) and (e) of this section.

(c) The health maintenance organization shall impose a fifteen dollar copayment on all visits to a physician or other provider with the exception of visits for pre-natal and post-natal care, well child visits provided pursuant to paragraph two of subsection (j) of section four thousand three hundred three of this article, preventive health services provided pursuant to subparagraph (F) of paragraph four of subsection (b) of section four thousand three hundred twenty-two of this article, or items or services for bone mineral density provided pursuant to subparagraph (D) of paragraph twenty-six of subsection (b) of section four thousand three hundred twenty-two of this article for which no copayment shall apply. A copayment of fifteen dollars shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. A fifty dollar copayment shall be imposed on emergency services rendered in the emergency room of a hospital; however, this copayment must be waived if hospital admission results. Surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence. A five hundred dollar copayment shall be imposed on inpatient hospital services per continuous hospital confinement. Ambulatory surgical services shall be subject to a facility copayment charge of seventy-five dollars. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.

(d) The provisions of each health maintenance organization contract describing administrative procedures and other provisions not affecting the scope of, or conditions for obtaining, covered benefits, such as, but not limited to, eligibility and termination provisions, may be of the type generally used by the health maintenance organization, as long as the superintendent determines that the terms and description of those administrative and other provisions are unlikely to affect consumers'

determinations of which health maintenance organization's contract to purchase and are not contrary to law. Each contract may also include limitations and conditions on coverage of benefits described in this section provided the superintendent determines the limitations and conditions on coverage were commonly included in health maintenance organization and/or health insurance products covering individuals on a direct payment basis prior to January first, nineteen hundred ninety-six, and are not contrary to law.

(e) The superintendent shall be authorized to modify, by regulation, the copayments, deductibles and coinsurance amounts described in this section, if the superintendent determines such amendments are necessary to moderate potential premiums. On or after January first, nineteen hundred ninety-eight, the superintendent shall be authorized to establish one or more additional standardized individual enrollee direct payment contracts if the superintendent determines, after one or more public hearings, additional contracts with different levels of benefits are necessary to meet the needs of the public.

(f) No contract issued pursuant to this section or section four thousand three hundred twenty-two of this article 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 subsection, 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.