§ 4322. Standardization of individual enrollee direct payment contracts offered by health maintenance organizations which provide out-of-plan benefits 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 to individuals, in addition to the standardized contract required by section four thousand three hundred twenty-one of this article, a standardized individual enrollee direct payment contract on an open enrollment basis as prescribed by section four thousand three hundred seventeen of this article and section four thousand four hundred six of the public health law, and regulations promulgated thereunder, with an out-of-plan benefit system, 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. The out-of-plan benefit system shall either be provided by the health maintenance organization pursuant to subdivision two of section four thousand four hundred six of the public health law or through an accompanying insurance contract providing out-of-plan benefits offered by a company appropriately licensed pursuant to this chapter. On and after January first, nineteen hundred ninety-six, and until September thirtieth, two thousand thirteen, the contracts issued pursuant to this section and section four thousand three hundred twenty-one 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-one of this article shall also be the only contracts issued by the health maintenance organization 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 prohibit health maintenance

organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

(i) On and after January first, two thousand fourteen, each contract that is not a grandfathered health plan shall provide coverage for the essential health benefit package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a); and

(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).

(b) The in-plan and out-of-plan covered benefits for the standardized individual enrollee direct payment contract shall include 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.

The in-plan and out-of-plan covered services include the following:

(1) Inpatient hospital services, including:

(A) daily room and board;

(B) general nursing care;

(C) special diets; and

(D) miscellaneous hospital services.

(2) Outpatient hospital services including:

(A) diagnostic and treatment services;

(B) x-rays; and

(C) laboratory tests.

(3) Physician services including:

(A) consultant and referral services;

(B) primary and preventive care services;

(C) in-hospital medical services;

(D) surgical services;

(E) anesthetic services; and

(F) second surgical opinion.

(4) Preventive health services including:

(A) periodic physical examinations, including eye and ear examinations to determine the need for vision and hearing correction;

(B) well child care from birth;

(C) pediatric and adult immunizations;

(D) mammography screening, as provided in subsection (p) of section four thousand three hundred three of this article;

(E) cervical cytology screening as provided in subsection (t) of section four thousand three hundred three of this article; and

(F) for a contract that is not a grandfathered health plan, the following additional preventive health services:

(i) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(ii) 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;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(v) For purposes of this subparagraph, "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).

(5) Emergency services.

(6) Diagnostic laboratory services.

(7) Therapeutic and diagnostic radiologic services.

(8) Preadmission testing.

(9) Home health services up to two hundred visits per member per calendar year.

(10) Maternity care.

(11) Chemotherapy services.

(12) Hemodialysis services consistent with the provisions of subsection (gg) of section four thousand three hundred three of this article.

(13) Outpatient physical therapy up to ninety visits per condition per calendar year.

(14) Hospice care up to two hundred ten days.

(15) Skilled nursing facility care when preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.

(16) Equipment, supplies and self-management education for the treatment of diabetes.

(17) Inpatient diagnosis and treatment of mental, nervous or emotional disorders or ailments up to thirty days per calendar year combined with inpatient treatment of alcoholism and substance abuse.

(18) Inpatient diagnosis and treatment of alcoholism and alcohol abuse and substance abuse and substance dependence up to thirty days per calendar year for detoxification combined with inpatient treatment of mental, nervous or emotional disorders or ailments.

(19) Outpatient diagnosis and treatment of mental, nervous or emotional disorders or ailments up to thirty non-emergency and three emergency visits per calendar year.

(20) Ambulance services.

(21) Private duty nursing up to five thousand dollars per individual per calendar year up to a ten thousand dollar individual lifetime maximum.

(22) Prosthetics, orthotics, durable medical equipment and medical supplies.

(23) Inpatient physical rehabilitation services.

(24) Blood and blood products.

(25) Prescription drugs, including contraceptive drugs or devices approved by the federal food and drug administration or generic equivalents approved as substitutes by such food and drug administration and nutritional supplements (formulas), whether administered orally or via a feeding tube for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria, obtained at a participating pharmacy under a prescription written by an in-plan or

out-of-plan provider. Health maintenance organizations, in addition to providing coverage for prescription drugs at a participating pharmacy, may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician or other provider.

Health maintenance organizations shall impose a one hundred dollar individual deductible and a three hundred dollar family deductible per calendar year for prescription drugs obtained at a participating pharmacy. Health maintenance organizations may not impose a deductible on prescriptions obtained through the mail order drug program.

In addition to the deductible, a ten dollar copayment shall be imposed on up to a thirty-four day supply of brand name prescription drugs obtained at a participating pharmacy. A five dollar copayment shall be imposed on up to a thirty-four day supply of generic prescription drugs or brand name drugs for which there is no generic equivalent obtained at a participating pharmacy.

If a mail order drug program is utilized, a twenty dollar copayment shall be imposed on a ninety day supply of brand name prescription drugs. A ten dollar copayment shall be imposed on a ninety day supply of generic prescription drugs or brand name drugs for which there is no generic equivalent obtained through the mail order drug program.

In no event shall the copayment exceed the cost of the prescribed drug.

(26) 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 subparagraphs (A), (B) and (C) of this paragraph, 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:

(A) For purposes of subparagraphs (B) and (C) of this paragraph, 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.

(B) For purposes of subparagraphs (A) and (C) of this paragraph, 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.

(C) Such coverage required pursuant to subparagraph (A) or (B) of 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 policy.

(D) In addition to subparagraph (A), (B) or (C) of this paragraph, except for a grandfathered health plan under subparagraph (E) of this paragraph, coverage shall be provided for the following items or services for bone mineral density, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) 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

(ii) with respect to women, such additional preventive care and screenings for bone mineral density not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, "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).

(27) 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 under such policy 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.

(b-1) The in-plan and out-of-plan covered benefits for the standardized individual enrollee direct payment contracts established by this section and section four thousand three hundred twenty-one of this article shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by health maintenance organizations or insurers for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(b-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages

for any decision or action pursuant to subsection (b-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(b-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the contracts established by this section and section four thousand three hundred twenty-one of this article for those persons required to register as sex offenders pursuant to article six-C of the correction law.

(c) The in-plan benefit system shall impose a ten 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 this section or items or services for bone mineral density provided pursuant to subparagraph (D) of paragraph twenty-six of subsection (b) of this section for which no copayment shall apply. A copayment of ten dollars shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. A thirty-five 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.

(d) The out-of-plan benefit system shall have an annual deductible established at one thousand dollars per calendar year for an individual and two thousand dollars per year for a family. Coinsurance shall be established at twenty percent with the health maintenance organization or insurer paying eighty percent of the usual, customary and reasonable charges, or eighty percent of the amounts listed on a fee schedule filed with and approved by the superintendent which provides a comparable level of reimbursement. Coinsurance of ten percent shall apply to outpatient visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. The benefits described in subparagraph

(F) of paragraph three and paragraphs seventeen and eighteen of subsection (b) of this section shall not be subject to the deductible or coinsurance. The benefits described in paragraph nine of subsection (b) of this section shall not be subject to the deductible. The out-of-plan out-of-pocket maximum deductible and coinsurance shall be established at three thousand dollars per calendar year for an individual and five thousand dollars per calendar year for a family. The out-of-plan lifetime benefit maximum shall be established at five hundred thousand dollars for benefits that are not essential health benefits. A lifetime limit on the dollar amount of essential health benefits for any individual shall not be established. For purposes of this subsection, "essential health benefits" shall have the meaning ascribed by section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b).

(e) The provisions of each 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 issued by the health maintenance organization and/or insurer, 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 the 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.

(f) A health maintenance organization may offer the required out-of-plan benefits by means of a rider to a contract offering in-plan benefits only.

(g) Day and visit limitations on benefits included in this section are aggregate limitations regardless of whether services are received in-plan or out-of-plan. The five thousand dollar per individual per calendar year limitation and ten thousand dollar lifetime limitation on private duty nursing is also an aggregate limitation for in-plan and out-of-plan benefits combined.

(h) 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.

(i) On and after January first, two thousand fourteen, each contract that is not a grandfathered health plan shall provide coverage for the essential health benefit package. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a); and

(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).