§ 4804. Access to specialty care. (a) If an insurer offering a managed care product determines that it does not have a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, the insurer shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the non-participating provider and the insured or the insured's designee, at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

(b) An insurer offering a managed care product shall have a procedure by which an insured enrolled in such managed care product who needs ongoing care from a specialist may receive a standing referral to such specialist. If the insurer, or the primary care provider in consultation with the insurer and the specialist, determines that such a standing referral is appropriate, the insurer shall make such a referral to a specialist. In no event shall an insurer be required to permit an insured to elect to have a non-participating specialist, except pursuant to the provisions of subsection (a) of this section. Such referral shall be pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the specialist, and the insured or the insured's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(c) An insurer shall have a procedure by which a new insured upon enrollment in a managed care product, or an insured in a managed care product upon diagnosis, with (1) a life-threatening condition or disease or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer, or primary care provider in consultation with the insurer and the specialist, if any, determines that the insured's care would most appropriately be

coordinated by such a specialist, the insurer shall refer the insured to such specialist. In no event shall an insurer be required to permit an insured to elect to have a non-participating specialist, except pursuant to the provisions of subsection (a) of this section. Such referral shall be pursuant to a treatment plan approved by the insurer, in consultation with the primary care provider if appropriate, the specialist, and the insured or the insured's designee. Such specialist shall be permitted to treat the insured without a referral from the insured's primary care provider and may authorize such referrals, procedures, tests and other medical services as the insured's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If an insurer refers an insured to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

(d) An insurer offering a managed care product shall have a procedure by which an insured enrolled in such managed care product with (1) a life-threatening condition or disease or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the insurer, or the primary care provider or the specialist designated pursuant to subsection (c) of this section, in consultation with the insurer, determines that the insured's care would most appropriately be provided by such a specialty care center, the insurer shall refer the insured to such center. In no event shall an insurer be required to permit an insured to elect to have a non-participating speciality care center, unless the insurer does not have an appropriate specialty care center to treat the insured's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the insurer, in consultation with the primary care provider, if any, or a specialist designated pursuant to subsection (c) of this section, and the insured or the insured's designee. If an insurer refers an insured to a specialty care center that does not participate in the insurer's managed care provider network, services provided pursuant to the approved treatment plan shall

be provided at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network. For purposes of this subsection, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(e) (1) If an insured's health care provider leaves the insurer's in-network benefits portion of its network of providers for a managed care product for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph one of subsection (b) of section forty-eight hundred three of this chapter, the insurer shall provide written notice to the insured of the provider's disaffiliation and permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of: (A) ninety days from the later of the date of the notice to the insured of the provider's disaffiliation from the insurer's network or the effective date of the provider's disaffiliation from the insurer's network; or (B) if the insured is pregnant at the time of the provider's disaffiliation, the duration of the pregnancy and post-partum care directly related to the delivery.

(2) During the transitional period the health care provider shall: (A) continue to accept reimbursement from the insurer at the rates applicable prior to the start of the transitional period, and continue to accept the in-network cost-sharing from the insured, if any, as payment in full; (B) adhere to the insurer's quality assurance requirements and provide to the insurer necessary medical information related to such care; and (C) otherwise adhere to the insurer's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer.

* (f) If a new insured whose health care provider is not a member of the insurer's in-network benefits portion of the provider network enrolls in the managed care product, the insurer shall permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of up to sixty

days from the effective date of enrollment, if (1) the insured has a life-threatening disease or condition or a degenerative and disabling disease or condition or (2) the insured has entered the second trimester of pregnancy at the time of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an insured elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the insurer for the transitional period only if the health care provider agrees (A) to accept reimbursement from the insurer at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the insurer's network for such services; (B) to adhere to the insurer's quality assurance requirements and agrees to provide to the insurer necessary medical information related to such care; and (C) to otherwise adhere to the insurer's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer. In no event shall this subsection be construed to require an insurer to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the insured's contract.

* NB Effective until January 1, 2027

* (f) If a new insured whose health care provider is not a member of the insurer's in-network benefits portion of the provider network enrolls in the managed care product, the insurer shall permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of up to ninety days from the effective date of enrollment. If the insured is pregnant at the time of enrollment, the transitional period shall include the provision of care for the duration of the pregnancy and postpartum care directly related to the delivery. If an insured elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the insurer for the transitional period only if the health care provider agrees: (A) to accept reimbursement from the insurer at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network

benefits portion of the insurer's network for such services; (B) to adhere to the insurer's quality assurance requirements and agrees to provide to the insurer necessary medical information related to such care; and (C) to otherwise adhere to the insurer's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer. In no event shall this subsection be construed to require an insurer to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the insured's contract.

* NB Effective January 1, 2027