

Out-of-Network Law (OON) Guidance (Part H of Chapter 60 of the Laws of 2014)

Health Plan Disclosure Requirements

1. Provider Directory:

- Insurance Law §§ 3217-a(a)(17) and 4324(a)(17) and Public Health Law § 4408(r) require health plan provider directories to include a listing by specialty of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The law requires a health plan to post the listing on its website and further requires a health plan to update its website within 15 days of the addition or termination of a provider from its network or a change in a physician's hospital affiliation. Health plans should include language in their provider contracts requiring physicians to annually report hospital affiliations and languages spoken to health plans for inclusion in the health plan's provider directory, and to report any changes in hospital affiliations within 15 days of the change. The Department of Financial Services understands that health plans may be relying on physicians to report changes in physician hospital affiliations and the Department will take that into account with respect to this requirement.

2. OON Reimbursement Compared to UCR:

- Insurance Law §§ 3217-a(a)(19)(B) and 4324(a)(20)(B) and Public Health Law § 4408(1)(t)(ii) require health plans to disclose the amount they will reimburse under their OON methodology set forth as a percentage of the usual and customary cost ("UCR"). This requirement will be satisfied if a health plan provides the approximate percentage of UCR that equates to the reimbursement under the health plan's OON methodology.

3. OON Reimbursement Examples:

- Insurance Law §§ 3217-a(a)(19)(C) and 4324(a)(20)(C) and Public Health Law § 4408(1)(t)(iii) require health plans to provide examples of anticipated out-of-pocket costs for frequently billed OON services. This requirement will be satisfied if a health plan provides at least three examples which include examples for a colonoscopy (CPT code 45380), spinal surgery (CPT code 63030), and breast reconstruction (CPT code 19357) in a format provided by the Department of Financial Services.

4. Determining OON Out-of-Pocket Costs:

- Insurance Law §§ 3217-a(a)(20) and 4324(a)(21) and Public Health Law § 4408(1)(u) require health plans to disclose information that permits an insured or prospective insured to determine out-of-pocket costs for OON services. A health plan may satisfy this requirement through a link on its website to an independent

source which can be used to determine UCR for OON services. FAIR Health may be used as the independent source to determine UCR and use of FAIR Health will satisfy the requirements of these sections. If a health plan uses FAIR Health, the health plan will need to contact FAIR Health in order to set up a licensing arrangement to establish a link. If a health plan does not use FAIR Health, the health plan will need to contact the Department of Financial Services for approval.

5. Reimbursement for Specific OON Service:

- Insurance Law §§ 3217-a(b)(14) and 4324(b)(14) and Public Health Law § 4408(2)(n) require health plans to disclose, upon request, the approximate dollar amount that they will pay for a specific out-of-network service. If a health plan is unable to identify a specific dollar amount because the current procedural terminology (CPT) code(s) or diagnosis code(s) were not submitted with the request, a health plan may disclose the range of dollar amounts that it will pay for the OON service. The health plan should also include a disclaimer that the dollar amount could change based on the actual services provided and CPT code(s) or diagnosis code(s) submitted. A health plan may use either of the following disclaimer statements:
 - Please note that this amount is only an estimate based on the information submitted and not a guaranteed amount. Your actual out-of-pocket costs may differ based on a number of factors, including, for example, your eligibility, the actual services provided to you, the procedure codes submitted by your provider, whether other providers render services to you, the location of the services, your cost-sharing requirements, or other variables that may impact the cost of services. Also, even though your provider may bill separately for multiple procedure codes, we may determine that there is a single code that should have been billed for all of the procedures, and we will pay for only that code.
 - This payment estimate is not a guarantee. The actual payment will depend on a number of factors, including, for example, the services you receive, the amount billed by your doctor or other provider, the actual procedure codes submitted, and your eligibility for benefits at the time you receive the services.

OON Make Available Benefit

1. Insurance Law § 3241(b)(1)(A) requires health plans that issue a comprehensive group policy that covers out-of-network services to make available at least one alternative option for out-of-network (“OON”) coverage using UCR after imposition of 20% coinsurance (“OON make available benefit”). UCR in this case is the 80th percentile of charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as the requested service as reported in a benchmarking database maintained by a nonprofit organization specified by the

Superintendent of Financial Services. FAIR Health data may be used as the independent source to determine UCR. A health plan will need to contact FAIR Health in order to set up a licensing arrangement to use FAIR Health data.

2. The OON make available benefit is applied on a licensed entity basis. For example, if an insurer offers out-of-network coverage but an affiliated HMO does not, only the insurer is required to offer the OON make available benefit.
3. The OON make available benefit does not require health plans to offer OON benefits in a market in which they do not currently offer any coverage, or in which they do not offer out-of-network coverage. For example, if a health plan only offers coverage to large groups, or only offers out-of-network coverage to large groups, the health plan would not be required to offer the OON make available benefit in the small group market.
4. If an HMO offers combination products with an Insurance Law Article 42 and 43 POS product, either of the Article 42 or 43 affiliates can satisfy the OON make available benefit requirement.
5. The OON make available benefit is not required to attach to every metal level. A health plan should not offer the OON make available benefit at the bronze level only, unless the health plan offers all other OON coverage at the bronze level only.
6. A health plan may impose a deductible on the OON make available benefit if the deductible is comparable to the deductible imposed on other out-of-network options offered by the health plan.
7. The OON coverage may be made available through a rider or it can be embedded in a contract.
8. Pursuant to federal guaranteed availability requirements and state NYSOH participation requirements, if a health plan offers the OON make available benefit outside the NYSOH, and the health plan participates on the NYSOH, it is required to offer the benefit inside the NYSOH. If a health plan offers the OON make available benefit inside the NYSOH, it is required to offer the benefit outside the NYSOH. A health plan is required to offer the OON make available benefit at the same metal level in the same geographical region inside and outside the NYSOH.
9. If a health plan has existing policy form language approved that meets the requirements of the OON make available benefit, the health plan may use the previously approved language. However, the health plan should provide the Department of Financial Services with the state tracking number for the submission containing the previously approved policy form language when making a new submission.

10. If there is no OON coverage available in a rating region, a health plan that issues a comprehensive group policy in the rating region may be required to make available at least one option for OON coverage using UCR after imposition of 20% coinsurance.

UCR

1. FAIR Health may be used as the independent source to determine UCR. If a health plan uses FAIR Health as its independent source, it should contact FAIR Health to set up a licensing arrangement to use FAIR Health data. If a health plan does not use FAIR Health, the health plan will need to contact the Department of Financial Services for approval.

Claim Submission

1. Insurance Law § 3224-a requires health plans to accept claims submitted by an insured in writing and electronically. A health plan may establish a designated electronic and mailing address for submission of claims and should prominently post the address on its website and in plan materials. A health plan may also post language on its website to refer insureds to an address on their health plan identification card.

Initial Utilization Review Preauthorization Approval Determinations

1. Insurance Law § 4903(b) and Public Health Law § 4903(2) require initial utilization review preauthorization approval determinations to identify whether the services are considered in-network or out-of-network.
 - This requirement is applicable when the provider who will be performing the service is identified at the time the preauthorization request is made.
 - This requirement is not applicable to concurrent or retrospective utilization determinations pursuant to Insurance Law § 4903(c) and (d) and Public Health Law § 4903(3) and (4).
 - Initial utilization review preauthorization denial determinations (for example medical necessity or experimental or investigational denials) do not need to identify whether the services are considered in-network or out-of-network.
 - Initial determinations that deny an out-of-network service or referral because the insured does not have out-of-network benefits are subject to the grievance procedure under Insurance Law § 4802 and Public Health Law § 4408-a and are not subject to the utilization review requirements of Insurance Law § 4903(b) and Public Health Law § 4903(2).

2. Health Plans may use the following template language in their initial utilization review preauthorization approval determinations to comply with Insurance Law § 4903(b) and Public Health Law § 4903(2) to address when the provider has not been identified; when the provider has been identified; and when the provider is out-of-network:

- You have not identified the provider that will provide this service.
- [provider name], the provider that you identified to provide this service, is a participating provider with our plan. You will not be responsible for any payments beyond your applicable in-network cost-sharing requirements.
- [provider name], the provider that you identified to provide this service, does not participate with our plan. You will be responsible for the difference between our payment and the provider's charge, in addition to your applicable out-of-network cost-sharing requirements. If you believe there is not an appropriate in-network provider to provide this service, you may request a referral or authorization to an out-of-network provider. *{Drafting Note: To be used for PPO or POS coverage.}*

3. Insurance Law § 4903(b) and Public Health Law § 4903(2) require initial utilization review preauthorization approval determinations to identify the dollar amount a health plan will pay if the service is reimbursed under the insured's out-of-network benefits (such as PPO or POS coverage). If a health plan is unable to identify a specific dollar amount because the CPT code or codes or diagnosis code were not submitted with the request, a health plan may disclose the range of dollar amounts that it will pay for the OON service. Health plans may use the following template language in their initial utilization review preauthorization approval determinations to address the dollar amount a health plan will pay if the service is reimbursed under the insured's out-of-network benefits (such as PPO or POS coverage):

- Our payment for these services can range from \$XX to \$XX, depending on the actual services provided.
- Based on the CPT codes you provided, our payment for these services will be approximately \$XX.

4. Health plans should also include a disclaimer that the approval is not a guarantee of payment and the dollar amount could change based on the actual services provided and CPT code or codes submitted. Health plans may use the following disclaimer language:

- Please note that this amount is only an estimate based on the information submitted and not a guaranteed amount. Your actual out-of-pocket costs may differ based on a number of factors, including, for example, your eligibility, the actual services provided to you, the procedure codes submitted by your provider, whether other providers render

services to you, the location of the services, your cost-sharing requirements, or other variables that may impact the cost of services. Also, even though your provider may bill separately for multiple procedure codes, we may determine that there is a single code that should have been billed for all of the procedures and we will pay for only that code.

- This payment estimate is not a guarantee. The actual payment will depend on a number of factors, including, for example, the services you receive, the amount billed by your doctor or other provider, the actual procedure codes submitted, and your eligibility for benefits at the time you receive the services.

5. Insurance Law § 4903(b) and Public Health Law § 4903(2) require initial utilization review preauthorization approval determinations to provide information explaining how the insured may determine the anticipated out-of-pocket costs for out-of-network services in a geographical area or zip code based upon the difference between what the health plan will reimburse and the usual and customary cost for out-of-network services. Health plans may use the following language to comply with this requirement:

- You can determine your anticipated out-of-pocket cost for these services by contacting your provider for the amount that he/she will charge, or by visiting [link to FAIR Health or plan calculator] to determine the usual and customary cost for these services in your geographic area or zip code, and comparing it to our estimated payment.

{Drafting Note: If a health plan will be using FAIR Health as its independent source, it will need to contact FAIR Health to set up a licensing arrangement.}

Out-of-Network Referral Denial – Initial Denials

1. If a health plan denies a referral to an out-of-network provider because the health plan has an in-network provider(s) with the appropriate training and experience to meet the particular health care needs of an insured and who is able to provide the requested service, the health plan should, in its initial denial letter:

- Provide the name of the in-network provider(s) with the appropriate training and experience who is able to provide the requested service.
- Include language that provides “If you believe there is not an appropriate in-network provider to provide this service, you may file a utilization review appeal if you submit a written statement from your attending physician that: (1) in-network providers do not have the appropriate training and experience to meet your needs and; (2) recommends an out-of-network provider with the appropriate training and experience who is able to provide the service. For this purpose, your attending physician must be a licensed, board

certified or board eligible physician qualified to practice in the specialty area appropriate to treat you for the service.”

2. If an insured requests a referral or authorization to an out-of-network provider for a service that requires preauthorization, and the health plan believes the service could be provided in-network and further believes that the service is not medically necessary, the health plan should include both denial reasons in one initial denial letter. If a health plan is unable to include both denial reasons in one initial denial letter, the health plan may issue two separate initial denial letters, a grievance determination for the services of the out-of-network provider, and a utilization review determination for the medical necessity of the service. If the health plan issues two separate letters, the health plan should, in each letter, clarify that another letter has been issued.
3. If an insured requests a referral or authorization to an out-of-network provider for a service that requires preauthorization, and the health plan believes the service could not be provided in-network but further believes the service is not medically necessary, the health plan should deny the service as not medically necessary and also clearly indicate agreement that the referral to the out-of-network provider is appropriate (in the event the medical necessity determination is overturned on appeal). If the medical necessity determination is overturned on internal appeal or external appeal, the health plan should not require the insured to repeat the authorization request for the out-of-network referral.

Out-of-Network Referral Denial – Internal Appeals

1. Insurance Law § 4904(a-2) and Public Health Law § 4904(1-b) require an appeal regarding a referral to an out-of-network provider to be treated as a utilization review appeal and not a grievance if the insured submits a written statement from the insured’s attending physician that: (1) the in-network provider(s) does not have the appropriate training and experience to meet the insured’s particular health care needs; and (2) recommends an out-of-network provider with the appropriate training and experience to meet the insured’s particular health care needs who is able to perform the requested service.
2. If a health plan denies both a referral or authorization to an out-of-network provider and preauthorization for a service, and an insured appeals the denial of a referral or authorization to an out-of-network provider and provides the requisite written statement from his or her attending physician described above, the health plan should review both issues on appeal and address both the referral to the out-of-network provider and the medical necessity of the service in the final adverse utilization review appeal determination. The final adverse determination should indicate whether the health plan is upholding its denial of a referral to an out-of-network provider, and whether it is upholding its medical necessity denial (because it does not believe the services are medically necessary either in or out-of-network).

3. A health plan, in its final adverse utilization review appeal determination of a referral to an out-of-network provider, should provide the name of at least one in-network provider with the appropriate training and experience to meet the insured's particular health care needs who is able to perform the requested service. The external appeal agent will only consider the providers listed in the final adverse utilization review appeal determination letter when making its determination about the health plan's in-network providers.
4. A health plan should verify that the in-network provider(s) that it identified performs the requested service or treatment, is accepting new patients, and can see the insured within a reasonable amount of time, taking the insured's condition into consideration, at the time the final adverse utilization review appeal determination letter is issued.

Out-of-Network Referral Denial – External Appeals

1. Insurance Law § 4914(b)(4)(D)(ii)(I) and Public Health Law § 4914(2)(d)(D)(ii)(1) require external appeal agents to consider the training and experience of the in-network provider or providers proposed by the plan, the training and experience of the out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the insured's medical record, and any other pertinent information.
2. Insurance Law § 4914(b)(4)(D)(ii)(I) and Public Health Law § 4914(2)(d)(D)(ii)(1) provide that an external appeal agent shall overturn a health plan's denial if the agent finds that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of the insured who is able to provide the requested service, and that the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome.
3. External appeal agents may need to request information from the health plan to determine whether the in-network provider is able to provide the requested health service. External appeal agents may also need to request information from the insured and the insured's attending physician to determine whether the recommended out-of-network provider is able to provide the requested health service.
4. If a final adverse determination denies both a referral or authorization to an out-of-network provider and a preauthorization for a service as not medically necessary, the external appeal agent will first review the medical necessity of the service.
 - If the external appeal agent finds the service to be medically necessary, the external appeal agent will then review whether the health plan has a provider with the

appropriate training and experience to meet the particular health care needs of the insured who is able to provide the requested service.

- If the external appeal agent does not find the service to be medically necessary, the external appeal agent will not review whether the health plan has a provider with the appropriate training and experience to meet the particular health care needs of the insured who is able to provide the requested service.

Surprise Bills

1. Financial Services Law § 603(h) defines a “surprise bill” as a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable, or a non-participating physician renders services without the insured’s knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician; or (2) an insured for services rendered by a non-participating provider where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health plan.
 - In order for a participating physician to be considered available, the insured should have a meaningful opportunity to choose an in-network physician in advance of the services.
 - A surprise bill includes services referred by a participating physician to a non-participating provider without the explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health plan. A referral to a non-participating provider occurs when (1) the health care services are performed by a non-participating health care provider in the participating physician’s office or practice during the course of the same visit; (2) the participating physician sends a specimen taken from the patient in the physician’s office to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under the insured’s contract (i.e. a gatekeeper).
2. The independent dispute resolution (IDR) process in Article 6 of the Financial Services Law could apply to surprise bills for health care services that are provided by out-of-state providers if the service is performed in part in New York and the out-of-state provider has a sufficient nexus with New York.

- For example, if the insured is covered under an HMO or insurance policy or contract that is issued for delivery in New York and has blood drawn in New York by his or her participating physician. The participating physician sends the sample to an out-of-state laboratory that regularly conducts business with the New York provider. The laboratory may be providing services in New York and subject to the IDR process.
3. If a health plan or provider does not believe that a bill meets the definition of a surprise bill, the health plan or provider may contact the Consumer Assistance Bureau of the Department of Financial Services and may submit any relevant information to the Consumer Assistance Bureau. If the dispute has been submitted to an independent dispute resolution entity, a health plan, provider or consumer should also submit any relevant information to the independent dispute resolution entity.
 4. The Department of Financial Services has developed a standard assignment of benefits form for consumers to use.
 5. If a consumer submits an assignment of benefits to a health plan for a bill that may be a surprise bill but does not use the Department of Financial Services' standard assignment of benefits form, the health plan should contact the consumer and request that the consumer complete the Department of Financial Services' assignment of benefits form in order for the bill to be considered a surprise bill. The health plan should provide the consumer with a copy of the Department of Financial Services' standard assignment of benefits form.
 6. If a health plan receives a bill that it believes is a surprise bill, but does not receive an assignment of benefits form, the health plan may pay the amount that the health plan determines is reasonable for the health care services rendered. Otherwise, the health plan is required to process the claim according to the terms of the subscriber contract in relation to out-of-network claims. Note also, the health plan is nevertheless required to comply with HMO hold harmless rules required by the Department of Health for HMO and gatekeeper EPO products.
 7. Financial Services Law § 606 requires providers to hold insured patients that have completed an assignment of benefits form harmless for a surprise bill. HMOs and gatekeeper EPOs are also required to hold insureds harmless for a surprise bill pursuant to hold harmless requirements imposed under the Public Health Law and regulations.
 8. Examples of surprise bills include but are not limited to the following:
 - An insured's contract does not require the insured to obtain a referral before getting services and the contract covers out-of-network services. The insured has blood drawn

in a participating physician's office and the specimen is sent to a non-participating laboratory without the insured's explicit written consent acknowledging that the participating physician is referring the insured to a non-participating laboratory and that the referral may result in costs not covered by the health plan. The bill would be a surprise bill and would be covered as in-network.

- An insured is admitted to a participating hospital following emergency services. During that hospital stay, consultation services are provided by specialists who do not participate with the insured's health plan and either: (1) a participating physician is unavailable; or (2) a non-participating physician renders services without the insured's knowledge; or (3) or unforeseen services arise at the time services are rendered.
- An insured is admitted to a participating hospital for a scheduled hospital admission. During that hospital stay, consultation services are provided by specialists who do not participate with the insured's health plan and either: (1) a participating physician is unavailable; or (2) a non-participating physician renders services without the insured's knowledge; or (3) or unforeseen services arise at the time services are rendered.

9. Examples of bills that are not surprise bills include but are not limited to the following:

- An insured's contract does not require the insured to obtain a referral before getting services. A participating physician provides the insured with a list of local laboratories and recommends that the insured make an appointment to have blood work done.
- An insured's contract does not require the insured to obtain a referral before getting services. A participating provider who is not a physician (for example a speech therapist) refers the insured to a non-participating provider (for example a durable medical equipment provider).
- An insured requests a referral or authorization to a non-participating provider, the referral or authorization is denied by the health plan, and the insured subsequently obtains the services of the non-participating provider.
- An insured is admitted to a non-participating hospital. During that hospital stay, consultation services are provided by specialists who do not participate with the insured's health plan.

Emergency Services

1. The Affordable Care Act (ACA) requires a health plan to reimburse out-of-network emergency services at least the greater of: 1) the amount the health plan has negotiated with participating providers for emergency services (and if more than one amount is negotiated,

the median of the amounts); 2) 100% of the allowed amount for services provided by a non-participating provider (i.e., the amount that the health plan would pay in the absence of any cost-sharing that would otherwise apply for services of non-participating providers); or 3) the amount that would be paid under Medicare.

2. Public Health Law and regulation currently require HMOs to hold insureds harmless for charges in excess of the in-network deductible, copayments or coinsurance for OON emergency services in a hospital. Beginning on renewal, on and after March 31, 2015, Insurance Law § 3241(c) will also require insurers to hold insureds harmless for charges in excess of the in-network deductible, copayments or coinsurance for OON emergency services in a hospital. The hold harmless requirements for out-of-network emergency services apply to both physician services in a hospital and hospital charges, both within and outside New York. However, the IDR process in Article 6 of the Financial Services Law for emergency services applies only to physician services in a hospital in New York.
3. When a dispute for out-of-network emergency physician services is submitted to IDR, a health plan will need to provide reimbursement for the out-of-network service in the amount determined by the IDR entity, which may exceed the reimbursement amount required under the ACA.
4. With respect to disputes involving out-of-network emergency physician services in a hospital that are not submitted to IDR, or disputes involving out-of-network emergency hospital services that are not eligible for IDR, health plans may need to pay more than the reimbursement required under the ACA in order to ensure that an insured is held harmless.
5. A physician bill for emergency services or that is a surprise bill is exempt from the IDR process when physician fees are subject to schedules or other monetary limitations under any other law, including Workers Compensation, no-fault, managed long term care, Medicare, and Medicaid fee-for-service. Medicaid managed care is exempt from IDR if the bill is for emergency services and is not exempt from IDR if the bill is a surprise bill.
6. If an emergency room physician requests a consultation from a specialist to evaluate a patient in the emergency room of a hospital, and the specialist does not participate with the patient's insurance, a bill from the specialist would be considered a bill for emergency services and could be subject to the IDR process.

Physician Disclosure Requirements

1. If a patient has an unscheduled hospital admission (for example, through the emergency department) and is stabilized but requires additional inpatient treatment, a physician that treats the patient during the hospital admission:

- Would not be required to provide the patient with written documentation identifying the health care plans in which the physician participates because the services are not being rendered at the physician's office, practice or health center. See Public Health Law § 24(1).
 - Would not be required to verbally tell the patient the health care plans in which the physician participates because the patient did not schedule an appointment. See Public Health Law § 24(1).
 - Would not be required to tell the patient that the amount the physician will bill is available on request (if the physician does not participate with the patient's health plan) because the services are not being rendered at the physician's office, practice or health center. See Public Health Law § 24(2).
 - Would not be required to provide the patient with the name, practice name, mailing address and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services because the services are not being provided in connection with care in the physician's office or coordinated or referred as part of the office visit. See Public Health Law § 24(3).
 - Would not be subject to the disclosure requirements in § 24(4) of the Public Health Law for services provided during the admission because § 24(4) applies only to a scheduled hospital admission.
2. Public Health Law § 24(3) requires a physician to provide a patient or a prospective patient with the name, practice name, mailing address and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.
- If the physician coordinates or makes a referral to a specific physician in a practice, the physician should disclose the name of the physician.
 - If the physician only coordinates or makes a referral to the overall practice and it is up to the practice to schedule the physician, the physician need only disclose the name of the practice.
3. Public Health Law § 24(4) requires a physician, for a patient's scheduled hospital admission or scheduled outpatient hospital services, to provide a patient and the hospital with the name, practice name, mailing address and telephone number of any other physician whose

services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency services are scheduled.

- If the physician arranges for a specific physician in a practice, the physician should disclose the name of the physician.
- If the physician only arranges for the overall practice and it is up to the practice to schedule the physician, the physician need only disclose the name of the practice.

Dental Coverage

1. The following provisions of the OON law apply to stand-alone dental coverage:
 - The electronic claim submission requirements in Insurance Law § 3224-a(j).
 - The network adequacy requirements in Insurance Law § 3241(a).
 - The right to an external appeal of an out-of-network referral denial in Insurance Law § 4900(g-6-a) if the coverage meets the definition of a “managed care product” in Insurance Law § 4801(c).
 - The requirements for utilization review determinations in Insurance Law § 4903(b).

Effective Dates

1. **Health plan disclosure requirements.** Effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
2. **Provider disclosure requirements.** Effective for health care services provided on and after March 31, 2015.
3. **Right to OON if no in-network provider.** Currently effective for HMOs. Effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
4. **External appeal rights for OON service denials for insurance coverage.** Currently effective for HMOs. Effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
5. **New external appeal rights for OON referral denials.** Effective for HMO and managed care insurance product denials on and after March 31, 2015. For all other insurance policies and contracts, effective on issuance or renewal on and after March 31, 2015.
6. **IDR process for surprise bills and emergency services.** Effective for health care services provided on and after March 31, 2015.

- 7. Hold harmless for emergency services.** With regard to emergency services billed under CPT codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, effective for health care services provided on and after March 31, 2015. For all other emergency services, effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
- 8. Utilization review notification requirements.** Effective for health care services provided on and after March 31, 2015.
- 9. Network Adequacy Requirements.** Effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
- 10. OON Make Available Benefit.** Effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.
- 11. Claim Forms.** For non-participating physicians, the requirement to send a claim form with a bill for OON services is effective for health care services provided on and after March 31, 2015. For health plans, requirements regarding claim submissions are effective for insurance policies and contracts on issuance or renewal on and after March 31, 2015.