Know Your Rights: Getting Treatment for Mental Health and Substance Use Disorders

The New York State Department of Financial Services (DFS) and the New York State Department of Health (DOH) have issued new rules that health insurers, including Health Maintenance Organizations (HMOs), must follow when you need treatment for mental health and substance use disorders.

These rules apply to individual and group health insurance policies that are subject to New York law, including policies purchased through the New York State of Health Marketplace. These rules do not apply to self-funded Employee Retirement Income Security Act (ERISA) employer plans. The rules will take effect for Medicaid Managed Care, Essential Plan, and Child Health Plus coverage on July 1, 2025. For all other insurance policies, these rules will take effect on a rolling basis when you renew or purchase an insurance policy on or after July 1, 2025.

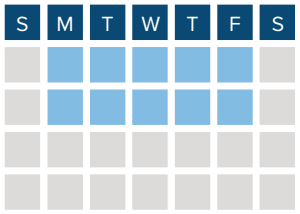
If you have Medicare, different rules apply. Check with the Centers for Medicare & Medicaid Services (CMS) by calling at (800)-MEDICARE, or with the Medicare Rights Center at (800) 333-4114 or www.medicarerights.org.

In-Network Appointments

You are entitled to see a health care provider for outpatient mental health and substance use disorder care within the following timeframes. You also have a right to request an in-person appointment instead of a telehealth appointment.

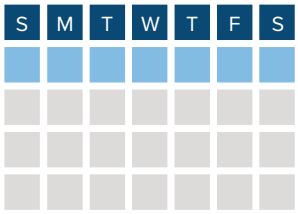
10 business days

First appointment with a health care professional or facility



7 calendar days

A follow-up appointment after being discharged from a hospital or emergency room



Check your health insurance policy for a list of covered services.

Get Help Finding Mental Health and Substance Use Disorder Health Care Providers

Insurers must have dedicated employees who can help you find an in-network health care provider. Information on how to contact these employees directly, including a telephone number, should be available on your insurer's website.

Whether you reach out by telephone or email, your insurer must provide you with a list of available in-network health care providers within **3 business days** of your request.

If you would like to research in-network health care provider options on your own, you can review your insurer's provider directory. The provider directory must contain a health care provider's location, the services provided, telehealth options, languages spoken, any restrictions for the conditions treated or ages served, and facility affiliations. If the health care provider is a facility, the directory must provide details regarding the level of care offered, such as inpatient, outpatient, or partial hospitalization.

Can't Find an In-Network Health Care Provider for Mental Health or Substance Use Disorder Services?

If you cannot find an in-network health care provider that is able to schedule you for an appointment in the required 7- or 10-day timeframe, you have the right to request care from an out-of-network health care provider at no additional cost to you. Here is what you can do:

1. **File an Access Complaint:** Call your insurer or go to their website to file a complaint about provider access.

2. **Receive a Response:** Your insurer has 3 business days to locate an in-network health care provider who can treat your specific condition and is located a reasonable distance from you (if you want an in-person appointment). Once your insurer receives your complaint, the appointment wait time resets. This means that your insurer must find an in-network health care provider to see you in the 7- or 10-day timeframe from when your insurer contacts the provider.

3. **If an In-Network Provider is Not Available:** Your insurer must approve a referral to an out-of-network health care provider that meets the above requirements and does not charge excessive or unreasonable rates.

Out-of-Pocket Costs

For in-network appointments, there is no change to your out-of-pocket costs. If you cannot access in-network care within the required timeframe, and your insurer approves an out-of-network referral, your copayment, coinsurance, and deductible to see the out-of-network health care provider will be the same as if you were seeing an in-network health care provider.

If You Believe Your Rights Have Been Violated: File a Complaint

If your insurer does not follow these rules, you should file an appeal with your insurer and also file a complaint with state regulators, as follows:

- **If you have Medicaid, Essential Plan, or Child Health Plus coverage**, file a complaint with the DOH at (800) 541-2831 for Medicaid, (800) 206-8125 for Medicaid Managed Care, (800) 698-4543 or locally at (518) 473-0566 for Child Health Plus, and (855) 355-5777 for Essential Plan coverage. More information on how to file a complaint with the DOH can be found at www.health.ny.gov/health_care/managed_care/complaints/ or by calling (800) 342-3736.

- **If you are covered by any health insurance plan not listed above,** file a complaint with the DFS online at www.dfs.ny.gov/complaint or by calling (800) 342-3736. DFS will work with your insurer to resolve your complaint or refer it to another state agency, if necessary.

- **If you have questions, need assistance, or want to file a complaint or an appeal,** you may also ask for help from New York's independent Behavioral Health Ombudsman. The Community Health Access to Addiction & Mental Healthcare Project (CHAMP) helpline can be reached by calling (888) 614-5400 Monday - Wednesday, 9 AM - 7 PM or Thursday - Friday, 9 AM - 4 PM or by sending an email to ombuds@oasas.ny.gov.

For more information about mental health and substance use disorder coverage requirements and protections, visit the DFS website at www.dfs.ny.gov/behavioralhealth.