[Alabama Code § 27-1-20.]

§ 27-1-20. Patient Right to Know Act: Alabama Insurance Code

(a) This section shall be known and may be cited as the "Patient Right to Know Act."

(b) As used in this section, unless the context clearly indicates otherwise, the following words shall have the following meanings:

(1) ENROLLEE. A person who purchases individual health care coverage or an employer who purchases a group health care plan.

(2) PROVIDER. A physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced nurse practitioner, registered optician, licensed professional counselor, physical therapist, and chiropractor.

(c)(1) All persons, firms, corporations, associations, health maintenance organizations, health insurance services, or preferred provider organizations, any employer-sponsored health benefit plan, or any similar organization or entity, providing health, accident, or dental insurance coverage, either directly or indirectly, shall provide an enrollee with a written description of the terms and conditions of the plan. The written plan description shall be in a simple, readable, and easily understandable format and shall include all of the following:

a. Coverage provisions including complete extent and exclusions or restrictions of coverage or service, including, but not limited to the following:

1. Outpatient physician services.

2. Referral to specialty physicians and other providers.

3. Choice of pharmacy providers.

4. Diagnostic tests, including mammography exams.

5. Dental services.

6. Chiropractic services.

7. Hospitalization.

8. Laboratory tests and services.

9. FDA approved therapies.

10. Prescription drug coverage.

11. Rehabilitation services, and physical, occupational, and vocational therapy.

12. Mental health services.

13. Long-term care.

14. Full range of reproductive services.

b. Extent of benefits provided or excluded, including prescription drug coverage with both generic and brand names.

c. Any exclusions or limitations by category of service, provider, and, if applicable, by the specific service or type of drug.

d. Any prior authorizations, including procedures for and limitations or restrictions on referrals to a provider other than primary care physicians, dentists, or other review requirements, including preauthorization review, concurrent review, postservice review, and postpayment review.

e. An explanation of the financial responsibility for payment of coinsurance or other noncovered or out-of-plan service.

f. Disclosure to enrollees that includes the following language:

"You have the right to information about how the plan operates its care delivery system and an explanation of the benefits to which participants are entitled under the terms of the plan."

g. The phone number and address for the enrollee to obtain additional information concerning the items described in paragraph f.

(2) The organization or entity may provide the information under paragraph f of subdivision (1) of this subsection by providing information in the entity's annual financial statement most recently submitted to the Department of Insurance.

(d) The information provided by subsection (c) shall be updated annually and shall be provided to any enrollee on a schedule established by the entity.