



ADMINISTRATIVE RULES OF MONTANA



6.6.5906 REQUIRED DISCLOSURES REGARDING NETWORK ADEQUACY

- (1) Each insurer shall have a preferred provider directory on its web site and available in hard copy, if requested. The provider directory must be searchable by specialty, including primary provider designation, county and city or town. The directory must include facilities and must be updated monthly to reflect whether or not the provider is accepting new patients, if that information is available, and any additions or subtractions to the provider list. There must be a separate and clearly designated directory for each health plan type, if more than one network is offered by that insurer. In addition, each insurer shall provide access to a directory of out-of-state participating providers that includes location, provider type, and specialty.
- (2) An insurer shall also include the following information displayed in a prominent manner in the outline of coverage:
 - (a) a description of the process required in ARM 6.6.5902 regarding how patients are provided access to and compensated for medically necessary care if there are no participating providers with the necessary expertise within a reasonable proximity who are able to provide the health care service without unreasonable delay; and
 - (b) a statement advising that out-of-network emergency room services to treat an emergency medical condition are reimbursed as if obtained in-network, if an in-network emergency room cannot be reasonably reached. That disclosure must include the definition of emergency medical condition provided in applicable federal law.
- (3) A provider or insurer shall provide a 60-day notice to the other party prior to terminating a provider contract.
 - (a) An insurer shall ensure that covered persons are notified at least 30 days before a provider contract termination is effective, or as soon as possible after the insurer learns of the termination, by a notice delivered electronically or by mail to, at a minimum:
 - (i) all covered persons who are identified as having obtained services from the provider within the last two years; and
 - (ii) in the case of a facility, all covered persons who live in the city or town that the facility serves.
 - (b) An insurer shall also use the following notification methods:
 - (i) a prompt correction of the provider directory; and
 - (ii) a request to the provider, asking that a notice be posted in the provider office or facility that notifies patients of the termination.

- (4) The notice in (3)(a) must disclose any applicable continuity of coverage provisions by referring to the section of the policy or certificate that contains those provisions. The notice must include a list of available preferred providers in the same geographic area who are the same provider type.
- (5) This rule is effective for policies issued or renewed on or after January 1, 2016.

Authorizing statute(s): 33-22-1707, MCA

Implementing statute(s): 33-22-1706, MCA

History: NEW, 2015 MAR p. 565, Eff. 5/15/15.