



ADMINISTRATIVE RULES OF MONTANA



6.6.2506 REQUIREMENTS FOR CONTRACTS AND EVIDENCES OF COVERAGE

- (1) Each subscriber is entitled to a contract or evidence of coverage as approved by the commissioner. The contract or evidence of coverage must be delivered or issued for delivery to a subscriber within a reasonable time after enrollment, but not more than 15 days from the later of the effective date of coverage or the date on which the health maintenance organization is notified of enrollment.
- (2) A health maintenance organization contract and evidence of coverage must contain:
 - (a) the name, address, and telephone number of the health maintenance organization and the location of and the manner in which information is available as to how services may be obtained;
 - (b) a statement that the contract, all applications, and any amendments thereto constitute the entire agreement between the parties. No portion of the charter, bylaws, or other document of the health maintenance organization may be part of the contract and evidence of coverage unless set forth in full in the contract and evidence of coverage or attached thereto.
 - (c) the time and date or occurrence upon which coverage takes effect, including any applicable waiting or affiliation periods, or describe how the time and date or occurrence upon with coverage takes effect is determined. The contract and evidence of coverage must contain the time and date or occurrence upon which coverage will terminate.
 - (d) eligibility requirements indicating the conditions that must be met to enroll as a subscriber or eligible dependent; the limiting age for subscribers and eligible dependents, including the effects of medicare eligibility; and a clear statement regarding coverage of newborn children. However, a health maintenance organization contract and evidence of coverage may not contain any provision excluding or limiting coverage for a newborn child. Medically diagnosed congenital defects and birth abnormalities must be treated the same as any other illness or injury for which coverage is provided.
 - (e) a specific description of benefits and services available within the service area and out of the service area;
 - (f) a specific description of benefits available for emergency care services 24 hours a day, seven days a week, including disclosure of any restrictions on emergency care services.
 - (g) a description of any copayments, limitations, or exclusions on the services, kind of services, benefits, or kind of benefits to be provided, such as any lawful copayments, limitations, or exclusions due to preexisting conditions, waiting or affiliation periods, or an enrollee's refusal of treatment;

- (h) the conditions upon which the health maintenance organization or the subscriber may cancel coverage;
 - (i) the conditions for, and any restrictions upon, the subscriber's right to renewal and right to reinstatement;
 - (j) a grace period of not less than 10 days for the payment of any premium except the first, during which coverage remains in effect if payment is made during the grace period. During the grace period, the health maintenance organization remains liable for providing the services and benefits contracted for, the contract holder remains liable for paying the premium for the time coverage was in effect during the grace period, and the subscriber remains liable for any copayments owed.
 - (k) procedures for filing claims that include:
 - (i) required notice to the health maintenance organization;
 - (ii) if any claim forms are required, how, when, and where to obtain and submit them;
 - (iii) requirements for filing proper proofs of loss;
 - (iv) time limit of payment of claims;
 - (v) notice of requirements for resolving disputed claims including arbitration; and
 - (vi) a statement of restrictions, if any, on assignment of sums payable to the enrollee by the health maintenance organization.
 - (l) in compliance with Title 33, chapter 32, MCA and ARM 6.6.2509(4), a description of the health maintenance organization's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee if a dispute arises under the contract; and
 - (m) a provision that a subscriber may return the contract within 10 days of receiving it and receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract or evidence of coverage is returned to the health maintenance organization or to the agent through whom it was purchased, it is considered void from the beginning.
- (3) In addition to the requirements under (2), a group contract and evidence of coverage must contain:
- (a) a provision that an enrollee who is an inpatient in a hospital or a skilled nursing facility on the date of discontinuance of the group contract shall be covered in accordance with the terms of the group contract until discharged from the hospital or skilled nursing facility, and that the enrollee may be charged the appropriate premium for coverage that was in effect prior to discontinuance of the group contract.
- (4) The contract and evidence of coverage may contain a provision for coordination of benefits consistent with the coordination of benefit rules applicable to other insurers in the jurisdiction. The provisions or rules for coordination of benefits established by a health maintenance organization may not relieve a health maintenance organization of its duty to provide or arrange for a covered health care service to any enrollee because the enrollee is entitled to coverage under any other contract, policy, or plan, including coverage provided under government programs. The health maintenance organization shall provide covered health care services first and then, at its option, seek coordination of benefits.

- (5) The contract and evidence of coverage may not contain any provision concerning subrogation for injuries caused by third parties unless the wording has been approved by the commissioner.
- (6) A contract and evidence of coverage that contains a provision not in conformity with the Montana Health Maintenance Organization Act is not invalid but must be construed and applied as if it were in full compliance with these rules and the Montana Health Maintenance Organization Act.
- (7) A contract or evidence of coverage delivered or issued for delivery to any person by a health maintenance organization required to obtain a certificate of authority in this state may not contain any definitions that extend, modify, or conflict with those definitions contained in the Montana Health Maintenance Organization Act or ARM 6.6.2503. A contract or evidence of coverage may include definitions of additional terms, so long as those additional definitions do not extend, modify, or conflict with the definitions contained in the Montana Health Maintenance Organization Act or ARM 6.6.2503. In addition, all definitions used in the contract and evidence of coverage must be in alphabetical order.

Authorizing statute(s): 33-31-103, MCA

Implementing statute(s): 33-31-301, 33-31-303, 33-31-307, 33-31-312, MCA

History: NEW, 1987 MAR p. 1770, Eff. 10/16/87; AMD, 1998 MAR p. 1698, Eff. 6/26/98; AMD, 2018 MAR p. 1102, Eff. 6/9/18.