

**[Alaska Stat. § 21.07.030.]**

**§ 21.07.030. Choice of health care provider: Patient Protections Under Health Care Insurance Policies**

(a) If a health care insurer offers a health care insurance policy that provides for coverage of medical care services only if the services are furnished through a network of health care providers that have entered into a contract with the health care insurer, the health care insurer shall also offer a non-network option to covered persons at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from increased costs caused by the use of a non-network provider. This subsection does not apply to a covered person who is offered non-network coverage through another health care insurance policy or through another health care insurer.

(b) The amount of any additional premium charged by the health care insurer for the additional cost of the creation and maintenance of the option described in (a) of this section and the amount of any additional cost sharing imposed under this option shall be paid by the covered person unless it is paid by an employer or other person through agreement with the health care insurer.

(c) A covered person may make a change to the medical care coverage option provided under this section only during a time period determined by the health care insurer. The time period described in this subsection must occur at least annually and last for at least 15 working days.

(d) If a health care insurer that offers a health care insurance policy requires or provides for a designation by a covered person of a participating primary care provider, the health care insurer shall permit the covered person to designate any participating primary care provider, including a pediatrician, that is available to accept the covered person.

(e) Except as provided in this subsection and (h) of this section, a health care insurer that offers a health care insurance policy shall permit a covered person to receive medically necessary or appropriate specialty care, subject to appropriate referral procedures, from any qualified participating health care provider that is available to accept the individual for medical care. This subsection does not apply to specialty care if the health care insurer clearly informs covered persons of the limitations on choice of participating health care providers with respect to medical care. In this subsection,

(1) “appropriate referral procedures” means procedures for referring patients to other health care providers as set out in the applicable member policy and as described under (a) of this section;

(2) “specialty care” means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

(f) If a contract between a health care provider and a health care insurer is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the health care insurer, the covered person may continue to receive medical care services from that provider as provided in this subsection, and the contract between the health care insurer and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the health care insurer. However, treatment is required to continue only while the health care insurance policy remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current policy or plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment;

(C) through completion of postpartum care, if the covered person is pregnant on the date of termination; or

(2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, “terminal” means a life expectancy of less than one year.

(g) The requirements of this section do not apply to medical care services covered by Medicaid.

(h) A health care insurer that offers a health care insurance policy that provides coverage for obstetrical and gynecological care and that requires designation by a covered person of a participating primary care provider may not require authorization or referral by any person, including a primary care provider, for a female patient to receive obstetrical and gynecological care from a participating health care professional who specializes in obstetrics or gynecology. A participating health care professional who specializes in obstetrics or gynecology shall agree to adhere to the health care insurer’s policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services under a treatment plan, if any, approved by the health care insurer. A health care insurer shall treat authorizations by a health care professional who specializes in obstetrical or gynecological care as the authorization of the primary care provider. This subsection may not be construed to

(1) waive any exclusions of coverage under the terms and conditions of the health care insurance policy with respect to coverage of obstetrical and gynecological care; or

(2) preclude a health care insurer from requiring that the health care provider who specializes in obstetrical or gynecological care to notify the primary care provider or the health care insurer of treatment decisions.