Cigna

Policy Name CONTINUITY OF CARE SERVICE REQUESTS		Policy Number HM-CLN-038
Business Segment Behavioral Health		
Initial Effective Date: 03/30/00	**Policy Committee Approval Date(s):** 3/9/21; 12/14/21; 7/26/22; 2/28/23; 7/11/23; 7/9/24; 11/12/24	
Replaces Policies: NA		

Purpose:
To ensure continuity of care and transition of customers who are in active treatment when their practitioner leaves the practitioner network or, in limited circumstances, when a client terminates its contract with Behavioral Health, and to adhere to federal regulations, state mandates, and/or Accreditation standards for continuity of care and transition of customers.

Policy Statement:
Continuity of care (COC) refers to the continuation of care for customers when

1. Any participating provider or facility leaves the network and ongoing care is requested.
2. A fully insured client terminates their contract with Behavioral Health and the client's replacement coverage does not include access to the health care professional at the in-network level and ongoing behavioral health care/services are requested

The Continuity of Care policy ensures continuity of care even if that behavioral health practitioner is a part of a group whose contract with the organization continues. Depending upon the requirements of each state, customers in active treatment will be given notification at least 30 calendar days prior to their participating practitioner's contract termination effective date. In the rare case where a practitioner's contract terminates due to a reason which may be harmful to the customer, (such as breach of contract), death of the practioner, or inability to locate the practitioner; Behavioral Health may notify customers within 15 days of termination decision date.

All customers will be appropriately transitioned to new practitioners based on the level of treatment and clinical needs at the time of termination. Customer notification and transition of care will require cooperation across departments in the organization.

*Customers are notified of client terminations with Behavioral Health by their employer or plan sponsor.

Definitions:
For purposes of this policy "customer" means an individual participant or member.

Continuity of Care (COC) – Refers to the continuation of care for customers when any participating provider or facility leaves the network and ongoing care is requested.

Transition of Care (TOC) - Refers to the process of transitioning medical care for new enrollees from non-participating health care professionals to participating health care professionals.

State/Federal Compliance:

Some states may require a shorter notification timeline than Accreditation or CMS standards. Operating Units should be aware of state variances and adjust local policies to comply with state time frames as needed. Please refer to Appendix A for State Specific turnaround time requirements.

Procedure(s):

A. Customer notification for when a provider leaves the network:
   1. Establish Notification Timeline:
      a. Behavioral Health will provide customers with 30 days notification that their practitioner's contract has terminated.
      b. When a customer is being seen by a practitioner who is in breach of contract, dies or whom Behavioral Health is unable to locate and the termination is effective 'immediately' or 'within 30 days,' an exception to the 30-day customer notification could occur. In these instances, Behavioral Health can provide customer notification as soon as possible within 15 days.
      c. Under the No Surprises Act, a customer has 90 days of COC available after receiving notice of provider termination. Calculation of the 90-day period should begin on the date notice of provider termination is provided and the customer has a full 90 days to request COC, although COC does not need to extend beyond 90 days from the date notice of provider termination is provided. Services eligible for COC are subject to benefit plan limitations and end when one of the following occurs:
         i. Care for the acute and/or chronic condition is completed.
         ii. Care is successfully transitioned to a participating provider.
         iii. Benefit limitations are exceeded.
         iv. Time period approved for COC coverage is exceeded.

B. Identify Customers to be Notified:
   1. Behavioral Health will make a best effort to identify and notify all customers in active treatment. Customers in active treatment are defined by:
      a. Customers receiving care by a practitioner within 12 months preceding the date on which practitioner terminates from the network.
   2. Behavioral Health's electronically generated reports will capture this population by identifying customers with claims in the 12 months period prior to decision date.

C. Implement Notification Process:
   1. Any of the following areas -- Professional Relations, Credentialing Committees, Operating Unit staff, Senior Managers, etc. – may submit a Practitioner Termination Form to Network Operations. Network Operations processes terminations requests within 2 business days of receipt of a request.
   2. Network Operations
      a. Will verify that termination is contractually permissible and establishes the termination effective date 60 days from the date of written notification from practitioner (for those practitioners voluntarily leaving the network).
      b. Will enter practitioner terminations in the database so that reports run by the field staff will reflect termination decisions. The entry shows up in the Data Warehouse report called "Contract Status Change Report."
   3. National Operations Administration Team
      a. Will run weekly reports of all practitioners terminated and customers affected by the termination.
      b. Will ensure that the report does not contain duplicate names.

c. Will document case notes that a termination notification letter is being sent to customer. Behavioral Health will use a letter format that fulfills customer and regulatory requirements.
d. Will prepare and mail letters to customers.
e. Will ensure that all letters have the correct telephone number for the appropriate Operating Unit or National Care Center, should the customer feel a need for more case coordination or transition.
f. Will file copies of weekly customer reports and letter templates on disk or shared drive for auditing purposes.
g. Will post to a shared drive, or deliver upon request, appropriate materials for sites to conduct clinical follow-up.

D. As part of a practitioner's ethical standards and community standards of practice, and as outlined in the practitioner's contract and the Provider Guide, it is the expectation that practitioners willfully leaving the network will notify customers, assist with transition, and coordinate transition with Behavioral Health. In addition, it is expected that practitioners will identify high-risk customers and inform Behavioral Health of any additional assistance needed for these customers.
E. When a practitioner's contract is discontinued, Behavioral Health allows continuation of treatment with the terminated practitioner through the lesser of the current period of active treatment, or for up to 90 calendar days for customers undergoing active treatment for a chronic or acute behavioral health condition. Additionally, Behavioral Health contractually requires practitioners to continue to provide services to customers at the contracted rate until treatment is completed, or the customer has been safely transitioned to another practitioner.
F. Client termination notifications are the responsibility of the employer or plan sponsor.
G. Process for COC (customer process)
    1. Requests for COC should be submitted no later than 90 calendar days after the customer is notified of the provider termination. Consideration may be given to requests received after the specified time period if the request was delayed due to circumstances beyond the customer's control (e.g. late notification of health care professional termination).
    2. The following COC requests may be approved for reimbursement of the terminating provider at an in-network benefit level for up to 90 calendar days, or according to federal/state law, and is provided ending on the earlier of
        a. the 90-day period beginning on such date; or
        b. the date on which such individual is no longer a continuing care patient with respect to such provider or facility
    3. Clinical Staff:
        a. Will review cases needing clinical follow-up.
        b. Will document efforts to coordinate with practitioner and report the conduct of any practitioner refusing to cooperate to professional relations for appropriate documentation.
        c. For practitioners terminated immediately for cause, Network Operations will send practitioners a letter with instructions for transitioning customers. In addition, Network Operations will alert Clinical Staff who will determine if customers require telephonic contact in addition to the letters of notification. Clinical staff, based on level of treatment and clinical needs of customer, will telephone customers that are high risk or require contact to ensure appropriate transition of care.
        d. Will document in case notes that clinical follow-up (when applicable) to assist customers in developing a plan to transition care has occurred.

4. Peer review
    a. For non-routine services that require authorization, requests which cannot be approved by the behavioral care manager are referred to a Medical Director for determination. The Medical Director reviews the treating provider's treatment plan to assess the individual health care needs of the customer and ensure a reasonable transition period to continue their course of treatment. Exceptions may be made on a case-by-case basis to authorize periods longer than the standard 90 calendar days to preserve continuity of care for a defined and limited treatment interval.
    b. The Medical Director will complete the required documentation and will forward to the appropriate staff member for recording in UM system and customer and/or provider notification.
    c. Coverage determination letter is sent to the customer and/or requesting provider. An adverse determination will include the rationale for the decision and guidance on obtaining information on participating providers.

H. State Law Exceptions:
    1. Some states may require a shorter notification timeline than Accreditation or CMS standards. Operating Units should be aware of state variances and adjust local policies to comply with state time frames as needed.

Compliance Measure(s):

Case record review shall indicate:
1. Compliant notification to customer of change in practitioner network status and instructions on how to contact Behavioral Health for assistance in the transition of care.
2. Where indicated, case notes will show clinical follow-up and efforts to transition care.
3. Where customers at high risk are pro-actively identified, case record will indicate telephonic outreach with assistance to assure continuity and coordination in the transition of care.

The Behavioral Health Quality Committee will monitor compliance quarterly with this policy by reviewing termination letters and updates.

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
HM-NET_023 Suspension, Termination or Non-renewal of Practitioner Contract Privileges
HM-CLN-037 Transition To or From a Group Benefit Plan Serviced by Behavioral Health

Links/PDFs: NA

APPENDIX A – STATE SPECIFIC TURNAROUND TIMES

Cigna

ALASKA
AS 21.07.030(f)

A. Conditions that Warrant Extended Coverage
    1. 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 provider based on the below requirements. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract, that person may continue to receive services from that provider based on the below requirements, and the contract between the health care insurer and the provider will remain in effect with respect to the continuing treatment. The covered person must be treated for the purposes of benefit determination or claim payment as if the provider were still under contract.
B. Length of Extended Coverage
    1. Treatment is required to continue only while the health care insurance policy remains in effect and:
        a. for the period that is the longest of the following:
            i. the end of the current policy or plan year;
            ii. 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;
            iii. through completion of postpartum care, if the covered person is pregnant on the date of termination; or
        b. 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.

ARIZONA
ARS 20-1057.04

A. **CONDITIONS THAT WARRANT EXTENDED COVERAGE**
    1. HMO plans
    2. Continued or transitional care provisions will be extended to members who are undergoing treatment with their current disaffiliated or non-participating provider for either a life threatening disease or condition or third trimester pregnancy care.
B. **LENGTH OF EXTENDED COVERAGE**
    1. Minimum transition period for both Continuity of Care and Transition of Care is as follows:
        a. Thirty (30) days for a life threatening condition
        b. From the third trimester of pregnancy up to six weeks after delivery

DELAWARE
CDR 18-1400-1403 (9.3)

A. HMO only products are impacted.
B. CONDITIONS THAT WARRANT EXTENDED COVERAGE
    1. Continuation is required if it is medically necessary, and pregnancy is a condition which would require continuity of care. However, if the provider was terminated because of unsafe health care practices which could compromise the health or safety of the enrollee, continuity of care is required.
C. LENGTH OF EXTENDED COVERAGE

1. In cases determined to be medically necessary, enrollees are assured continued coverage of services by a terminated provider up to 120 calendar days. In pregnancy cases, coverage shall continue to completion of post-partum care.

FLORIDA
F.S. 641.51(8)

A. If a contract between an HMO and a provider is terminated for any reason other than for cause, any patient of the provider undergoing active treatment must be allowed to continue coverage and care if medically necessary, until:
    a. completion of treatment of the condition for which the member was receiving care at the time of the termination;
    b. the member selects another treating provider; or
    c. the next open enrollment period offered by the HMO;
    d. whichever is longer; but not longer than 6 months after termination of the contract.
B. **CONDITIONS THAT WARRANT EXTENDED COVERAGE**
    a. Any condition for which the enrollee was receiving care at the time of termination; and
    b. Pregnancy (any trimester).
C. **LENGTH OF EXTENDED COVERAGE**
    a. 6 months after termination (or potentially earlier, as stated above); or
    b. Completion of postpartum care.

ILLINOIS
215 ILCS 134/25

A. Definition for Ongoing Course of Treatment
    1. treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
    2. treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;
    3. a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; or
    4. the third trimester of pregnancy through the post-partum period.
B. If an insured's physician leaves the health care plan's network of health care providers for reasons other than the termination of a contract in situations involving imminent harm to a patient or final disciplinary action by a State licensing board and the physician remains within the health care plan's service area, the health care plan must permit the enrollee to continue an ongoing course of treatment with the physician during a transitional period:
    1. Of 90 days from the date of the notice of the physician's termination from the health care plan to the enrollee if the enrollee has an ongoing course of treatment; or
    2. If the enrollee has entered the third trimester of pregnancy at the time of the physician's disaffiliation, that includes the provision of post-partum care directly related to the delivery.
C. HMOs and Insurers must authorize continuity of care during the transitional period only if the physician agrees:

1. To continue to accept reimbursement from the health care plan at the rates applicable prior to the start of the transitional period.
2. To adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to the care provided during the transitional period; and
3. To otherwise adhere to the health care plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

KENTUCKY

KRS 304.17A-643

A. This law requires health benefit plans to provide continuity of care for covered persons with special health circumstances when a provider's contract is terminated for reasons other than quality.
B. "Special circumstances" includes a circumstance in which a covered person has
    a. a disability,
    b. a congenital condition,
    c. a life-threatening illness,
    d. a terminal illness,
    e. or is past the twenty-fourth week of pregnancy where disruption of the covered person's continuity of care could cause medical harm.
C. The law permits the treating provider, with the agreement of the covered person, to request the continuity of care and to agree to care for the covered person under the same guidelines and payment schedule as required by the provider's contract, and to report to the plan on the care being provided.
D. Services must be provided for the period of time that applies to the particular condition.

LOUISIANA

22:1005

A. Continuity of care applies to enrollees:
    1. who have been diagnosed as being in a high risk pregnancy or past the 24th week of pregnancy through delivery and postpartum care related to the pregnancy and delivery; or
    2. who have been diagnosed with a life-threatening illness for up to three months following the date of contract termination.

MAINE

24-A M.R.S. § 4303(7)

A. Continued care provisions will be extended to enrollees who are engaged in an ongoing course of treatment with their provider and for enrollees who are in their 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during pregnancy.
    1. Coverage will continue for pregnant enrollees in their second trimester through delivery and postpartum.

MASSACHUSETTS
958 CMR 3.503

A. **CONDITIONS THAT WARRANT EXTENDED COVERAGE**
    1. A carrier shall provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network pursuant to the conditions listed above.
        a. Pregnancy: Continued coverage of treatment for a period up to and including the insured's first postpartum visit.
        b. Terminally ill: Continued coverage of treatment until the insured's death.

MINNESOTA
62Q.56

A. Continued or transitional care must be authorized for members undergoing treatment for
    1. an acute condition
    2. a disabling or chronic condition that is in an acute phase
    3. any life-threatening mental or physical illness
    4. a physical or mental disability persisting for, or with an expected duration of, at least one year, or that can be expected to result in death
    5. or pregnancy
B. Continued or transitional care must also be authorized in situations where the member is receiving culturally appropriate services from a terminated or non-participating provider or for a member who does not speak English, and there is no participating provider in the network who can satisfactorily accommodate either of these special needs.
C. Insurers must develop criteria that will be used to determine whether a need for continuity or transition of care exists based on diagnoses or special circumstances and how it will be provided.
D. Coverage must be extended to eligible members (see above) for a transitional period of up to 120 days.
    1. However, if a physician, advanced practice registered nurse, or physician assistant certifies that a member has a life expectancy of 180 days or less, uninterrupted coverage must be provided for the remainder of the member's life.

MICHIGAN
500.2212b

A. Continuity of care coverage applies for the following circumstances:
    1. an insured engaged in an ongoing course of treatment
    2. an insured in the second or third trimester of pregnancy
    3. an insured determined to be terminally ill prior to the date of the provider's termination from the network, or the date the provider learns of the termination
B. Continuity of care coverage applies for the following time periods:
    1. for 90 days from the date of the provider's notice to the insured of the provider's termination from the network.

2. through delivery and post-partum care for pregnant insureds in their second or third trimester.
3. for the remainder of the insured's life, if the insured is terminally ill.

NEW MEXICO
NMAC13.10.23.14

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
    1. In the event of a disaffiliation between a provider and the carrier (for reasons unrelated to medical competence or professional behavior), the carrier must permit the enrollee to continue an ongoing course of treatment for a transitional period of not less than 30 days and for a sufficient period to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of care.
    2. When the enrollee is in the third trimester of pregnancy, the transitional period shall continue through postpartum care directly related to the delivery.
B. LENGTH OF EXTENDED COVERAGE
    1. Coverage must be extended for a time that is sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of case and, in any event, shall not be less than a period of 30 days.
    2. If an enrollee has entered the third trimester of pregnancy at the time of the provider's disaffiliation or at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery.

NEW YORK
Ins Law Section 4804

A. If an existing insured/member's provider leaves the network, the carrier must permit the individual to continue an ongoing course of treatment with that provider during a transitional period of:
    1. Up to 90 days from the date of notice to the insured/member of the provider's disaffiliation from the network; or
    2. If the insured/member is in the second trimester of pregnancy, a period of time that includes post-partum care directly related to delivery.
    3. The above does not apply in cases of imminent harm to patient health, fraud, final disciplinary action by a state licensing board or other governmental agency.
B. Care will be authorized by the carrier during the transitional period only if the provider agrees to:
    1. Continue to accept reimbursement at the rates in place prior to the start of the transitional period as payment in full;
    2. Adhere to the carrier's quality assurance requirements and to provide necessary medical information related to the care; and
    3. Otherwise adhere to the carrier's policies and procedures, including, but not limited to, referrals, pre-authorizations and treatment plans approved by the carrier.

NEVADA
NRS 689B.0303

A. If a Participant is receiving medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during the course of the medical treatment, the policy must provide that:
    1. the Participant may continue to obtain medical treatment for the medical condition from the provider of health care, if:
        a. the Participant is actively undergoing a medically necessary course of treatment; and
        b. the provider of health and the Participant agree that continuity of care is desirable.
    2. The coverage must be provided until the later of:
        a. the 120th day after the date the contact is terminated; or
        b. if the medical condition is pregnancy, the 45th day after; (1) the date of delivery; or (2) if the pregnancy does not end in delivery, the date of the end of the pregnancy.
    3. These requirements do not apply to a provider of health care if:
        a. the provider of health care was under contract with the insurer and the insurer terminated that contract because of the medical incompetence or professional misconduct of the provider of health; and
        b. the insurer did not enter into another contract with the provider of health after the contract was terminated.

NORTH CAROLINA
58-67-88 SB 199 2001 session

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
    1. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
    2. In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time
    3. In the case of pregnancy, pregnancy from the start of the second trimester.
    4. In the case of a terminal illness, a medical prognosis that individual's life expectancy is six months or less.
B. Generally, the transitional period shall be extended up to 90 days except for the following:
    1. Pregnancy- If insured entered second trimester on date of notice or date of enrollment in new plan, and provider was treating the pregnancy before the date of notice, transitional period shall extend through 60 days of post-partum care.
    2. Terminal illness - If terminally ill (6 months or less to live) at time of provider's termination the transitional period shall extend for the remainder of the individual's life.

OREGON
ORS § 743B.225

A. An enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:
    1. The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or
    2. The 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

B. An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:
    1. The 45th day after the birth; or
    2. As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

RHODE ISLAND
RI ADC 14 000 022, Sections 5.14.2 and 6.3.1; RI ST § 23-17.18-1

A. Provider Payment/Reimbursement Following Contract Termination:
    1. Behavioral Health shall ensure that termination of a provider's contract shall not affect the method of payment, nor reduce the amount of reimbursement, to the provider for any participant in active treatment for an acute medical condition at the time the provider terminates the contract with Behavioral Health until the earlier of:
        a. The active treatment is concluded, or
        b. One (1) year has passed since the termination of the provider contract.
    2. Payment Terms: During the active treatment period, the provider shall be subject to the same terms and conditions of the terminated provider contract including, but not limited to reimbursement provisions limiting participant's liability.
    3. Right to Transfer Care to Participating Provider: In the event of contractual changes with a participating provider, Behavioral Health shall ensure participants have the right to transfer care to a participating provider in the same or similar specialty as the terminating treating provider.

TENNESSEE
TCA 56-7-2358

A. Requires managed care plans which use networks of contracted providers and those providers to allow an enrollee
    1. who is under active treatment for a particular injury or sickness, to continue to receive covered benefits from the treating provider for up to 120 days from date of notice of termination;
    2. who is in the second or third trimester of pregnancy to continue care with a treating provider until completion of postpartum care; and
    3. who is being treated at an inpatient facility to remain at the facility until the patient is discharged.

TEXAS
VTCA Ins. Code 843.362

A. **CONDITIONS THAT WARRANT EXTENDED COVERAGE**

1. Continuity of care applies to enrollees of "special circumstance." A "special circumstance" means a condition which the treating provider reasonably believes could cause harm to the enrollee if care is discontinued and includes a person with a disability, an acute condition or a life-threatening illness. The treating provider must identify the "special circumstance" and must request that the enrollee be permitted to continue treatment under his/her care.

B. **LENGTH OF EXTENDED COVERAGE**
   1. Continuity of care must be permitted for a period of 90 days from the effective date of the provider's termination from the provider network. Special continuity of care provisions apply as follows:
   2. For an enrollee who is past the 24th week of pregnancy, the continuity of care extends through the delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery. And
   3. For an enrollee who has been diagnosed with a terminal illness at the time of the provider's termination, treatment by the terminating provider may continue, for up to nine months.

VIRGINIA
Sec. 38.2-3407.10 (C) & (F)

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
   1. For terminating providers, continuity of care must be permitted if an enrollee:
      a. was in an active course of treatment from the provider before the notice of termination; and
      b. the enrollee requests to continue receiving health care services from the terminating provider.

B. LENGTH OF EXTENDED COVERAGE
   1. Continuity of care must be permitted for a period of 90 days from the date of the provider's notice of termination from the provider network.
   2. Special continuity of care provisions apply as follows:
      a. For an enrollee who has entered the second trimester of pregnancy, treatment by the terminating provider will continue, at the enrollee's option, through postpartum care directly related to the delivery; and
      b. For a terminally ill enrollee, treatment by the terminating provider may continue, at the enrollee's option, through the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.
      c. For an enrollee who has been determined by a medical professional to have a life-threatening condition at the time of a provider's termination of participation. The treatment must, at the enrollee's option, continue for up to 180 days for care directly related to the life-threatening condition

WISCONSIN
Statute 609.24

A. REQUIREMENT TO PROVIDE ACCESS.
   1. A defined network plan shall provide the coverage required with respect to the services of a provider for routine outpatient services for the following period of time:
      a. For an enrollee of a plan with no open enrollment period, until the end of the current plan year.

   b. For an enrollee of a plan with an open enrollment period, until the end of the plan year for which it was represented that the provider was, or would be, a participating provider.
2. If an enrollee is undergoing a course of treatment with a participating provider for services which are not routine outpatient services and whose participation with the plan terminates, the defined network plan shall provide the coverage with respect to the services of the provider for the following period of time:
   a. For the remainder of the course of treatment or for 90 days after the provider's participation with the plan terminates, whichever is shorter.
   b. If maternity care is the course of treatment and the enrollee is a woman who is in the 2nd or 3rd trimester of pregnancy when the provider's participation with the plan terminates, until the completion of postpartum care for the woman and infant.
3. The coverage required under this section need not be provided or may be discontinued if any of the following applies:
   a. The provider no longer practices in the defined network plan's geographic service area.
   b. The insurer issuing the defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.