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§19–701.

(a) In this subtitle the following words have the meanings indicated.

(b) “Benefit package” means a set of health care services to be provided to a member of a health maintenance organization under a contract that entitles the member to the health care services, whether the services are provided:

- (1) Directly by a health maintenance organization; or
- (2) Through a contract or arrangement with another person.

(c) “Commissioner” means the State Insurance Commissioner.

(d) “Covered service” means a health care service included in the benefit package of the health maintenance organization and rendered to a member or subscriber of the health maintenance organization by:

(1) A provider under contract with the health maintenance organization, when the service is obtained in accordance with the terms of the benefit contract of the member or subscriber; or

(2) A noncontracting provider under § 19–710.1 of this subtitle, when the service is:

(i) Obtained in accordance with the terms of the benefit contract of the member or subscriber;

(ii) Obtained pursuant to a verbal or written referral by:

1. The health maintenance organization of the member or subscriber; or

2. A provider under written contract with the health maintenance organization of the member or subscriber; or

(iii) Preauthorized or otherwise approved either verbally or in writing by:

1. The health maintenance organization of the member or subscriber; or

2. A provider under written contract with the health maintenance organization of the member or subscriber.

(e) “Emergency services” means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- (1) Placing the patient’s health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

(f) (1) “Health care services” means services, medical equipment, and supplies that are provided by a provider.

(2) “Health care services” includes:

- (i) Ambulance services;
- (ii) Appliances, drugs, medicines, and supplies;
- (iii) Chiropractic care and services;
- (iv) Convalescent institutional care;
- (v) Dental care and services;
- (vi) Extended care;
- (vii) Family planning or infertility services;
- (viii) Health education services;
- (ix) Home health care or medical social services;
- (x) Inpatient hospital services;
- (xi) Laboratory, radiological, or other diagnostic services;
- (xii) Medical care and services;
- (xiii) Mental health services;
- (xiv) Nursing care and services;
- (xv) Nursing home care;
- (xvi) Optical care and services;

- (xvii) Optometric care and services;
- (xviii) Osteopathic care and services;
- (xix) Outpatient services;
- (xx) Pharmaceutical services;
- (xxi) Physical therapy care and services;
- (xxii) Podiatric care and services;
- (xxiii) Preventive medical services;
- (xxiv) Psychological care and services;
- (xxv) Rehabilitative services;
- (xxvi) Surgical care and services;
- (xxvii) Treatment for alcoholism or drug abuse; and

(xxviii) Any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

(g) “Health maintenance organization” means any person, including a profit or nonprofit corporation organized under the laws of any state or country, that:

(1) Operates or proposes to operate in this State;

(2) Except as provided in § 19–703(b) and (e) of this subtitle, provides or otherwise makes available to its members health care services that include at least physician, hospitalization, laboratory, X-ray, emergency, and preventive services, out-of-area coverage, and any other health care services that the Commissioner determines to be available generally on an insured or prepaid basis in the area serviced by the health maintenance organization, and, at the option of the health maintenance organization, may provide additional coverage;

(3) Except for any copayment or deductible arrangement, is compensated only on a predetermined periodic rate basis for providing to members the minimum services that are specified in item (2) of this subsection;

(4) Assures its subscribers and members, the Commissioner, and the Department that one clearly specified legal and administrative focal point or element of the health maintenance organization has the responsibility of providing the availability, accessibility, quality, and effective use of comprehensive health care services; and

(5) Primarily provides services of physicians:

(i) Directly through physicians who are either employees or partners of the health maintenance organization; or

(ii) Under arrangements with one or more groups of physicians, who are organized on a group practice or individual practice basis, under which each group:

1. Is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis; and

2. Is provided with an effective incentive to avoid unnecessary inpatient use, whether the individual physician members of the group are paid on a fee-for-service or other basis.

(h) “Member” means a person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

(i) “Provider” means any person, including a physician or hospital, who is licensed or otherwise authorized in this State to provide health care services.

(j) “Subscriber” means a person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

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