

Article - Insurance

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§14–201. IN EFFECT

- (a) In this subtitle the following words have the meanings indicated.
- (b) “Allowed amount” means the dollar amount that an insurer determines is the value of the health care service provided by a provider before any cost sharing amounts are applied.
- (c) “Assignment of benefits” means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider insurance policy by an insured.
- (d) “Balance bill” means the difference between a nonpreferred provider’s bill for a health care service and the insurer’s allowed amount.
- (e) “Cost sharing amounts” means the amounts that an insured is responsible for under a preferred provider insurance policy, including any deductibles, coinsurance, or copayments.
- (f) “Covered service” means a health care service that is a covered benefit under a preferred provider insurance policy.
- (g) “Health care services” has the meaning stated in § 19–701 of the Health – General Article.
- (h) “Hospital–based physician” means:
- (1) a physician licensed in the State who is under contract to provide health care services to patients at a hospital; or
 - (2) a group physician practice that includes physicians licensed in the State that is under contract to provide health care services to patients at a hospital.
- (i) “Insured” means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.
- (j) “Medicare economic index” means the fixed–weight input price index that:
- (1) measures the weighted average annual price change for various inputs needed to produce physician services; and
 - (2) is used by the Centers for Medicare and Medicaid Services in the calculation of reimbursement of physician services under Title XVIII of the federal Social Security Act.

(k) “Nonpreferred provider” means a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable provider service contract.

(l) “On-call physician” means a physician who:

(1) has privileges at a hospital;

(2) is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or a hospital emergency department; and

(3) is not a hospital-based physician.

(m) “Preferential basis” means an arrangement under which the insured or subscriber under a preferred provider insurance policy is entitled to receive health care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than if the insured or subscriber received similar services from a nonpreferred provider.

(n) “Preferred provider” means a provider that has entered into a provider service contract.

(o) “Preferred provider insurance policy” means:

(1) a policy or insurance contract that is issued or delivered in the State by an insurer, under which health care services are to be provided to the insured by a preferred provider on a preferential basis; or

(2) another contract that is offered by an employer, third party administrator, or other entity, under which health care services are to be provided to the subscriber by a preferred provider on a preferential basis.

(p) “Provider” means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(q) “Provider service contract” means a contract between a provider and an insurer, employer, third party administrator, or other entity, under which the provider agrees to provide health care services on a preferential basis under specific preferred provider insurance policies.

(r) “Similarly licensed provider” means:

(1) for a physician:

(i) a physician who is board certified or eligible in the same practice specialty; or

(ii) a group physician practice that contains board certified or eligible physicians in the same practice specialty; or

(2) for a health care provider who is not a physician, a health care provider who holds the same type of license or certification.

(s) “Subscriber” means a person covered for benefits under a preferred provider insurance policy issued by a person that is not an insurer.

14–201. // EFFECTIVE SEPTEMBER 30, 2015 PER CHAPTER 537 OF 2010 //

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

(b) “Insured” means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.

(c) “Nonpreferred provider” means a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable provider service contract.

(d) “Preferential basis” means an arrangement under which the insured or subscriber under a preferred provider insurance policy is entitled to receive health care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than if the insured or subscriber received similar services from a nonpreferred provider.

(e) “Preferred provider” means a provider that has entered into a provider service contract.

(f) “Preferred provider insurance policy” means:

(1) a policy or insurance contract that is issued or delivered in the State by an insurer, under which health care services are to be provided to the insured by a preferred provider on a preferential basis; or

(2) another contract that is offered by an employer, third party administrator, or other entity, under which health care services are to be provided to the subscriber by a preferred provider on a preferential basis.

(g) “Provider” means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(h) “Provider service contract” means a contract between a provider and an insurer, employer, third party administrator, or other entity, under which the provider agrees to provide health care services on a preferential basis under specific preferred provider insurance policies.

(i) “Subscriber” means a person covered for benefits under a preferred provider

insurance policy issued by a person that is not an insurer.

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