

Article - Insurance

[Previous][Next]

§14–205.1.

(a) The Commissioner may authorize an insurer or nonprofit health service plan to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the insurer or nonprofit health service plan:

(1) has demonstrated to the Secretary of Health and Mental Hygiene that the provider panel of the insurer or nonprofit health service plan complies with the regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General Article; and

(2) does not restrict payment for covered services provided by nonpreferred providers:

(i) for emergency services, as defined in § 19–701 of the Health – General Article;

(ii) for an unforeseen illness, injury, or condition requiring immediate care; or

(iii) as required under § 15–830 of this article.

(b) (1) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through preferred providers, then the insurer or nonprofit health service plan with which the employer, association, or other private group arrangement is contracting for the coverage shall offer an option to include preferred and nonpreferred providers as an additional benefit for an employee or individual, at the employee's or individual's option, to accept or reject.

(2) The insurer or nonprofit health service plan shall provide to each employer, association, or other private group arrangement a disclosure statement on the group application that an option to include preferred and nonpreferred providers is available for the individual or employee to accept or reject.

(c) An employer, association, or other private group arrangement may require an employee or individual that accepts the additional coverage for preferred and nonpreferred providers to pay a premium greater than the amount of the premium for the coverage offered for preferred providers only.

[Previous][Next]