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§15–118.

(a) (1) In this section the following words have the meanings indicated.

(2) “Health care service” means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of human disease or dysfunction; or

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

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

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for health care services to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for health care services to individuals or groups under contracts that are issued or delivered in the State.

(c) If an entity subject to this section negotiates and enters into a contract with providers to render health care services to insureds, subscribers, or members at alternative rates of payment, and coinsurance payments are to be based on a percentage of the fee for health care services rendered by a provider, the entity shall calculate the amount of the coinsurance payment to be paid by the insured, subscriber, or member exclusively from the negotiated alternative rate for the health care service rendered.

(d) An entity subject to this section may not charge or collect from an insured, a subscriber, or a member a coinsurance payment amount that is greater than the amount calculated under subsection (c) of this section.

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