

Senate Bill 82

By: Senators Au of the 48th, Watson of the 1st, Burke of the 11th, Kirkpatrick of the 32nd, Hufstetler of the 52nd and others

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

1 To amend Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to
2 emergency medical services, so as to clarify that the prudent layperson standard is not
3 affected by the final diagnosis given; to amend Title 33 of the Official Code of Georgia
4 Annotated, relating to insurance, so as to also clarify that the prudent layperson standard is
5 not affected by the final diagnosis given; to provide for legislative findings; to provide for
6 related matters; to repeal conflicting laws; and for other purposes.

7 **BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:**

8 **SECTION 1.**

9 The General Assembly finds:

- 10 (1) This state recognizes a "prudent layperson" standard with regard to the need for
11 emergency care;
- 12 (2) Insurance companies operating in this state are required to adhere to that standard;
- 13 (3) Patients in this state have had emergency medical claims denied due to insurer failure
14 to adhere to the prudent layperson standard as intended;
- 15 (4) The federal court system has recognized that this standard is not intended to look to
16 the ultimate diagnosis that a patient receives. Rather, the only relevant considerations are

17 the patient's symptoms and whether a prudent layperson would think that emergency
18 medical attention is necessary based on those symptoms;

19 (5) This legislative body has intended and continues to intend that the prudent layperson
20 standard be applied in the same manner; and

21 (6) In order to better protect Georgians seeking emergency care, legislation is needed not
22 to change the meaning but to clarify the intended application of the prudent layperson
23 standard in this state.

24

SECTION 2.

25 Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to emergency
26 medical services, is amended by revising Code Section 31-11-81, relating to definitions
27 regarding emergency services, as follows:

28 "31-11-81.

29 As used in this article, the term:

30 (1) 'Emergency condition' means any medical condition of a recent onset and severity,
31 including but not limited to severe pain, regardless of the final diagnosis that is given,
32 that would lead a prudent layperson, possessing an average knowledge of medicine and
33 health, to believe that his or her condition, sickness, or injury is of such a nature that
34 failure to obtain immediate medical care could result in:

35 (A) Placing the patient's health in serious jeopardy;

36 (B) Serious impairment to bodily functions; or

37 (C) Serious dysfunction of any bodily organ or part.

38 (2) 'Emergency medical provider' means any provider of emergency medical
39 transportation licensed or permitted by the Department of Public Health, any hospital
40 licensed or permitted by the Department of Community Health, any hospital based
41 service, or any physician licensed by the Georgia Composite Medical Board who
42 provides emergency services.

43 (3) 'Emergency services' means emergency medical transportation or health care services
44 provided in a hospital emergency facility to evaluate and treat any emergency condition.
45 (4) 'Prospective authorization' means contacting for approval or authorization to evaluate
46 and treat a patient any insurer, health maintenance organization, hospital medical service
47 corporation, or health benefit plan, a representative of which is not physically present in
48 the hospital's emergency department at the time such patient presents for emergency
49 services."

50

SECTION 3.

51 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
52 revising Code Section 33-20A-3, relating to definitions regarding managed health care plans,
53 as follows:

54 "33-20A-3.

55 As used in this article, the term:

56 (1) 'Emergency services' or 'emergency care' means those health care services that are
57 provided for a condition of recent onset and sufficient severity, including, but not limited
58 to, severe pain, regardless of the final diagnosis that is given, that would lead a prudent
59 layperson, possessing an average knowledge of medicine and health, to believe that his
60 or her condition, sickness, or injury is of such a nature that failure to obtain immediate
61 medical care could result in:

62 (A) Placing the patient's health in serious jeopardy;

63 (B) Serious impairment to bodily functions; or

64 (C) Serious dysfunction of any bodily organ or part.

65 (2) 'Enrollee' means an individual who has elected to contract for or participate in a
66 managed care plan for that individual or for that individual and that individual's eligible
67 dependents.

68 (3) 'Facility' means a hospital, ambulatory surgical treatment center, birthing center,
69 diagnostic and treatment center, hospice, or similar institution for examination, diagnosis,
70 treatment, surgery, or maternity care but does not include physicians' or dentists' private
71 offices and treatment rooms in which such physicians or dentists primarily see, consult
72 with, and treat patients.

73 (4) 'Health benefit plan' has the same meaning as provided in Code Section 33-24-59.5.

74 (5) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,
75 pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse,
76 registered optician, licensed professional counselor, physical therapist, marriage and
77 family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8,
78 occupational therapist, speech language pathologist, audiologist, dietitian, or physician
79 assistant.

80 (6) 'Home health care provider' means any provider or agency that provides health care
81 services in a patient's home including the supply of durable medical equipment for use
82 in a patient's home.

83 (7) 'Limited utilization incentive plan' means any compensation arrangement between
84 the plan and a health care provider or provider group that has the effect of reducing or
85 limiting services to patients.

86 (8) 'Managed care contractor' means a person who:

87 (A) Establishes, operates, or maintains a network of participating providers;

88 (B) Conducts or arranges for utilization review activities; and

89 (C) Contracts with an insurance company, a hospital or medical service plan, an
90 employer, an employee organization, or any other entity providing coverage for health
91 care services to operate a managed care plan.

92 (9) 'Managed care entity' includes an insurance company, hospital or medical service
93 plan, hospital, health care provider network, physician hospital organization, health care

94 provider, health maintenance organization, health care corporation, employer or
95 employee organization, or managed care contractor that offers a managed care plan.

96 (10) 'Managed care plan' means a major medical, hospitalization, or dental plan that
97 provides for the financing and delivery of health care services to persons enrolled in such
98 plan through:

99 (A) Arrangements with selected providers to furnish health care services;

100 (B) Explicit standards for the selection of participating providers; and

101 (C) Cost savings for persons enrolled in the plan to use the participating providers and
102 procedures provided for by the plan; provided, however, that the term 'managed care
103 plan' does not apply to Chapter 9 of Title 34, relating to workers' compensation.

104 (11) 'Nonurgent procedure' means any nonemergency or elective care that can be
105 scheduled at least 24 hours prior to the service without posing a significant threat to the
106 patient's health or well-being.

107 (12) 'Out of network' or 'point of service' refers to health care items or services provided
108 to an enrollee by providers who do not belong to the provider network in the managed
109 care plan.

110 (13) 'Patient' means a person who seeks or receives health care services under a managed
111 care plan.

112 (14) 'Precertification' or 'preauthorization' means any written or oral determination made
113 at any time by an insurer or any agent thereof that an enrollee's receipt of health care
114 services is a covered benefit under the applicable plan and that any requirement of
115 medical necessity or other requirements imposed by such plan as prerequisites for
116 payment for such services have been satisfied. 'Agent' as used in this paragraph shall not
117 include an agent or agency as defined in Code Section 33-23-1.

118 (15) 'Qualified managed care plan' means a managed care plan that the Commissioner
119 certifies as meeting the requirements of this article.

120 (16) 'Verification of benefits' means any written or oral determination by an insurer or
121 agent thereof of whether given health care services are a covered benefit under the
122 enrollee's health benefit plan without a determination of precertification or
123 preauthorization as to such services. 'Agent' as used in this paragraph shall not include
124 an agent or agency as defined in Code Section 33-23-1."

125 **SECTION 4.**

126 Said title is further amended by revising Code Section 33-20E-2, relating to application to
127 insurers and definitions regarding surprise billing, as follows:

128 "33-20E-2.

129 (a) This chapter shall apply to all insurers providing a healthcare plan that pays for the
130 provision of healthcare services to covered persons.

131 (b) As used in this chapter, the term:

132 (1) 'Balance bill' means the amount that a nonparticipating provider charges for services
133 provided to a covered person. Such amount equals the difference between the amount
134 paid or offered by the insurer and the amount of the nonparticipating provider's bill
135 charge, but shall not include any amount for coinsurance, copayments, or deductibles due
136 by the covered person.

137 (2) 'Contracted amount' means the median in-network amount paid during the 2017
138 calendar year by an insurer for the emergency or nonemergency services provided by
139 in-network providers engaged in the same or similar specialties and provided in the same
140 or nearest geographical area. Such amount shall be annually adjusted by the department
141 for inflation which may be based on the Consumer Price Index, and shall not include
142 Medicare or Medicaid rates.

143 (3) 'Covered person' means an individual who is insured under a healthcare plan.

144 (4) 'Emergency medical provider' means any physician licensed by the Georgia
145 Composite Medical Board who provides emergency medical services and any other

146 healthcare provider licensed or otherwise authorized in this state to render emergency
147 medical services.

148 (5) 'Emergency medical services' means medical services rendered after the recent onset
149 of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of
150 sufficient severity, including, but not limited to, severe pain, regardless of the final
151 diagnosis that is given, that would lead a prudent layperson possessing an average
152 knowledge of medicine and health to believe that his or her condition, sickness, or injury
153 is of such a nature that failure to obtain immediate medical care could result in:

154 (A) Placing the patient's health in serious jeopardy;

155 (B) Serious impairment to bodily functions; or

156 (C) Serious dysfunction of any bodily organ or part.

157 (6) 'Facility' means a hospital, an ambulatory surgical treatment center, birthing center,
158 diagnostic and treatment center, hospice, or similar institution.

159 (7) 'Geographic area' means a specific portion of this state which shall consist of one or
160 more zip ZIP codes as defined by the Commissioner pursuant to department rule and
161 regulation.

162 (8) 'Healthcare plan' means any hospital or medical insurance policy or certificate,
163 healthcare plan contract or certificate, qualified higher deductible health plan, health
164 maintenance organization or other managed care subscriber contract, or state healthcare
165 plan. This term shall not include limited benefit insurance policies or plans listed under
166 paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies issued in
167 accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating to
168 workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act
169 (Medicare), or any plan or program not described in this paragraph over which the
170 Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of
171 Code Section 33-1-2 and any other provision of this title, for purposes of this chapter this
172 term shall include stand-alone dental insurance and stand-alone vision insurance.

173 (9) 'Healthcare provider' or 'provider' means any physician, other individual, or facility
174 other than a hospital licensed or otherwise authorized in this state to furnish healthcare
175 services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist,
176 clinical social worker, advanced practice registered nurse, registered optician, licensed
177 professional counselor, physical therapist, marriage and family therapist, chiropractor,
178 athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist,
179 speech-language pathologist, audiologist, dietitian, or physician assistant.

180 (10) 'Healthcare services' means emergency or nonemergency medical services.

181 (11) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
182 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
183 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
184 costs of healthcare services, including those of an accident and sickness insurance
185 company, a health maintenance organization, a healthcare plan, a managed care plan, or
186 any other entity providing a health insurance plan, a health benefit plan, or healthcare
187 services.

188 (12) 'Nonemergency medical services' means the examination or treatment of persons
189 for the prevention of illness or the correction or treatment of any physical or mental
190 condition resulting from an illness, injury, or other human physical problem which does
191 not qualify as an emergency medical service and includes, but is not limited to:

192 (A) Hospital services which include the general and usual care, services, supplies, and
193 equipment furnished by hospitals;

194 (B) Medical services which include the general and usual care and services rendered
195 and administered by doctors of medicine, dentistry, optometry, and other providers; and

196 (C) Other medical services which, by way of illustration only and without limiting the
197 scope of this chapter, include the provision of appliances and supplies; nursing care by
198 a registered nurse; institutional services, including the general and usual care, services,
199 supplies, and equipment furnished by healthcare institutions and agencies or entities

200 other than hospitals; physiotherapy; drugs and medications; therapeutic services and
201 equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron
202 lungs; orthopedic services and appliances, including wheelchairs, trusses, braces,
203 crutches, and prosthetic devices, including artificial limbs and eyes; and any other
204 appliance, supply, or service related to healthcare which does not qualify as an
205 emergency medical service.

206 (13) 'Out-of-network' refers to healthcare services provided to a covered person by
207 providers or facilities who do not belong to the provider network in the healthcare plan.

208 (14) 'Nonparticipating provider' means a healthcare provider who has not entered into
209 a contract with a healthcare plan for the delivery of medical services.

210 (15) 'Participating provider' means a healthcare provider that has entered into a contract
211 with an insurer for the delivery of healthcare services to covered persons under a
212 healthcare plan.

213 (16) 'Resolution organization' means a qualified, independent, third-party claim dispute
214 resolution entity selected by and contracted with the department.

215 (17) 'State healthcare plan' means:

216 (A) The state employees' health insurance plan established pursuant to Article 1 of
217 Chapter 18 of Title 45;

218 (B) The health insurance plan for public school teachers established pursuant to
219 Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;

220 (C) The health insurance plan for public school employees established pursuant to
221 Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and

222 (D) The Regents Health Plan established pursuant to authority granted to the board
223 pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.

224 (18) 'Surprise bill' means a bill resulting from an occurrence in which charges arise from
225 a covered person receiving healthcare services from an out-of-network provider at an
226 in-network facility."

227

SECTION 5.

228 Said title is further amended by revising Code Section 33-21A-2, relating to definitions
229 regarding Medicaid care management organizations, as follows:

230 "33-21A-2.

231 As used in this chapter, the term:

232 (1) 'Care management organization' means an entity that is organized for the purpose of
233 providing or arranging health care, which has been granted a certificate of authority by
234 the Commissioner of Insurance as a health maintenance organization pursuant to
235 Chapter 21 of this title, and which has entered into a contract with the Department of
236 Community Health to provide or arrange health care services on a prepaid, capitated basis
237 to members.

238 (2) 'Coordination of care' means early identification of members who have or may have
239 special needs; assessment of a member's risk factors; development of a plan of care;
240 referrals and assistance to ensure timely access to providers; actively linking the member
241 to providers, medical services, and residential, social, and other support services where
242 needed; monitoring; continuity of care; and follow-up and documentation, all as further
243 described pursuant to the terms of the contracts between the Department of Community
244 Health and the care management organizations.

245 (3) 'Critical access hospital' means a hospital that meets the requirements of the federal
246 Centers for Medicare and Medicaid Services to be designated as a critical access hospital
247 and that is recognized by the Department of Community Health as a critical access
248 hospital for purposes of Medicaid.

249 (4) 'Emergency health care services' means health care services that are provided for a
250 condition of recent onset and sufficient severity, including, but not limited to, severe pain,
251 regardless of the final diagnosis that is given, that would lead a prudent layperson,
252 possessing an average knowledge of medicine and health, to believe that his or her

253 condition, sickness, or injury is of such a nature that failure to obtain immediate medical
254 care could result in:

255 (A) Placing the patient's health in serious jeopardy;

256 (B) Serious impairment to bodily functions; or

257 (C) Serious dysfunction of any bodily organ or part.

258 (5) 'Health care provider' or 'provider' means any person, partnership, professional
259 association, corporation, facility, or institution certified, licensed, or registered by the
260 State of Georgia that has contracted with a care management organization to provide
261 health care services to members.

262 (6) 'Health care services' has the same meaning as in paragraph (5) of Code
263 Section 33-21-1.

264 (7) 'Health maintenance organization' means an entity which has been issued a certificate
265 of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to
266 establish and operate a health maintenance organization.

267 (8) 'Hospital Statistical and Reimbursement Report' or 'HS&R report' means a report
268 created by a care management organization, using the same format that is used by the
269 Department of Community Health in completing HS&R reports, that includes data related
270 to an individual hospital, including aggregate statistics and reimbursement data for all
271 Medicaid recipients who are covered by the care management organization and who
272 received health care services at such hospital during a specific fiscal year, including data
273 regarding services that were provided out of network. HS&R reports are utilized by the
274 Department of Community Health for purposes of the Indigent Care Trust Fund's
275 disproportionate share hospital survey and are also utilized by hospitals to claim
276 payments under medicare's disproportionate share hospital program.

277 (9) 'Medicaid' means the joint federal and state program of medical assistance established
278 by Title XIX of the federal Social Security Act, which is administered in this state by the
279 Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

280 (10) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently
281 enrolled in a care management organization plan.

282 (11) 'PeachCare for Kids' means the State of Georgia's State Children's Health Insurance
283 Program established pursuant to Title XXI of the federal Social Security Act, which is
284 administered in this state by the Department of Community Health pursuant to Article 13
285 of Chapter 5 of Title 49.

286 (12) 'Post-stabilization services' means covered services related to an emergency medical
287 condition that are provided after a member is stabilized in order to maintain the stabilized
288 condition or to improve or resolve the member's condition.

289 (13) 'Responsible health organization' means the entity that a health care provider
290 reasonably identifies to be responsible for providing or arranging health care services for
291 a patient who is a Medicaid or PeachCare for Kids recipient after the provider has
292 properly conducted an eligibility verification in accordance with the procedures of the
293 Department of Community Health."

294

SECTION 6.

295 Said title is further amended by revising Code Section 33-24-59.27, relating to right to shop
296 for insurance coverage, disclosure of pricing information, and notice, effective July 1, 2021,
297 as follows:

298 "33-24-59.27.

299 (a) This Code section shall be known and may be cited as the 'Georgia Right to Shop Act.'

300 (b) As used in this Code section, the term:

301 (1) 'Covered person' means an individual who is covered under a health benefit policy.

302 (2) 'Emergency services' means those health care services that are provided for a
303 condition of recent onset and sufficient severity, including, but not limited to, severe pain,
304 regardless of the final diagnosis that is given, that would lead a prudent layperson,
305 possessing an average knowledge of medicine and health, to believe that his or her

306 condition, sickness, or injury is of such a nature that failure to obtain immediate medical
307 care could result in:

308 (A) Placing the patient's health in serious jeopardy;

309 (B) Serious impairment to bodily functions; or

310 (C) Serious dysfunction of any bodily organ or part.

311 (3) 'Health benefit policy' or 'policy' means any individual or group plan, policy, or
312 contract for health care services issued, delivered, issued for delivery, executed, or
313 renewed in this state, including, but not limited to, those contracts executed by the state
314 on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

315 (4) 'Health care provider' or 'provider' means any physician, dentist, podiatrist,
316 pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse,
317 registered optician, licensed professional counselor, physical therapist, marriage and
318 family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8,
319 occupational therapist, speech language pathologist, audiologist, dietitian, or physician
320 assistant.

321 (5) 'Health care service' means:

322 (A) Physical and occupational therapy services;

323 (B) Obstetrical and gynecological services;

324 (C) Radiology and imaging services;

325 (D) Laboratory services;

326 (E) Infusion therapy;

327 (F) Inpatient or outpatient surgical procedures;

328 (G) Outpatient nonsurgical diagnostic tests or procedures; and

329 (H) Any services designated by the Commissioner as shoppable by health care
330 consumers.

331 (6) 'Hierarchical Condition Category Methodology' means a coding system designed by
332 the Centers for Medicare and Medicaid Services to estimate future health care costs for
333 patients.

334 (7) 'Insurer' means an accident and sickness insurer, fraternal benefit society, hospital
335 service corporation, medical service corporation, health care corporation, health
336 maintenance organization, preferred provider organization, provider sponsored ~~health~~
337 health care corporation, managed care entity, or any similar entity authorized to issue
338 contracts under this title or to provide health benefit policies.

339 (c) Each insurer shall make available on its publicly accessible website an interactive
340 mechanism whereby any member of the public may:

341 (1) For each health benefit policy offered, compare the payment amounts accepted by
342 in-network providers from such insurer for the provision of a particular health care
343 service within the previous year;

344 (2) For each health benefit policy offered, obtain an estimate of the average amount
345 accepted by in-network providers from such insurer for the provision of a particular
346 health care service within the previous year;

347 (3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs
348 that such covered person would owe his or her provider following the provision of a
349 particular health care service;

350 (4) Compare quality metrics applicable to in-network providers for major diagnostic
351 categories with adjustments by risk and severity based upon the Hierarchical Condition
352 Category Methodology or a nationally recognized health care quality reporting standard
353 designated by the Commissioner. Metrics shall be based on reasonably universal and
354 uniform data bases with sufficient claim volume. If applicable to the provider, quality
355 metrics shall include, but not be limited to:

356 (A) Risk adjusted and absolute hospital readmission rates;

357 (B) Risk adjusted and absolute hospitalization rates;

358 (C) Admission volume;

359 (D) Utilization volume;

360 (E) Risk adjusted rates of adverse events; and

361 (F) Risk adjusted and absolute relative total cost of care.

362 The Commissioner shall promulgate rules and regulations which define the following
363 terms: risk adjusted hospital readmission rates, absolute hospital readmission rates, risk
364 adjusted hospitalization rates, absolute hospitalization rates, admission volume,
365 utilization volume, risk adjusted rates of adverse events, risk adjusted total cost of care,
366 and absolute relative total cost of care. Such terms shall be defined in accordance with
367 federal law or regulation or as otherwise determined necessary by the Commissioner; and

368 (5) Access any all-payer health claims data base which may be maintained by the
369 department.

370 (d) An insurer shall provide notification on its website that the actual amount that a
371 covered person will be responsible to pay following the receipt of a particular health care
372 service may vary due to unforeseen costs that arise during the provision of such service.

373 (e) Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection
374 (c) of this Code section shall provide the following:

375 (1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or
376 her deductible; and

377 (2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his
378 or her deductible.

379 (f) An insurer may contract with a third party to satisfy part or all of the requirements of
380 this Code section.

381 (g) Nothing in this Code section shall prohibit an insurer from charging a covered person
382 cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of
383 subsection (c) of this Code section if such additional cost sharing resulted from the
384 unforeseen provision of additional health care services and the cost-sharing requirements

385 of such unforeseen health care services were disclosed in such covered person's policy or
386 certificate of insurance.

387 (h) The requirements of this Code section, with the exception of paragraph (4) of
388 subsection (c) of this Code section, shall not apply to any health maintenance organization
389 health benefits plan as defined in paragraph (4) of Code Section 33-21-1."

390 **SECTION 7.**

391 Said title is further amended by revising Code Section 33-30-22, relating to definitions
392 regarding preferred provider arrangements, as follows:

393 "33-30-22.

394 As used in this article, the term:

395 (1) 'Emergency services' or 'emergency care' means those health care services that are
396 provided for a condition of recent onset and sufficient severity, including, but not limited
397 to, severe pain, regardless of the final diagnosis that is given, that would lead a prudent
398 layperson, possessing an average knowledge of medicine and health, to believe that his
399 or her condition, sickness, or injury is of such a nature that failure to obtain immediate
400 medical care could result in:

401 (A) Placing the patient's health in serious jeopardy;

402 (B) Serious impairment to bodily functions; or

403 (C) Serious dysfunction of any bodily organ or part.

404 (2) 'Health benefit plan' means the health insurance policy or subscriber agreement
405 between the covered person or the policyholder and the health care insurer which defines
406 the covered services and benefit levels available.

407 (3) 'Health care insurer' means an insurer, a fraternal benefit society, a health care plan,
408 or a health maintenance organization authorized to sell accident and sickness insurance
409 policies, subscriber certificates, or other contracts of insurance by whatever name called
410 under this title.

411 (4) 'Health care provider' means any person duly licensed or legally authorized to
412 provide health care services.

413 (5) 'Health care services' means services rendered or products sold by a health care
414 provider within the scope of the provider's license or legal authorization. The term
415 includes, but is not limited to, hospital, medical, surgical, dental, vision, chiropractic,
416 psychological, and pharmaceutical services or products.

417 (6) 'Preferred provider' means a health care provider or group of providers who have
418 contracted to provide specified covered services.

419 (7) 'Preferred provider arrangement' means a contract between or on behalf of the health
420 care insurer and a preferred provider which complies with all the requirements of this
421 article."

422 **SECTION 8.**

423 All laws and parts of laws in conflict with this Act are repealed.