VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 38.2-4300 of the Code of Virginia, relating to health maintenance organizations; emergency services.

[H 2583]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4300 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-4300. Definitions.

As used in this chapter:

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title.

"Copayment" means a payment required of enrollees as a condition of the receipt of specific health services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers 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 (i) serious jeopardy to the mental or physical health of the individual, or (ii) danger of serious impairment of the individual's bodily functions, or (iii) serious disfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrolee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least ninety percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees

and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.