[27 R.I. Gen. Laws § 27-19-1.]

§ 27-19-1. Definitions: Nonprofit Hospital Service Corporations

As used in this chapter:

(1) "Contracting hospital" means an eligible hospital which has contracted with a nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit hospital service plan operated by the corporation;

(2) "Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.

(3) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and federal regulations adopted thereunder;

(4) "Commissioner" or "health insurance commissioner" means that individual appointed pursuant to § 42-14.5-1 of the General laws;

(5) "Eligible hospital" is one which is maintained either by the state or by any of its political subdivisions or by a corporation organized for hospital purposes under the laws of this state or of any other state or of the United States, which is designated as an eligible hospital by a majority of the directors of the nonprofit hospital service corporation;

(6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the federal Affordable Care Act [42 U.S.C. § 18022(b)].

(7) "Grandfathered health plan" means any group health plan or health insurance coverage subject to 42 U.S.C. § 18011;

(8) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan;

(9) "Group health plan" means an employee welfare benefit plan as defined 29 U.S.C. § 1002(1), to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise;

(10) "Health benefits" or "covered benefits" means coverage or benefits for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body including coverage or benefits for transportation primarily for and essential thereto, and including medical services as defined in R.I. Gen. Laws § 27-19-17;

(11) "Health-care facility" means an institution providing health-care services or a health-care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(12) "Health-care professional" means a physician or other health-care practitioner licensed, accredited or certified to perform specified health-care services consistent with state law;

(13) "Health-care provider" or "provider" means a health-care professional or a health-care facility;

(14) "Health-care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(15) "Health insurance carrier" means a person, firm, corporation or other entity subject to the jurisdiction of the commissioner under this chapter, and includes nonprofit hospital service corporations. Such term does not include a group health plan. The use of this term shall not be construed to subject a nonprofit hospital service corporation to the insurance laws of this state other than as set forth in R.I. Gen. Laws § 27-19-2;

(16) "Health plan" or "health benefit plan" means health insurance coverage and a group health plan, including coverage provided through an association plan if it covers Rhode Island residents. Except to the extent specifically provided by the federal Affordable Care Act, the term "health plan" shall not include a group health plan to the extent state regulation of the health plan is pre-empted under section 514 of the federal Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1144]. The term also shall not include:

(A)(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to federal Pub. L. No. 104-191, the federal health insurance portability and accountability act of 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other insurance benefits.

(B) The following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Other excepted benefits specified in federal regulations issued pursuant to federal Pub. L. No. 104-191 ("HIPAA").

(C) The following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(D) The following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. § 1395ss].

(ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(17) "Nonprofit hospital service corporation" means any corporation organized pursuant to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital service plan;

(18) "Nonprofit hospital service plan" means a plan by which specified hospital care is to be provided to subscribers to the plan by a contracting hospital;

(19) "Office of the health insurance commissioner" means the agency established under § 42-14.5-1;

(20) "Rescission" means a cancellation or discontinuance of coverage that has retroactive effect for reasons unrelated to timely payment of required premiums or contribution to costs of coverage; and

(21) "Subscribers" mean those persons, whether or not residents of this state, who have contracted with a nonprofit hospital service corporation for hospital care pursuant to a nonprofit hospital service plan operated by the corporation.