304.17A-500 Definitions for KRS 304.17A-500 to 304.17A-590.

As used in KRS 304.17A-500 to 304.17A-590, unless the context requires otherwise:

(1) "Areas other than urban areas" means a classification code that does not meet the definition of urban area;

(2) "Contract holder" means an employer or organization that purchases a health benefit plan;

(3) "Covered person" means a person on whose behalf an insurer offering the plan is obligated to pay benefits or provide services under the health insurance policy;

(4) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

(b) With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;

(5) "Enrollee" means a person who is enrolled in a plan offered by a health maintenance organization as defined in KRS 304.38-030(5);

(6) "Grievance" means a written complaint submitted by or on behalf of an enrollee;

(7) "Health insurance policy" means "health benefit plan" as defined in KRS 304.17A-005;

(8) "Insurer" has the meaning provided in KRS 304.17A-005;

(9) "Managed care plan" means a health insurance policy that integrates the financing and delivery of appropriate health care services to enrollees by arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health care services and financial incentives for enrollees to use the participating providers and procedures provided for in the plan;

(10) "Participating health care provider" means a health care provider that has entered into an agreement with an insurer to provide health care services;

(11) "Quality assurance or improvement" means the ongoing evaluation by a managed care plan of the quality of health care services provided to its enrollees;

(12) "Record" means any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the

patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient;

(13) "Risk sharing arrangement" means any agreement that allows an insurer to share the financial risk of providing health care services to enrollees or insureds with another entity or provider where there is a chance of financial loss to the entity or provider as a result of the delivery of a service. A risk sharing arrangement shall not include a reinsurance contract with an accredited or admitted reinsurer;

(14) "Urban area" means a classification code whereby the zip code population density is greater than three thousand (3,000) persons per square mile; and

(15) "Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

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