(4) Preferred provider policies or preferred provider contracts offered under this section shall provide for payment of services rendered by nonpreferred providers. Unless the insurer demonstrates to the satisfaction of the Insurance Commissioner that an alternative level of payment is more appropriate under the circumstances, aggregate payments in any full calendar year made under this paragraph to nonpreferred providers after all deductible and copayment provisions have been applied may not on the average be less than 80% of the aggregate payments in that full calendar year to preferred providers for similar services in the same geographic area pursuant to the preferred providers' agreements to provide the services.

(c) If the rates for each institutional provider under a preferred provider policy or preferred provider contract vary based upon individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates may not be deemed to constitute unfair discrimination under this article.

(d) This section does not apply to any employee benefit plan regulated by federal law or by the Employee Retirement Income Security Act of 1974 (ERISA).]

[490J.

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

(2) "Provider" means any person, including a physician or hospital, who is licensed or otherwise authorized to provide health care services within the scope of the license or authorization.

(3) "Preferred provider arrangement" means any contract or agreement, formal or otherwise, under which health services are to be provided to certain persons on a preferential basis.

(4) "Preferential basis" means that the subscriber or other 3rd party beneficiary under a preferred provider arrangement is entitled to receive health care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than would be the case if the beneficiary or patient received similar services from a nonpreferred provider.

(5) "Preferred provider" means the provider who has agreed to the preferential terms of a preferred provider arrangement.

(6) "Nonpreferred provider" means a provider who is not a preferred provider.

(b) Each insurer, nonprofit health service plan, dental plan organization, or similar organization, and each employer, administrator, or other entity establishing a preferred provider arrangement shall, upon request of the Commissioner, submit to the Insurance Commissioner a written summary description of the arrangement, contracts, or agreements establishing the preferred provider arrangement, and prototype copies of agreements with preferred providers.

(c) The Commissioner may impose a penalty of not less than $50 or more than