~~(VII) A HEALTH BENEFIT PLAN ISSUED BY A MANAGED CARE ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.~~

[(h)**]** (I) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

[(i)**]** (J) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

[(j)**]** (K) (1) "Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

[(k)**]** (L) "Private review agent" has the meaning stated in § 15–10B–01 of this title.

15–10A–01.1.

THIS SUBTITLE APPLIES TO A HEALTH BENEFIT PLAN THAT:

(1) IS DELIVERED OR ISSUED IN THE STATE; OR

(2) COVERS INDIVIDUALS WHO RESIDE OR WORK IN THE STATE IF THE HEALTH BENEFIT PLAN IS DELIVERED OR ISSUED IN A STATE THAT THE COMMISSIONER DETERMINES DOES NOT HAVE AN EXTERNAL COMPLAINT PROCESS FOR ADVERSE DECISIONS OR GRIEVANCES COMPARABLE TO THE COMPLAINT PROCESS ESTABLISHED IN THIS SUBTITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1999.

May 27, 1999

The Honorable Casper R. Taylor, Jr.
Speaker of the House