START\_STATUTE20-2801.  Definitions

In this chapter, unless the context otherwise requires:

1.  "Coverage" means the contractual obligation of a health care services plan to pay its enrollee or a contracted or noncontracted provider for medically necessary emergency services rendered by the provider to an enrollee, as specified in the governing agreement, contract or policy between the plan and the enrollee, subject to applicable copayments, coinsurance and deductibles.

2.  "Emergency ambulance services" means services provided by an ambulance service authorized to operate pursuant to title 36, chapter 21.1 following the onset of a medical condition that manifests itself by symptoms of pain, illness or injury that the absence of accessing an ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:

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

(b)  Serious impairment to bodily functions.

(c)  Serious dysfunction of any bodily organ or part.

3.  "Emergency services" means health care services that are provided to an enrollee in a licensed hospital emergency facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a)  Serious jeopardy to the patient's health.

(b)  Serious impairment to bodily functions.

(c)  Serious dysfunction of any bodily organ or part.

4.  "Enrollee" means an individual, or a dependent of that individual, who is currently enrolled with and covered by a health care services plan.

5.  "Health care services plan" means a plan offered by a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation or medical service corporation that contractually agrees to pay or make reimbursement for health care expenses for one or more individuals residing in Arizona but does not apply to benefits provided under limited benefit coverage as defined in section 20‑1137.

6.  "Prior authorization" means authorization by telephone or telefacsimile given in advance of the performance of an emergency service on an enrollee, by a health care services plan after receipt of necessary medical and enrollment information on the enrollee. Prior authorization shall not be considered as a guarantee of full payment.

7.  "Provider" means any physician, hospital or other person that is licensed or otherwise authorized to furnish emergency services in this state. END\_STATUTE