

2024 -- S 2176

LC004141

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators DiMario, Lauria, Lawson, Pearson, Ujifusa, Valverde, Euer, Murray, and Bissaillon

Date Introduced: January 24, 2024

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-76 of the General Laws in Chapter 27-18 entitled "Accident  
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-76. Emergency services.**

4 (a) As used in this section:

5 (1) "Emergency medical condition" means a medical condition manifesting itself by acute  
6 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses  
7 an average knowledge of health and medicine, could reasonably expect the absence of immediate  
8 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to  
9 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to  
10 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

11 (2) "Emergency services" means, with respect to an emergency medical condition:

12 ~~(A)~~(i) A medical screening examination (as required under section 1867 of the Social  
13 Security Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a  
14 hospital, including ancillary services routinely available to the emergency department to evaluate  
15 such emergency medical condition, ~~and~~ ;

16 ~~(B)~~(ii) Such further medical examination and treatment, to the extent they are within the  
17 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of  
18 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; and

19 (iii) Transportation for emergency services by ambulance or rescue.

1 (3) "Stabilize," with respect to an emergency medical condition has the meaning given in  
2 § 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

3 (b) If a health insurance carrier offering health insurance coverage provides any benefits  
4 with respect to services in an emergency department of a hospital, the carrier must cover emergency  
5 services in compliance with this section.

6 (c) A health insurance carrier shall provide coverage for emergency services in the  
7 following manner:

8 (1) Without the need for any prior authorization determination, even if the emergency  
9 services are provided on an out-of-network basis;

10 (2) Without regard to whether the healthcare provider furnishing the emergency services is  
11 a participating network provider with respect to the services;

12 (3) If the emergency services are provided out of network, without imposing any  
13 administrative requirement or limitation on coverage that is more restrictive than the requirements  
14 or limitations that apply to emergency services received from in-network providers;

15 (4) If the emergency services are provided out of network, by complying with the cost-  
16 sharing requirements of subsection (d) of this section; and

17 (5) Without regard to any other term or condition of the coverage, other than:

18 (A) The exclusion of or coordination of benefits;

19 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title  
20 XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

21 (C) Applicable cost-sharing.

22 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate  
23 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot  
24 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the  
25 services were provided in-network; provided, however, that a participant or beneficiary may be  
26 required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-  
27 network provider charges over the amount the health insurance carrier is required to pay under  
28 subdivision (1) of this subsection. A health insurance carrier complies with the requirements of this  
29 subsection if it provides benefits with respect to an emergency service in an amount equal to the  
30 greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)  
31 (which are adjusted for in-network cost-sharing requirements).

32 (A) The amount negotiated with in-network providers for the emergency service furnished,  
33 excluding any in-network copayment or coinsurance imposed with respect to the participant or  
34 beneficiary. If there is more than one amount negotiated with in-network providers for the

1 emergency service, the amount described under this subdivision (A) is the median of these amounts,  
2 excluding any in-network copayment or coinsurance imposed with respect to the participant or  
3 beneficiary. In determining the median described in the preceding sentence, the amount negotiated  
4 with each in-network provider is treated as a separate amount (even if the same amount is paid to  
5 more than one provider). If there is no per-service amount negotiated with in-network providers  
6 (such as under a capitation or other similar payment arrangement), the amount under this  
7 subdivision (A) is disregarded.

8 (B) The amount for the emergency service shall be calculated using the same method the  
9 plan generally uses to determine payments for out-of-network services (such as the usual,  
10 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed  
11 with respect to the participant or beneficiary. The amount in this subdivision (B) is determined  
12 without reduction for out-of-network cost-sharing that generally applies under the plan or health  
13 insurance coverage with respect to out-of-network services.

14 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the  
15 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network  
16 copayment or coinsurance imposed with respect to the participant or beneficiary.

17 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such  
18 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services  
19 provided out of network if the cost-sharing requirement generally applies to out-of-network  
20 benefits. A deductible may be imposed with respect to out-of-network emergency services only as  
21 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum  
22 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-  
23 network emergency services.

24 (e) The provisions of this section apply for plan years beginning on or after September 23,  
25 2010.

26 (f) This section shall not apply to grandfathered health plans. This section shall not apply  
27 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability  
28 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health;  
29 (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9)  
30 other limited benefit policies.

31 SECTION 2. Section 27-19-66 of the General Laws in Chapter 27-19 entitled "Nonprofit  
32 Hospital Service Corporations" is hereby amended to read as follows:

33 **27-19-66. Emergency services.**

34 (a) As used in this section:

1 (1) "Emergency medical condition" means a medical condition manifesting itself by acute  
2 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses  
3 an average knowledge of health and medicine, could reasonably expect the absence of immediate  
4 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to  
5 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to  
6 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

7 (2) "Emergency services" means, with respect to an emergency medical condition:

8 (i) A medical screening examination (as required under section 1867 of the Social Security  
9 Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital,  
10 including ancillary services routinely available to the emergency department to evaluate such  
11 emergency medical condition; ~~and~~

12 (ii) Such further medical examination and treatment, to the extent they are within the  
13 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of  
14 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; and

15 (iii) Transportation for emergency services by ambulance or rescue.

16 (3) "Stabilize," with respect to an emergency medical condition has the meaning given in  
17 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

18 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with  
19 respect to services in an emergency department of a hospital, the plan must cover emergency  
20 services consistent with the rules of this section.

21 (c) A nonprofit hospital service corporation shall provide coverage for emergency services  
22 in the following manner:

23 (1) Without the need for any prior authorization determination, even if the emergency  
24 services are provided on an out-of-network basis;

25 (2) Without regard to whether the healthcare provider furnishing the emergency services is  
26 a participating network provider with respect to the services;

27 (3) If the emergency services are provided out of network, without imposing any  
28 administrative requirement or limitation on coverage that is more restrictive than the requirements  
29 or limitations that apply to emergency services received from in-network providers;

30 (4) If the emergency services are provided out of network, by complying with the cost-  
31 sharing requirements of subsection (d) of this section; and

32 (5) Without regard to any other term or condition of the coverage, other than:

33 (i) The exclusion of or coordination of benefits;

34 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title

1 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue  
2 Code; or

3 (iii) Applicable cost sharing.

4 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate  
5 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot  
6 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the  
7 services were provided in-network. However, a participant or beneficiary may be required to pay,  
8 in addition to the in-network cost sharing, the excess of the amount the out-of-network provider  
9 charges over the amount the plan or health insurance carrier is required to pay under subsection  
10 (d)(1). A group health plan or health insurance carrier complies with the requirements of this  
11 subsection (d) if it provides benefits with respect to an emergency service in an amount equal to  
12 the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii) of this  
13 section (which are adjusted for in-network cost-sharing requirements).

14 (i) The amount negotiated with in-network providers for the emergency service furnished,  
15 excluding any in-network copayment or coinsurance imposed with respect to the participant or  
16 beneficiary. If there is more than one amount negotiated with in-network providers for the  
17 emergency service, the amount described under this subsection (d)(1)(i) is the median of these  
18 amounts, excluding any in-network copayment or coinsurance imposed with respect to the  
19 participant or beneficiary. In determining the median described in the preceding sentence, the  
20 amount negotiated with each in-network provider is treated as a separate amount (even if the same  
21 amount is paid to more than one provider). If there is no per-service amount negotiated with in-  
22 network providers (such as under a capitation or other similar payment arrangement), the amount  
23 under this subsection (d)(1)(i) is disregarded.

24 (ii) The amount for the emergency service shall be calculated using the same method the  
25 plan generally uses to determine payments for out-of-network services (such as the usual,  
26 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed  
27 with respect to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined  
28 without reduction for out-of-network cost sharing that generally applies under the plan or health  
29 insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally  
30 pays seventy percent (70%) of the usual, customary, and reasonable amount for out-of-network  
31 services, the amount in this subsection (d)(1)(ii) for an emergency service is the total, that is, one  
32 hundred percent (100%), of the usual, customary, and reasonable amount for the service, not  
33 reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-network  
34 services (but reduced by the in-network copayment or coinsurance that the individual would be

1 responsible for if the emergency service had been provided in-network).

2 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the  
3 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network  
4 copayment or coinsurance imposed with respect to the participant or beneficiary.

5 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such  
6 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services  
7 provided out of network if the cost-sharing requirement generally applies to out-of-network  
8 benefits. A deductible may be imposed with respect to out-of-network emergency services only as  
9 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum  
10 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-  
11 network emergency services.

12 (e) The provisions of this section apply for plan years beginning on or after September 23,  
13 2010.

14 (f) This section shall not apply to insurance coverage providing benefits for: (1) Hospital  
15 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare  
16 supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily  
17 injury or death by accident or both; and (9) Other limited benefit policies.

18 SECTION 3. Section 27-20-62 of the General Laws in Chapter 27-20 entitled "Nonprofit  
19 Medical Service Corporations" is hereby amended to read as follows:

20 **27-20-62. Emergency services.**

21 (a) As used in this section:

22 (1) "Emergency medical condition" means a medical condition manifesting itself by acute  
23 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses  
24 an average knowledge of health and medicine, could reasonably expect the absence of immediate  
25 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to  
26 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to  
27 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

28 (2) "Emergency services" means, with respect to an emergency medical condition:

29 (i) A medical screening examination (as required under section 1867 of the Social Security  
30 Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital,  
31 including ancillary services routinely available to the emergency department to evaluate the  
32 emergency medical condition; **and**

33 (ii) Further medical examination and treatment, to the extent they are within the capabilities  
34 of the staff and facilities available at the hospital, as are required under section 1867 of the Social

1 Security Act (42 U.S.C. § 1395dd) to stabilize the patient; [and](#)

2 [\(iii\) Transportation for emergency services by ambulance or rescue.](#)

3 (3) “Stabilize,” with respect to an emergency medical condition has the meaning given in  
4 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

5 (b) If a nonprofit medical service corporation offering health insurance coverage provides  
6 any benefits with respect to services in an emergency department of a hospital, it must cover  
7 emergency services consistent with the rules of this section.

8 (c) A nonprofit medical service corporation shall provide coverage for emergency services  
9 in the following manner:

10 (1) Without the need for any prior authorization determination, even if the emergency  
11 services are provided on an out-of-network basis;

12 (2) Without regard to whether the healthcare provider furnishing the emergency services is  
13 a participating network provider with respect to the services;

14 (3) If the emergency services are provided out of network, without imposing any  
15 administrative requirement or limitation on coverage that is more restrictive than the requirements  
16 or limitations that apply to emergency services received from in-network providers;

17 (4) If the emergency services are provided out of network, by complying with the cost-  
18 sharing requirements of subsection (d) of this section; and

19 (5) Without regard to any other term or condition of the coverage, other than:

20 (i) The exclusion of or coordination of benefits;

21 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title  
22 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue  
23 Code; or

24 (iii) Applicable cost sharing.

25 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate  
26 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot  
27 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the  
28 services were provided in-network. However, a participant or beneficiary may be required to pay,  
29 in addition to the in-network cost sharing, the excess of the amount the out-of-network provider  
30 charges over the amount the plan or health insurance carrier is required to pay under subsection  
31 (d)(1). A group health plan or health insurance carrier complies with the requirements of this  
32 subsection (d) if it provides benefits with respect to an emergency service in an amount equal to  
33 the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii) of this  
34 section (which are adjusted for in-network cost-sharing requirements).

1 (i) The amount negotiated with in-network providers for the emergency service furnished,  
2 excluding any in-network copayment or coinsurance imposed with respect to the participant or  
3 beneficiary. If there is more than one amount negotiated with in-network providers for the  
4 emergency service, the amount described under this subsection (d)(1)(i) is the median of these  
5 amounts, excluding any in-network copayment or coinsurance imposed with respect to the  
6 participant or beneficiary. In determining the median described in the preceding sentence, the  
7 amount negotiated with each in-network provider is treated as a separate amount (even if the same  
8 amount is paid to more than one provider). If there is no per-service amount negotiated with in-  
9 network providers (such as under a capitation or other similar payment arrangement), the amount  
10 under this subsection (d)(1)(i) is disregarded.

11 (ii) The amount for the emergency service shall be calculated using the same method the  
12 plan generally uses to determine payments for out-of-network services (such as the usual,  
13 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed  
14 with respect to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined  
15 without reduction for out-of-network cost sharing that generally applies under the plan or health  
16 insurance coverage with respect to out-of-network services.

17 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the  
18 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network  
19 copayment or coinsurance imposed with respect to the participant or beneficiary.

20 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such  
21 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services  
22 provided out of network if the cost-sharing requirement generally applies to out-of-network  
23 benefits. A deductible may be imposed with respect to out-of-network emergency services only as  
24 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum  
25 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-  
26 network emergency services.

27 (f) The provisions of this section shall apply to grandfathered health plans. This section  
28 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;  
29 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited  
30 benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident  
31 or both; and (9) Other limited benefit policies.

32 SECTION 4. Section 27-41-79 of the General Laws in Chapter 27-41 entitled "Health  
33 Maintenance Organizations" is hereby amended to read as follows:

34 **27-41-79. Emergency services.**



1 (a) As used in this section:

2 (1) “Emergency medical condition” means a medical condition manifesting itself by acute  
3 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses  
4 an average knowledge of health and medicine, could reasonably expect the absence of immediate  
5 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to  
6 a pregnant woman her unborn child in serious jeopardy; (ii) Constituting a serious impairment to  
7 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

8 (2) “Emergency services” means, with respect to an emergency medical condition:

9 (i) A medical screening examination (as required under section 1867 of the Social Security  
10 Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital,  
11 including ancillary services routinely available to the emergency department to evaluate such  
12 emergency medical condition; ~~and~~

13 (ii) Such further medical examination and treatment, to the extent they are within the  
14 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of  
15 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; and

16 (iii) Transportation for emergency services by ambulance or rescue.

17 (3) “Stabilize,” with respect to an emergency medical condition has the meaning given in  
18 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

19 (b) If a health maintenance organization offering group health insurance coverage provides  
20 any benefits with respect to services in an emergency department of a hospital, it must cover  
21 emergency services consistent with the rules of this section.

22 (c) A health maintenance organization shall provide coverage for emergency services in  
23 the following manner:

24 (1) Without the need for any prior authorization determination, even if the emergency  
25 services are provided on an out-of-network basis;

26 (2) Without regard to whether the healthcare provider furnishing the emergency services is  
27 a participating network provider with respect to the services;

28 (3) If the emergency services are provided out of network, without imposing any  
29 administrative requirement or limitation on coverage that is more restrictive than the requirements  
30 or limitations that apply to emergency services received from in-network providers;

31 (4) If the emergency services are provided out of network, by complying with the cost-  
32 sharing requirements of subsection (d) of this section; and

33 (5) Without regard to any other term or condition of the coverage, other than:

34 (i) The exclusion of or coordination of benefits;

1 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title  
2 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue  
3 Code; or

4 (iii) Applicable cost sharing.

5 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate  
6 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot  
7 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the  
8 services were provided in-network; provided, however, that a participant or beneficiary may be  
9 required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-  
10 network provider charges over the amount the plan or health maintenance organization is required  
11 to pay under subsection (d)(1). A health maintenance organization complies with the requirements  
12 of this subsection (d) if it provides benefits with respect to an emergency service in an amount  
13 equal to the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii)  
14 of this section (which are adjusted for in-network cost-sharing requirements).

15 (i) The amount negotiated with in-network providers for the emergency service furnished,  
16 excluding any in-network copayment or coinsurance imposed with respect to the participant or  
17 beneficiary. If there is more than one amount negotiated with in-network providers for the  
18 emergency service, the amount described under this subsection (d)(1)(i) is the median of these  
19 amounts, excluding any in-network copayment or coinsurance imposed with respect to the  
20 participant or beneficiary. In determining the median described in the preceding sentence, the  
21 amount negotiated with each in-network provider is treated as a separate amount (even if the same  
22 amount is paid to more than one provider). If there is no per-service amount negotiated with in-  
23 network providers (such as under a capitation or other similar payment arrangement), the amount  
24 under this subsection (d)(1)(i) is disregarded.

25 (ii) The amount for the emergency service calculated using the same method the plan  
26 generally uses to determine payments for out-of-network services (such as the usual, customary,  
27 and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect  
28 to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined without  
29 reduction for out-of-network cost sharing that generally applies under the plan or health insurance  
30 coverage with respect to out-of-network services.

31 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the  
32 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network  
33 copayment or coinsurance imposed with respect to the participant or beneficiary.

34 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such

1 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services  
2 provided out of network if the cost-sharing requirement generally applies to out-of-network  
3 benefits. A deductible may be imposed with respect to out-of-network emergency services only as  
4 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum  
5 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-  
6 network emergency services.

7 (e) The provisions of this section apply for plan years beginning on or after September 23,  
8 2010.

9 (f) The provisions of this section shall apply to grandfathered health plans. This section  
10 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;  
11 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited  
12 benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident  
13 or both; and (9) Other limited benefit policies.

14 SECTION 5. This act shall take effect upon passage.

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LC004141  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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- 1           This act would mandate health insurance coverage to include transportation for emergency
- 2 services by ambulance or rescue.
- 3           This act would take effect upon passage.

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