191—27.2(514F) Definitions. As used in this chapter, unless the context otherwise requires:

"Commissioner" means the commissioner of insurance.

"Covered person" means a person on whose behalf the health care insurer is obligated to pay for or provide health care services.

"Covered services" means health care services which the health care insurer is obligated to pay for or provide under the health benefit plan.

"Emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

"Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

"Health care insurer" means a third-party payer of health benefits including, but not limited to, a person providing a policy or contract providing for third-party payment or prepayment of health or medical expenses, including the following:

1. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
2. An individual or group hospital or medical service contract issued pursuant to Iowa Code chapter 509, 514 or 514A.
3. An individual or group health maintenance organization contract regulated under Iowa Code chapter 514B.
4. An individual or group Medicare supplement policy.
5. A fraternal benefit society.

"Health care provider" or *"provider"* means a provider of health care services as defined in rule 191—34.2(514).

"Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

"Preferred provider" means a health care provider or group of providers who have contracted to provide specified covered services.

"Preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this chapter.