**Section 4521.20 Definitions**

"ACA" means the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.).

"Act" means the Health Maintenance Organization Act [215 ILCS 125].

"Advertisement" has the meaning ascribed in Section 1-21(1) of the Act.

"Base Rates" means the rate generated before any classification deviations are applied.

"Basic Health Care Services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, infertility treatment, prenatal and postnatal care, delivery and inpatient services for maternity care, and preventative services required pursuant to 42 U.S.C. 300gg-13, all of which are subject to limitations set forth in this Part (see Section 1-2(3) of the Act).

"Cancellation" means the termination of a group contract, evidence of coverage, or individual contract by an HMO prior to the expiration date of the group contract, evidence of coverage, or individual contract.

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Consumer" means any enrollee, provided that the individual is not or has not been in the previous two years an employee (including the employee's spouse or dependent) of the HMO or affiliate of the HMO or a provider furnishing health care services to the HMO or affiliate of the HMO.

"Copayment" means the amount an enrollee must pay in order to receive a specific covered service that is not fully prepaid.

"Deductible" means the amount an enrollee is responsible to pay out of pocket before the HMO begins to pay the costs associated with treatment.

"Director" means the Director of the Illinois Department of Insurance.

"Department" means the Illinois Department of Insurance.

"Department of Insurance Complaint" means a written complaint filed by or on behalf of an enrollee, with the Department pursuant to Section 4-6 of the Act, excluding complaints filed by Illinois Department of Healthcare and Family Services HMO members under Section 5-11 of the Public Aid Code [305 ILCS 5/5-11] and complaints subject to handling by the Centers for Medicare and Medicaid Services (CMMS) pursuant to a contract entered into between CMMS and the HMO.

"Enrollee"has the meaning ascribed in Section 1-2(4) of the Act.

"Evidence of Coverage" has the meaning ascribed in Section 1-2(5) of the Act.

"Governing Body" means the board of trustees, or directors, or, if otherwise designated in the basic organizational document bylaws, those individuals vested with the ultimate responsibility for the management of any organization that has been issued or is applying for a certificate of authority as an HMO.

"Grievance" means any written complaint submitted to the HMO by or on behalf of an enrollee regarding any aspect of the HMO relative to the enrollee, but shall not include any complaint by or on behalf of a provider.

"Grievance Committee" means individuals who have been appointed by the HMO to respond to grievances that have been filed on appeal from the HMO's simplified complaint process established pursuant to Section 4521.40(d). At least 50% of the individuals on this committee shall be enrollees who are consumers.

"Group Contract"has the meaning ascribed in Section 1-2(6) of the Act.

"Health Care Plan" has the meaning ascribed in Section 1-2(7) of the Act.

"Health Care Services"has the meaning ascribed in Section 1-2(8) of the Act.

"HMO" means Health Maintenance Organization.

"Individual Contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

"Limited Insurance Representative" means an individual appointed by an HMO to represent the HMO in the enrollment of recipients of Medicaid or Medicare in the HMO.

"Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and Physician Hospital Organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services.

"Notice of Availability of the Department", as required by this Part, shall be no less informative than the following:

The regulations of the Illinois Department of Insurance (50 Ill. Adm. Code 4521.110(p)) require that we advise you that if you wish to take this matter up with the Illinois Department of Insurance it maintains a Consumer Division in Chicago at 122 S. Michigan Avenue, 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767-0001. The Department can also be contacted by phone at (217) 782-4515 or its website at: https://idoi.illinois.gov.

"Nursing Home" means a skilled nursing care facility that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act [210 ILCS 45].

"Point of Service Plan" means a plan in which an eligible enrollee is covered under both an HMO evidence of coverage and an indemnity insurance policy or certificate and may select, on a point-of-service basis, between using the HMO or the indemnity benefit program.

"Primary Care Physician" means a provider who has contracted with an HMO to provide primary care services as defined by the contract and who is:

a physician licensed to practice medicine in all of its branches who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, or family practice;

a chiropractic physician licensed to treat human ailments without the use of drugs or operative surgery.

"Producer" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment (see Section 1-2(13) of the Act).

"Provider"has the meaning ascribed in Section 1-2(12) of the Act.

"Renewal" means the issuance and delivery by an HMO of a group contract or individual contract superseding at the end of the contract period a contract previously issued and delivered by the same HMO or the issuance and delivery of a certificate or notice extending the term of the group or individual contract beyond its contract term.

"Solicitation" means any method by which information relative to an HMO is made known to the public for the purpose of informing or influencing potential enrollees to enroll in a Health Care Plan, regardless of the media or technique used.

"State" means any governing body, department or agency of the State of Illinois that has regulatory authority under the Act.

"Subscriber"has the meaning ascribed in Section 1-2(16) of the Act.

"Supplemental Health Care Services" means any health care service other than basic health care services.

"Usual and Customary Fee" means the fee, as reasonably determined by the HMO, that is based on the fee the provider who renders the service usually charges its patients for the same service. The fee shall be within the range of usual fees other providers of similar type, training, and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

(Source: Amended at 48 Ill. Reg. 7266, effective April 30, 2024)