**Section 4520.20 Applicability** **and Scope**

The requirements of this Part are applicable to:

a) Policies and contracts amended, delivered, issued, or renewed by health care plans pursuant to the Act; and

b) The program of health benefits under the State Employees Group Insurance Act, with the exception of the fee for service program which only needs to comply with Section 85 and the definition of "emergency medical condition" contained in Section 10 of the Act; the Counties Code; the Illinois Municipal Code; the Comprehensive Health Insurance Plan Act; the Health Maintenance Organization Act; the Limited Health Service Organization Act, except for plans offering only dental services, or only vision services; the Voluntary Health Services Plans Act; and the medical assistance program and other programs administered by the Department of Public Aid under the Illinois Public Aid Code, except that complaints shall be handled consistent with the requirements of Section 4520.80(a) of this Part; and

c) Third party administrators, as defined in Article XXXI¼ of the Code, and entities regulated under Article XX½ of the Code, generally referred to as Preferred Provider Organizations (PPOs) must comply with the requirements of Section 4520.90 and Exhibit A of this Part pursuant to Section 55 of the Act; and

d) Any person who conducts a utilization review program in this State, except that the provisions of Section 85 of the Act are not applicable to bodily injury liability claims (including uninsured motorist and underinsured motorist coverage claims) arising under property and casualty contracts issued under Class 2 and Class 3 of Section 4 of the Code [215 ILCS 5/4] and does not include the retrospective review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment. Section 85 is also specifically applicable to third party administrators, PPOs and insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of the Code. For purposes of this Part, an entity shall be considered to be conducting a utilization review program in this State if it evaluates the use of health care services, procedures, and facilities by persons who are either covered under contracts of insurance entered into in this State, or enrolled in an entity licensed pursuant to the Health Maintenance Organization Act, the Limited Health Service Organization Act or the Voluntary Health Services Plans Act; and

e) Preferred provider administrators, as defined in Section 370g(g) of the Code, and insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of the Code must also comply with the definition of the term emergency medical condition, as defined in Section 10 of the Act.

(Source: Amended at 28 Ill. Reg. 13711, effective September 28, 2004)