**Section 4521.20 Definitions**

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

"*Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations* (Section 1-2(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 USC 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.

"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" means an individual who has been enrolled in a health care plan.* (Section 1-2(4) of the Act)

*"Evidence of Coverage" means any certificate, agreement, or contract issued to enrollees setting out the coverage to which they are entitled in exchange for a per capita prepaid sum.* (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" means a contract for health care services which by its terms limits eligibility to members of a specified group* (Section 1-2(6) of the Act).

"Health Care Plan" means any arrangement in which any organization undertakes to provide or arrange for, and pay for or reimburse the cost of, any basic health care services from providers selected by the HMO. The arrangement consists of arranging for, or the provision of, the health care services, as distinguished from mere indemnification against the cost of the services, except as otherwise authorized by Section 2-3 of the Act, on a per capita prepaid basis, through insurance or otherwise (see Section 1-2(7) of the Act). A health care plan also includes any arrangement in which an organization undertakes to provide or arrange for, or pay for or reimburse the cost of, any health care services for persons who are enrolled in the integrated health care program established under Section 5-16.3 of the Illinois Public Aid Code through providers selected by the organization and the arrangement consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A health care plan also includes any arrangement pursuant to Section 4-17 of the Act. Nothing in the definition of Health Care Plan, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

"*Health Care Services" means any services included in the furnishing to any individual of medical or dental care, or the hospitalization or incident to the furnishing of such care or hospitalization as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury* (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(n)) 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.

"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" means any physician, hospital facility, or other person which is licensed or otherwise authorized to furnish health care services and also includes any other entity that arranges for the delivery or furnishing of health care services* (Section 1-2(12) of the Act). For purposes of Section 4521.50, "provider" shall also mean an MCO.

"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" means a person who has entered into a contractual relationship with the HMO for the provision of or arrangement of at least Basic Health Care Services to the beneficiaries of such contract* (Section 1-2(15) 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 38 Ill. Reg. 2272, effective January 2, 2014)