**Section 4520.30 Definitions**

"Act" means the Managed Care Reform and Patient Rights Act [215 ILCS 134].

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

"Department" means the Illinois Department of Insurance.

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

"Health Care Plan" means a plan that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan. For purposes of this definition, "health care plan" shall not include the following:

indemnity health insurance policies including those using a contracted provider network;

health care plans that offer only dental or only vision coverage;

preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health Care Provider" means any physician, hospital facility, nursing home or other person that is licensed or otherwise authorized to deliver health care services. Nothing in the Act shall be construed to define independent practice associations or physician hospital organizations as health care providers.

"Long-Standing Relationship" means the continuous relationship between an enrollee and his or her primary care physician of not less than 5 years; except in the case of a child 5 years or under who has had a continuous relationship with the same primary care physician since birth, placement for adoption, guardianship or foster care.

"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), which delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish such health care services.

"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].

"Ongoing Course of Treatment" means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a physician because of the potential for changes in the therapeutic regimen.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Referral Arrangement" means that, for each referral or standing referral, a referral arrangement exists between a participating primary care physician and a participating specialist physician or a participating health care provider when a participating primary care physician makes a referral of an enrollee for that referral or standing referral to a participating specialist physician or participating health care provider.

"Standing Referral" means a written referral from the primary care physician for an ongoing course of treatment pursuant to a treatment plan specifying needed services and time frames developed by a specialist in consultation with the primary care physician and in accordance with procedures developed by the health care plan.

"Utilization Review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization Review Organization" means an entity that has established one or more utilization review programs. This definition does not include:

persons providing utilization review program services only to the federal government;

self-insured health plans under the Federal Employee Retirement Income Security Act of 1974 (ERISA); however, this Part does not apply to persons conducting a utilization review program on behalf of these health plans;

hospitals and medical groups performing utilization review activities for internal purposes; however, this Part does apply when the hospital or medical group is conducting utilization review for another person.

"Utilization Review Program" means a program established by a person to perform utilization review.

(Source: Amended at 38 Ill. Reg. 23431, effective November 25, 2014)