**Section 240.20 Definitions**

 "Act" means the Health Maintenance Organization Act (Ill. Rev. Stat. 1987, ch. 111½, pars. 1401 et seq.).

 *"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, including any reasonable deductibles and co-payments.* (See also the Department of Insurance regulations located at 50 Ill. Adm. Code 6101.130.) (Section 1-2 of the Act)

 "Director of Department of Public Health" means the Director of the Illinois Department of Public Health, or such person or office as designated by the Director of the Department of Public Health to act in the Director's behalf.

 "Encounter" means a face to face contact between an enrollee and a basic health care service provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgement in the care of the enrollee.

 "Enrollee" or "member" means an individual who has been enrolled as a subscriber or as an eligible dependent of a subscriber and for whom the HMO has accepted the contractual responsibility for providing or arranging for at least, health care services and basic health care services.

 *"Evidence of Coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled in exchange for a per capita prepaid sum.* (Section 1-2 of the Act)

 "Grievance" means any written complaint by an enrollee regarding any aspect of the HMO relative to the enrollee. (See also the Department of Insurance regulations on HMO's, 50 Ill. Adm. Code 6101.40 for clarification.)

 *"Health Care Plan" means any arrangement whereby any organization undertakes to provide, arrange for and pay for or reimburse the cost of basic health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services, on a prepaid basis, through insurance or otherwise.* (Section 1-2 of the Act)

 *"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 of the Act)

 *"Health Maintenance Organization" or "HMO" means any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.* (Section 1-2 of the Act)

 "Medical Director" means a physician licensed to practice medicine in all its branches in Illinois and who shall be responsible for final review when questions of medical practice arise in the HMO in order to assure the quality of health care services provided.

 "Peer Review" means the evaluation

 by similarly licensed practicing physicians of the effectiveness and efficiency of services ordered or performed by other similarly licensed practicing physicians, or

 by other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed.

 "Plan Service Area" means the geographic territory to be served by the HMO.

 "Primary Care Physician" means a provider who has contracted with a Health Maintenance Organization 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, or

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

 *"Provider" means any physician, hospital facility, or other person which is licensed* by state law *or otherwise authorized* by state, federal, or local law *to furnish health care services.* (Section 1-2 of the Act)

 "Quality Assessment Monitoring" means the planned, systematic, and routine collection of information by the HMO according to previously determined indicators of quality and appropriateness of patient care and clinical performance encompassing basic and supplemental health care services and providers. After periodic assessment and evaluation by the HMO, quality assessment monitoring can detect trends and identify opportunities for improving enrollees' care.

 "Supplemental Benefits" or "Selective Benefits" means any services or benefits provided by the HMO over and above those required as basic health care services.

 "Utilization Review" means the study of the appropriateness of the use of particular services and the appropriateness of the volume of services used.

(Source: Amended at 14 Ill. Reg. 2403, effective February 15, 1990)