[215 Ill. Comp. Stat. § 130/1002.]

§ 130/1002. Definitions: Limited Health Service Organization Act

As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

"Advertisement" means any printed or published material, audiovisual material and descriptive literature of the limited 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 limited health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

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

"Director" means the Director of Insurance.

"Enrollee" means an individual who has been enrolled in a limited health care plan.

"Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which that enrollee is entitled in exchange for a per capita prepaid sum.

"Group contract" means a contract for limited health services which by its terms limits eligibility to members of a specified group.

"In-plan covered services" means covered limited health services obtained from providers who are employed by, under contract with, referred by, or otherwise affiliated with the LHSO and emergency services.

"Limited health care plan" means any arrangement whereby an organization undertakes to provide or arrange for and, pay for or reimburse the cost of any limited health services from providers selected by the limited health service organization and such arrangement consists of arranging for or the provision of such limited health services on a per capita prepaid basis, as distinguished from mere indemnification against the cost of such limited services on a per capita prepaid basis through insurance except as otherwise provided under Section 3009.

"Limited health service" means ambulance care services, dental care services, vision care services, pharmaceutical services, clinical laboratory services, and podiatric care services. Limited health service shall not include hospital, medical, surgical or emergency services except when those services are essential to the delivery of the limited health service. Essential hospital, medical, surgical, or emergency services shall be covered unless specifically excluded.

"Limited health service organization" (LHSO) means any organization formed under the laws of this or another state to provide or arrange for one or more limited health care plans under a system which causes any part of the risk of limited health care delivery to be borne by the organization or its providers.

"Net worth" means admitted assets, as defined in Section 1003 of this Act, minus liabilities.

"Organization" means any insurance company or other corporation organized under the laws of this or another state for the purpose of operating one or more limited health care plans and doing no business other than that of a health maintenance organization or a limited health service organization or an insurance company. Organization does not include (1) any entity otherwise authorized on the effective date of this Act pursuant to the laws of this State either to provide any limited health service on a prepayment basis or to indemnity for any limited health service; nor does it include (2) any provider or other entity when providing or arranging for the provision of limited health services pursuant to a contract with a limited health service organization or with any entity described in (1) of this definition.

"Out-of-plan covered services" means non-emergency, self-referred covered limited health services obtained from providers who are not otherwise employed by, under contract with, or otherwise affiliated with the LHSO or services obtained without a referral from providers who have contracted to provide limited health services to the enrollee on behalf of the limited health care plan.

"Point-of-service product" (POS) means a group contract that includes both in-plan covered services and out-of-plan covered services as well as a POS contract in which the risk for out-of-plan covered services is borne through reinsurance. This term does not apply to indemnity benefits offered through an LHSO that are underwritten in whole by a licensed insurance carrier and offered in conjunction with the LHSO benefit package.

"Provider" means any physician, dentist, health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services and also includes any other entity that arranges for the delivery or furnishing of limited health service.

"Per capita prepaid" means a basis of payment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the limited health service organization or for limited health services which are provided during a definite time period regardless of the frequency or extent of the services rendered, except for copayments of a fixed amount by the limited health service organization.

"Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an organization authorized to provide or arrange for such services under this Act.

"Uncovered expense" means the cost of limited health services that are the obligation of a limited health service organization for which an enrollee may be liable in the event of the insolvency of the organization. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered covered expenses.