[Tenn. Code Ann. § 56-32-102.]

§ 56-32-102. Chapter definitions: Health Maintenance Organization Act of 1986

As used in this chapter, unless the context otherwise requires:

(1) For the purposes of regulating an HMO that participates in the TennCare program under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), or any successor to the TennCare program, "affiliate" means any entity that exercises control over or is controlled by the HMO, directly or indirectly through:

(A) Equity ownership of voting securities;

(B) Common managerial control; or

(C) Collusive participation by the management of the HMO and affiliate in the management of the HMO or the affiliate;

(2) "Basic health care services" means all those health services that a defined population might reasonably require in order to be in good health, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care and outpatient preventative medical services. In addition, an HMO that participates in the TennCare program under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), or any successor to the TennCare program, "basic health care services" includes, but is not limited to, services made necessary as the result of Title XIX federal programs or waivers for which TennCare is primarily responsible for implementation or enforcement;

(3) "Coinsurance" means an enrollee's share of covered medical expenses when an enrollee and the HMO share in a specific ratio of the covered medical expenses; provided, however, that coinsurance shall not expand the ability of an HMO to offer out-of-network benefits except as otherwise provided in this chapter;

(4) "Commissioner" means the commissioner of commerce and insurance;

(5) "Enrollee" means an individual who is enrolled in an HMO;

(6) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which the enrollee is entitled;

(7) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization, or incidental to the furnishing of the 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, injury or physical disability;

(8) "Health maintenance organization (HMO)" means any person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis. The HMO may provide physician services directly through physician employees or under arrangements with individual physicians or a group or groups of

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physicians. The HMO may also provide or arrange for other health care services on a prepayment or other financial basis. Additionally, the HMO may provide or arrange for basic health care services on a prepayment or other financial basis with physician-hospital organizations; by so doing, the physician-hospital organization is not deemed to be an insurer or HMO;

(9)

(A) “Person” means any natural or artificial person including, but not limited to, an individual, partnership, association, trust or corporation;

(B) For the purposes of regulating an HMO that participates in the TennCare program under Title XIX of the federal Social Security Act (42 U.S.C. § 1396 et seq.), or any successor to the TennCare program, “person” includes an individual, insurer, company, association, organization, Lloyds, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation, agent, general agent, broker, solicitor, service representative, adjuster, and every legal entity;

(10) “Physician-hospital organization” means an organization formed to allow hospitals and physicians to jointly obtain provider contracts with HMOs and other payers of health care benefits. The organization may obtain direct aggregate or excess stop-loss insurance coverage;

(11) “Provider” means any physician, hospital or other person that is licensed or otherwise authorized in this state to furnish health care services; and

(12) “Uncovered expenditures” means the costs of health care services that are covered by an HMO for which an enrollee would also be liable in the event of the organization's insolvency.

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