Superseded 5/9/2017

31A-8-101 Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:
- (a) emergency care;
- (b) inpatient hospital and physician care;
- (c) outpatient medical services; and
- (d) out-of-area coverage.

(2) "Director of health" means:
- (a) the executive director of the Department of Health; or
- (b) the authorized representative of the executive director of the Department of Health.

(3) "Enrollee" means an individual:
- (a) who has entered into a contract with an organization for health care; or
- (b) in whose behalf an arrangement for health care has been made.

(4) "Health care" is as defined in Section 31A-1-301.

(5) "Health maintenance organization" means any person:
- (a) other than:
  - (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
  - (ii) an individual who contracts to render professional or personal services that the individual directly performs; and
- (b) that:
  - (i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and
  - (ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.

(6)
- (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, services:
  - (i) of:
    - (A) dentists;
    - (B) optometrists;
    - (C) physical therapists;
    - (D) podiatrists;
    - (E) psychologists;
    - (F) physicians;
    - (G) chiropractic physicians;
    - (H) naturopathic physicians;
    - (I) osteopathic physicians;
    - (J) social workers;
    - (K) family counselors;
    - (L) other health care providers; or
    - (M) reasonable combinations of the services described in this Subsection (6)(a)(i);
  - (ii) to an enrollee;
  - (iii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and
  - (iv) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection (6)(a).

(b) "Limited health plan" does not include:
(i) a health maintenance organization;
(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
(iii) an individual who contracts to render professional or personal services that the individual performs.

(7)
(a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.
(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(8) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:
(a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or
(b) "organization expenses," which is described in Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who:
(a) furnishes health care directly to the enrollee; and
(b) is licensed or otherwise authorized to furnish the health care in this state.

(11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

(12) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.