**Section 2001.2 Definitions and Cross-References**

a) The following definitions shall apply to this Part:

"ACA" means the Patient Protection and Affordable Care Act(42 USC 18001 et seq.).

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

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

"EHB" means essential health benefit or benefits.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended (29 USC 1001 et seq.).

"Excepted benefits", as defined at 26 USC 9832, means benefits under one or more (or any combination) of the following:

Benefits not subject to requirements:

Coverage only for accident, disability income insurance, or any combination thereof;

Coverage issued as a supplement to liability insurance;

Liability insurance, including general liability insurance and automobile liability insurance;

Workers' compensation or similar insurance;

Automobile medical payment insurance;

Credit-only insurance;

Coverage for on-site medical clinics;

Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Benefits not subject to requirements if offered separately:

Limited scope dental or vision benefits; and

Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Benefits not subject to requirements if offered as independent, noncoordinated benefits:

Coverage only for a specified disease or illness;

Hospital indemnity or other fixed indemnity insurance paid as a fixed dollar amount per day or other period, paid per event or service, or upon benefits paid upon a basis other than period of time, regardless of the amount of expenses incurred.

Benefits not subject to requirements if offered as a separate insurance policy: Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act (42 USC 1395ss(g)(1)), coverage supplemental to the coverage provided under 10 USC 55, and similar supplemental coverage provided to coverage under a group health plan.

"Health Benefits Exchange" or "Exchange" means the Illinois Health Benefits Exchange established pursuant to 42 USC 18031(b) and 215 ILCS 122/5-5, also known as the Illinois Health Insurance Marketplace.

"HHS" means the United States Department of Health and Human Services.

"Network Plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

"PHS Act" means the Public Health Service Act (42 USC 201 et seq.).

"Preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period. (See 45 CFR 144.103.)

"SBC" means summary of benefits and coverage.

"Secretary" means the Secretary of the United States Department of Health and Human Services, except when specified otherwise within this Part.

"Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period of time that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. (See 42 USC 300gg(b)(4).)

b) In this Part, parenthetical cross-references following rule text are to the federal statutes or regulations relating to that Illinois rule provision.

(Source: Amended at 38 Ill. Reg. 23379, effective November 25, 2014)