**Section 2008.50 Policy Definitions and Terms**

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless that policy or certificate contains definitions or terms that conform to the requirements of this Section.

"Accident", "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while the insurance is in force."

That definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no fault plan, unless prohibited by law.

"Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent Nursing Home", "Extended Care Facility" or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

"Duplication of Insurance" means a transaction in which new accident and health insurance is to be purchased and it is known to the producer or should be known to the producer or the issuer, in the case of a direct response solicitation, that the new insurance will provide some of the benefits or coverages which the proposed insured already has under existing accident and health insurance.

"Health Care Expenses", for purposes of Section 2008.80, means expenses of a nonprofit health, hospital or medical service corporation, prepaid health plan or similar organization associated with the delivery of health care services in which providers of the health care services are reimbursed for such services on an other than fee for service basis that are analogous to incurred losses of insurers.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission but not more restrictively than as defined in the Medicare program.

"Medicare" shall be defined in the policy and certificate as "The Health Insurance for the Aged and Disabled Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended", or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged and Disabled Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

"Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

"Over-Insurance" means duplication of insurance to such extent that the combination of the existing insurance and the proposed insurance would substantially exceed any loss reasonably expected to be incurred.

"Physician" shall not be defined more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined more restrictively than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(Source: Amended at 42 Ill. Reg. 21625, effective November 26, 2018)