**Section 2040.30 Definitions**

Except as provided in this Section, terms used in this Part have the meanings given in Section 5 of the Illinois Health Insurance Portability and Accountability Act [215 ILCS 97]. The following definitions also apply to this Part:

"CMMS' enforcement discretion" means the non-enforcement policy expressed by the federal Centers for Medicare & Medicaid Services in the FAQ document dated March 24, 2020, addressed to "All Qualified Health Plan and Stand-alone Dental Plan Issuers on the Federally-facilitated Exchanges and State-based Exchanges on the Federal Platform", which had the subject heading "Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency" (Department of Health & Human Services, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mail Stop C4-21-26, Baltimore MD 21244-1850) (no later editions or amendments included).

AGENCY NOTE: the FAQ document may be available online at https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf.

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

"Cost-sharing" means any expenditure required by or on behalf of an enrollee related to health insurance coverage. Such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

"COVID-19" means the respiratory disease recognized by the United States Centers for Disease Control and Prevention as "coronavirus disease 2019", or the novel coronavirus named "SARS-CoV-2" that causes this respiratory disease.

"Department" means the Illinois Department of Insurance.

"Employer" has the meaning ascribed in 29 USC 1003(5).

"Excepted benefits" has the meaning ascribed in the following federal regulations:

For individual health insurance coverage, the provisions in 45 CFR 148.220; and

For group health insurance coverage, the provisions in 45 CFR 146.145(b).

"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.

"Health care provider" or "Provider" has the meaning ascribed in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care services" has the meaning ascribed in Section 10 of the Managed Care Reform and Patient Rights Act [215 ILCS 134].

"Health maintenance organization" has the meaning ascribed in Section 1-2(9) of the HMO Act.

"HMO Act" means the Health Maintenance Organization Act [215 ILCS 125].

"Insured" means a resident, employee, employer, or other natural or legal person that has a policy, contract, certificate, or other agreement with an issuer for health insurance coverage.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Non-network provider" means any provider that has not entered into an agreement described in Section 370i of the Code or Section 2-8 of the HMO Act.

"Qualified health plan" has the meaning given in 45 CFR 155.20.

"Short-term, limited-duration health insurance coverage" has the meaning ascribed in Section 5 of the Short-Term, Limited Duration Health Insurance Coverage Act [215 ILCS 190].

"Stand-alone dental plan" has the meaning ascribed in 45 CFR 156.400.