

TITLE 50: INSURANCE
PART 2007 MINIMUM STANDARDS OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE

Section 2007.70 Accident and Health Minimum Standards for Benefits

- a) The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsection. No individual policy of accident and health insurance shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Director finds that such policies are Limited Benefit Health Insurance in which case the Outline of Coverage shall comply with Section 2007.80(c) of this Part.
- b) Nothing in this Section shall preclude the issuance of any policy combining two or more categories of coverage as set forth in Section 355a(4) of the Illinois Insurance Code [215 ILCS 5/355(a)(4)].
 - 1) General Rules
 - A) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.
 - B) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 2007.80(a)(1) of this Part. The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be defined as in 50 Ill. Adm. Code 2003.
 - C) In a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force by the younger spouse to the age or for the durational period as specified in said definition.
 - D) If a policy contains a status-type military service exclusion of a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rate basis.
 - E) Policies providing normal pregnancy benefits shall provide that in the event the insurer cancels or refuses to renew the policy there shall be an extension of benefits for pregnancy commencing while the policy is in force and at the same level for which benefits would have been payable had the policy remained in force.
 - F) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the

convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

- G) Any medical, surgical or other expense benefit for the recipient insured in a transplant operation may specify the limits for such specific benefit relating to donors, or shall provide reimbursement of such expense of the live donor to the extent that such benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
- H) A policy may contain a provision relating to recurrent disabilities provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.
- I) Any pre-existing condition exclusion shall be administered in accordance with 50 Ill. Adm. Code 2005. When a definition of preexisting condition(s) is required by 50 Ill. Adm. Code 2005.50, for purposes of readability, it may be summarized in the appropriate policy provision by a definition reading substantially as follows:

"A pre-existing illness (condition) means any condition that was diagnosed or treated by a physician within 24 months prior to the effective date of the coverage, or produced symptoms within 12 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or treatment."
- J) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time the disability commences if the accident occurred while the policy was in force.
- K) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.
- L) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits payable are less than the maximum amount payable under the policy.
- M) Nonrenewal of the policy shall be without prejudice to any continuous loss which commenced while the accident and sickness policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the covered person limited to a period of one year for health care benefits, limited to the duration of the policy benefit period (if any), and/or limited to the payment of the maximum benefits. The extension of benefits requirement does not apply to single premium nonrenewal policies.
- N) Total Disability or Totally Disabled for the purposes of this Section means the complete incapacity of the covered person as the result of an injury or sickness:

- i) to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age; and
 - ii) which requires the regular care of a physician other than a covered person.
- O) Extension and limitation of coverage means if a covered person is totally disabled on his/her coverage termination date the coverage provided for that covered person by this policy and any attached riders will be extended. During the extended coverage the applicable policy and rider provisions, exclusions, exceptions and limitations will be the same as would have applied had coverage not terminated for such covered person. This extension is limited to confinement and/or expenses incurred:
 - i) for the injury or sickness which caused the total disability;
 - ii) during the uninterrupted continuance of the total disability; and
 - iii) during the twelve months following the covered person's coverage termination date.
- P) All policies issued, whether or not such policy contains the refund provision, shall be administered to provide a refund of any unearned premiums upon death of any insured member from date of death if the Company receives a written request for unearned premium from the policy owner or the person entitled thereto.

2) Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a policy of accident and health insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness. Coverage shall be for at least the following:

- A) Daily hospital room and board in an amount not less than the lesser of:
 - i) 80% of the charges for semi-private room accommodations; or
 - ii) \$100.00 per day; except that \$100.00 may be reduced to \$70.00 outside the metropolitan area.
- B) Miscellaneous charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the charges incurred up to at least \$1,000.00 or ten times the daily hospital room and board benefits.
- C) Hospital outpatient services consisting of:
 - i) hospital services on the day surgery is performed;

- ii) hospital services rendered within 72 hours after accidental injury, in an amount not less than \$50.00; and
 - iii) X-ray and laboratory tests for the purpose of a diagnosis and treatment of an accidental injury or a sickness, in an amount not less than \$100.00, but only to the extent that benefits for x-ray and laboratory tests would have been provided if rendered to an in-patient of the hospital.
 - D) Benefits provided under subsection (b)(2)(A) and (B) above, may be provided subject to a combined deductible amount not in excess of \$100.00.
- 3) **Basic Medical-Surgical Expense Coverage**

"Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness. Coverage shall be for at least the following:

 - A) **Surgical services:**
 - i) in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$500.00 for any one procedure; or
 - ii) not less than 80% of the reasonable charges.
 - B) **Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services:**
 - i) in an amount not less than 80% of the reasonable charges; or
 - ii) 15% of the surgical service benefit.
 - C) **In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury, other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or \$5.00 per day for not less than twenty-one (21) days during one period of confinement.**
- 4) **Hospital Confinement Indemnity Coverage**

"Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance which provides for not less than \$30.00 per day and for not less than thirty-one (31) days during any one period of confinement for each person insured under the policy. The policy may contain a benefit limit less than \$30.00 per day if the policy benefit period is extended to reflect a maximum amount payable under a \$30.00 per day policy with a thirty-one (31) day maximum confinement period for any one period of confinement.
- 5) **Major Medical Expense Coverage**

"Major Medical Expense Coverage" is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$10,000.00; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person. The aggregate maximum shall be increased not less than \$3.00 for each \$1.00 by which the deductible exceeds the minimum. Major medical expense insurance shall provide for each covered person coverage of:

- A) Daily hospital room and board expenses, prior to application of the co-payment percentage, for not less than \$50.00 daily or, in lieu thereof, the average daily cost of semi-private room rate in the area where the insured resides, for a period of not less than thirty-one days during any period of continuous hospital confinement;
- B) Miscellaneous Hospital Services, prior to application of the co-payment percentage, for an aggregate maximum of not less than \$1,500.00 or 15 times the daily room and board rate if specified in dollar amount;
- C) Surgical Services, prior to application of the co-payment percentage, to a maximum of not less than \$600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount; anesthetic services, prior to application of the co-payment percentage, of at least 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthetic services at the same unit value as used for surgical schedule;
- D) Physician visits, in or out of the hospital with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than \$8.00 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than \$600.00;
- E) Out of Hospital Diagnostic X-rays and Tests, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than \$600.00;
- F) Not fewer than 3 of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than \$1,000.00:
 - i) private duty registered, or if not available, licensed practical nurse services performed by other than a family member while the insured is hospital confined;
 - ii) convalescent nursing home care;
 - iii) diagnosis and treatment by a radiologist or physiotherapist;
 - iv) rental of special medical equipment, as defined by the insurer in the policy;

- v) artificial limbs or eyes, casts, splints, trusses or braces;
- vi) treatment for functional nervous disorders, and mental or emotional disorders;
- vii) out of hospital prescription drugs and medications.

6) Disability Income Protection Coverage

"Disability Income Protection Coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which has a maximum period of time for which it is payable during disability of at least six (6) months. A disability income protection policy may provide for reduction by the amount of Social Security benefits at inception of any claim but no benefit reduction shall be permitted to offset a Social Security benefit increase during a benefit period.

7) Accident Only Coverage

"Accident Only Coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000.00 and a single dismemberment shall be at least \$500.00.

8) Specified Coverages

"Specified Disease Coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet the following general requirements and one of the following sets of minimum standards for benefits. Insurance covering cancer, whether cancer only or in conjunction with other condition(s) or disease(s), shall meet the standards of subsection (b)(8)(C) or (D) below. Insurance covering specified disease(s) other than cancer shall meet the standards of subsections (b)(8)(B) or (D) below.

A) General Requirements:

- i) All advertising materials used in conjunction with a specified disease policy shall accompany the policy filing.
- ii) Policies covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as specified disease covered under this Section.
- iii) Any policy issued pursuant to this Section which conditions payment upon pathological diagnosis of a covered disease shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.
- iv) Notwithstanding any other provision of this Part, specified disease policies shall provide benefits to any covered person not only for the specified disease(s), but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).
- v) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

- vi) No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days.
- vii) Payment may be conditioned upon a covered person receiving medically necessary care or treatment.
- viii) Except for the uniform policy provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.
- ix) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of medical care or hospital confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date.
- x) Skin cancer benefits within a cancer policy shall not be limited as it is a minimum standard of specified disease coverage and is a risk purported to be assumed. Skin cancer may only be excluded if it is in an additional benefit provision added to compliment underlying coverage not required by this Section.

B) The following minimum benefit standards apply to noncancer coverages: A policy which provides coverage for each person insured under the policy for a specifically named disease (or disease(s)) with a deductible amount not in excess of (\$250.00) and an overall aggregate benefit limit, per person, of not less than (\$10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses:

- i) Hospital room and board and any other hospital furnished medical services or supplies;
- ii) Treatment by a legally qualified physician or surgeon;
- iii) Private duty services of a registered nurse (R.N.);
- iv) X-ray, radium, cobalt, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;
- v) Professional ambulance for local service to or from a local hospital;
- vi) Blood transfusions, including expense incurred for blood donors;
- vii) Drugs and medicines prescribed by a physician;
- viii) The rental of an iron lung or similar mechanical apparatus;
- ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician;
- x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

xi) May include coverage of any other expenses necessarily incurred for treatment of the disease.

C) A policy which provides coverage for each person insured under the policy for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment that are prescribed by a physician as necessary for the treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of \$250.00 and an overall aggregate benefit limit, per person, of not less than \$10,000 and a benefit period of not less than two (2) years for at least the following:

- i) Treatment by, or under the direction of, a legally qualified physician or surgeon;
- ii) X-ray, radium, cobalt, chemotherapy, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;
- iii) Hospital room and board and any other hospital furnished medical services or supplies;
- iv) Blood transfusions and the administration thereof, including expense incurred for blood donors;
- v) Drugs and medicines prescribed by a physician;
- vi) Professional ambulance for local service to or from a local hospital;
- vii) Private duty services of a registered nurse (R.N.) provided in a hospital;
- viii) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, items (i), (ii), (iv), (v) and (vi) plus at least the following shall be included, but may be subject to copayment not to exceed 20% of covered charges when rendered on an out-patient basis;
- ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;
- x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease;
- xi) Home Health Care, that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required;
- xii) Physical, speech, hearing and occupational therapy;

- xiii) Special equipment including hospital bed, toilette, pulleys, aspirator, incontinence pants, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;
 - xiv) Reconstructive surgery when deemed necessary by the attending physician;
 - xv) Prosthetic devices; and
 - xvi) Nursing home care for non-custodial services.
- D) The following minimum benefit standards apply to specified disease coverages written on a per diem indemnity basis. Such coverages shall offer covered persons:
- i) A fixed sum payment of at least \$100 for each day of the hospital confinement for at least 365 days.
 - ii) A fixed sum payment equal to one-half of the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy for at least 365 days of treatment.
 - iii) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional; if a policy offers these benefits, they must equal the following:

A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days (approximately \$25.00 per day or \$2,500 minimum benefit). A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days (\$2,500). Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in the above requirements, whether by definition or otherwise, shall be no more restrictive than those under Medicare.
- E) "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or dismemberment combined, with a benefit amount not less than \$1,000 for double dismemberment and \$500.00 for single dismemberment.
- 9) **Limited Benefit Health Insurance Coverage**
 "Limited Benefit Health Insurance Coverage" is any policy or policies other than a policy or contract covering only a specified disease or diseases which provide benefits that are less than the minimum standards for benefits required under Section 2007.50(b)(2) through (7) of this Part. Such policies or contracts may be delivered or issued for delivery in this State only if the outline of coverage required by Section 2007.80(k) of this Part is completed and delivered as required by Section 2007.80(b) of this Part.
- 10) **Non-Conventional Coverage:** Nothing contained in this subsection (b) shall prohibit the issuance of a policy that does not fall within subsection (b)(1) through (9) above if such policy is experimental in nature and is appropriately and

prominently described in the outline of coverage required by Section 2007.80(l) of this Part.

- 11) The requirements of this Section do not apply to policies issued in compliance with Section 363 of the Illinois Insurance Code [215 ILCS 5/363].

(Source: Amended at 19 Ill. Reg. 16555, effective December 5, 1995)