

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

Section 2007.70b) 8) C) Accident and Health Minimum Standards for Benefits for Specified Disease – Cancer-only or in Combination with One or More Specified Diseases

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)].

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.

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.