**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 subsection (b). No individual policy of accident and health insurance shall be delivered or issued for delivery in this State that does not meet the required minimum standards for the specified categories, except that, if the Director finds that the policies are Limited Benefit Health Insurance, the Outline of Coverage shall comply with Section 2007.80(c).

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 5/355a(4)].

1) General Rules

A) With respect to excepted benefit policies and grandfathered health plans, 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) With respect to excepted benefit policies and grandfathered health plans, 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). The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be defined as in 50 Ill. Adm. Code 2003.

C) With respect to excepted benefit policies and grandfathered health plans, 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 the definition.

D) With respect to excepted benefit policies and grandfathered health plans, if a policy contains a status-type military service exclusion of a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to that person on a pro rata 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 those benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

G) With respect to excepted benefit policies and grandfathered health plans, any medical, surgical or other expense benefit for the recipient insured in a transplant operation may specify the limits for the specific benefit relating to donors, or shall provide reimbursement of the expense of the live donor to the extent that the benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

H) Preexisting condition exclusions are only allowed with respect to excepted benefits and grandfathered health plans. Any such preexisting condition exclusion shall be administered in accordance with 50 Ill. Adm. Code 2005. When a definition of preexisting conditions 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 preexisting 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."

I) Accidental death and dismemberment benefits shall be payable if the loss occurs within 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 30 days after the date of accident, nor shall any policy that 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.

J) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.

K) Any accident only policy providing benefits that 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.

L) With respect to excepted benefit policies and grandfathered health plans, nonrenewal of the policy shall be without prejudice to any continuous loss that 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.

M) "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) that requires the regular care of a physician other than a covered person.

N) 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 the 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 the covered person. This extension is limited to confinement and/or expenses incurred:

i) for the injury or sickness that caused the total disability;

ii) during the uninterrupted continuance of the total disability; and

iii) during the 12 months following the covered person's coverage termination date.

O) All policies issued, whether or not the 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 to the unearned premium.

2) Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a policy of accident and health insurance that provides coverage for a period of not less than 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) $1,000 per day; except that $1,000 may be reduced to $700 outside the metropolitan area.

B) Miscellaneous charges made by the hospital for services and supplies that 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 or 10 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; 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, 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), may be provided subject to a combined deductible amount not in excess of $100.

E) When combined with the basic medical-surgical expense coverage in subsection (b)(3), basic hospital expense coverage is an essential health benefit subject to the requirements described in 50 Ill. Adm. Code 2001.11.

3) Basic Medical-Surgical Expense Coverage

"Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance that 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 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 or her 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 21 days during one period of confinement.

D) When combined with the basic hospital expense coverage in subsection (b)(2), basic medical expense coverage is an essential health benefit subject to the requirements of 50 Ill. Adm. Code 2001.11.

4) With respect to excepted benefit policies, "Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance that provides for not less than $30 per day and for not less than 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 per day if the policy benefit period is extended to reflect a maximum amount payable under a $30 per day policy with a 31 day maximum confinement period for any one period of confinement.

5) "Major Medical Expense Coverage" is an accident and health insurance policy that provides hospital, medical and surgical expense coverage to an aggregate maximum of not less than $10,000; 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 those 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 the deductible may be increased by the amount of the benefits provided by the 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 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 31 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 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 for the most severe operation with the amounts provided for other operations reasonably related to that 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 the covered charges of not less than $600;

E) Out of Hospital Diagnostic X-rays and Tests, prior to application of the co-payment percentage, for an aggregate maximum of the covered charges of not less than $600;

F) Not fewer than 3 of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of the covered charges of not less than $1,000:

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;

G) Major medical expense coverage is an essential health benefit subject to the requirements of 50 Ill. Adm. Code 2001.11.

6) With respect to excepted benefit policies and grandfathered health plans, "Disability Income Protection Coverage" is a policy that 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 of sickness and injury that has a maximum period of time for which it is payable during disability of at least six 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) With respect to excepted benefit policies and grandfathered health plans, "Accident Only Coverage" is a policy of accident insurance that 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 and a single dismemberment shall be at least $500.

8) With respect to excepted benefit policies and grandfathered health plans, "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 conditions or diseases, shall meet the standards of subsection (b)(8)(C) or (D). Insurance covering specified diseases other than cancer shall meet the standards of subsections (b)(8)(B) or (D).

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 that 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 diseases, but also for any other conditions or diseases directly caused or aggravated by the specified diseases or the treatment of the specified diseases.

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 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 the 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 that provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of ($250) and an overall aggregate benefit limit, per person, of not less than ($10,000) and a benefit period of not less than two 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 that 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 and an overall aggregate benefit limit, per person, of not less than $10,000 and a benefit period of not less than two 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 their administration, 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, subsections (b)(8)(C)(i), (ii), (iv), (v) and (vi) plus at least subsections (b)(8)(C)(ix) through (b)(8)(C)(xvi) 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. These 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 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 that 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 for single dismemberment.

9) With respect to excepted benefit policies and grandfathered health plans, "Limited Benefit Health Insurance Coverage" is any policy or policies other than a policy or contract covering only a specified disease or diseases that provide benefits that are less than the minimum standards for benefits required under Section 2007.50(b)(2) through (7). The 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) is completed and delivered as required by Section 2007.80(b).

10) Non-Conventional Coverage: With respect to excepted benefit policies and grandfathered health plans, nothing contained in this subsection (b) shall prohibit the issuance of a policy that does not fall within subsections (b)(1) through (9) if the policy is experimental in nature and is appropriately and prominently described in the outline of coverage required by Section 2007.80(l).

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 38 Ill. Reg. 2138, effective January 2, 2014)