Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

INDIVIDUAL ACCIDENT AND HEALTH EXCEPTED BENEFIT CHECKLIST

TO BE COMPLETED BY COMPANY

Company Name:

SERFF TOI:

SERFF SUB TOI:

SERFF Tracking #:

	Line Of Business	Electronic References
☐	Basic Hospital Expense Coverage	Illinois Insurance Code
☐	Basic Medical-Surgical Expense Coverage	Administrative Rules
☐	Hospital Confinement Indemnity Coverage	Illinois Company Bulletins
☐	Disability Income Protection Coverage	
☐	Accident Only Coverage	
☐	Specified Disease (Expense Incurred)	
☐	Cancer Only/Cancer Specified Disease Combination (Expense Incurred)	
☐	Specified Disease (Per Diem)	
☐	Specified Accident	
☐	Limited Benefit Health Insurance	

Checklist Directions

- The checklist must be completed to indicate where in the filing the General Filing requirements appear, must acknowledge each General Form Requirement and must indicate where, in the policy form, each required provision appears (e.g. form number, page number and section number).
- For requirements marked as "Affirmed," companies are to acknowledge, by checking the appropriate box: 1) their compliance with prohibited language; or
  1) their compliance with prohibited language; or
  2) their understanding of the informational nature of the requirement.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

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Index Directions

All filings must include the requirements listed in "Part 1."
Only individual coverage filings need to include the requirements listed in "Part 2."
Specific single-coverage filings need to include the appropriate requirements associated with that filing in "Part 3."
Combination coverage filings must include all requirements for each specific coverage type included in the filings listed in "Part 3."

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PART 1 - ALL POLICIES

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.A.1	Review Requirements Checklist	Review Requirements Checklist	Each filing must include a completed Review Requirements Checklist that must contain a completed "Location in Filing" column for each required element of the filing. Please indicate the proper page # and form # for each entry	
1.A.2	Rate Filing	215 ILCS 5/355	No policy shall be issued until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be issued or delivered until the Director approves such policy. Rates must be submitted with a uniform transmittal document and contain a unique filing number.	SERFF Tracking #
1.A.3	Certificate of Compliance	50 IAC 916.40(b) 50 IAC 916.50 50 IAC 2001.130	Insurers must file for each policy: Certificate of Compliance; detailed description of purpose and manner of marketing; identifying number in lower left corner of first page.	
1.A.4	Electronic Notices and Devices	215 ILCS 5/143.34	Must provide clear notice if documents are going to be delivered electronically, receive consent from the insured for electronic delivery, and advise that consent can be withdrawn at any time.	
1.A.5	Letter of Submission	50 IAC 2001.130(a)(3)	Each form must bear an identifying form number in the lower left corner of the first page. The insurer shall file a letter of submission, or provide the following information in the Filing Description field under the General Information tab in SERFF containing: The name of the form, if any, and identifying form number; Whether the submission is a new form; If the form is intended to supersede another, the form number of the form replaced and the date it was approved by the Department, with all changes from the previously approved form highlighted.	
1.A.6	Outline of Coverage	50 IAC 2007.80	Must contain an outline of coverage as described in rule 50 IAC 2007.80: a) General Rules b) Outline of Coverage Requirements for Individual Coverages c) Basic Hospital Expense Coverage d) Basic Medical-Surgical Expense Coverage e) Basic Hospital and Medical Surgical Expense Coverage f) Hospital Confinement Indemnity Coverage g) Disability Income Protection Coverage h) Accident Only Coverage i) Specified Disease or Specified Accident Coverage j) Limited Benefit Health Coverage (Outline) k) Non-Conventional Coverage (Outline)	
1.A.7	Replacement Notice	50 IAC 2007.90(a)	All application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force.	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.B.1	Entire Contract *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.2	CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.	
1.B.2	Time Limit on Certain Defenses *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.3 42 USC 300gg-12	After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2 year period.	
1.B.3	Grace Period *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.4	A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.	
1.B.4	Reinstatement *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.5	If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the company or by any agent duly authorized by the company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the company or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.	
1.B.5	Notice of Claim *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.6	Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the company at (insert the location of such office as the company may designate for the purpose), or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company."	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.6	Claim Forms *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.7	The company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.	
1.B.7	Proof of Loss *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.8	Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.	
1.B.8	Timely Payment *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/368a(c) 215 ILCS 5/357.9	Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.	
1.B.9	Payment of Claims to Beneficiary, Estate, etc. *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.10	"Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."	
1.B.10	Physical Examinations and Autopsy *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.11	"The company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."	
1.B.11	Legal Action *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.12	"No civil action shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished."	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.12	Change of Beneficiary *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.13	"Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."	
1.B.13	Misstatement of Age *OPTIONAL*	215 ILCS 5/357.16	If included, policy must contain statutory required language. "If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."	
1.B.14	Other Insurance in Company *OPTIONAL*	215 ILCS 5/357.17	If included, policy must contain statutory required language. "If an accident or health or accident and health policy or policies previously issued by the company to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage or coverages) in excess of (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate." or, in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies."	
1.B.15	Insurance with Other Companies *OPTIONAL*	215 ILCS 5/357.18 215 ILCS 5/357.19	215 ILCS 5/357.18 "If there be other valid coverage, not with this company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage." 215 ILCS 5/357.19 "If there be other valid coverage, not with this company, providing benefits for the same loss on other than an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the company had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined."	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.16	Reimbursement Provisions *OPTIONAL*	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.40	If included, policy must contain statutory required language. (1) "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability." (2) "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, covered person's parents if the covered person is a minor, or covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability."	
1.B.17	Subrogation Provision *OPTIONAL*	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.50	If included, policy must contain statutory required language. If there be other valid coverage, not with this company, providing benefits for the same loss on other than an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the company had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. In addition to any other requirements set forth in the Code or Department's regulations, if an insurer includes a subrogation provision in its policy, that provision shall be in the form as follows: "We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability."	

SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.18	Relation of Earnings to Insurance *OPTIONAL*	215 ILCS 5/357.20	If included, policy must contain statutory required language. "If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the company will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."	
1.B.19	Premium – Unpaid *OPTIONAL*	215 ILCS 5/357.21	If included, policy must contain statutory required language. Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted.	
1.B.20	Cancellation *OPTIONAL*	215 ILCS 5/357.22	If included, policy must contain statutory required language. "The company may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the company, stating when, not less than 30 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the company, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the company will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the company cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." (Notice to the policy holder of the cancellable nature of his policy shall be set forth on the face of the policy.)	
1.B.21	Disclosure - Conformity with State Statutes *OPTIONAL*	215 ILCS 5/357.23	If included, policy must contain statutory required language. Any provision of the policy, which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.	
1.B.22	Premium - Pro-rata Refund	215 ILCS 5/357.31	Insurers must provide pro-rata refunds of premium upon receipt of proper notification of insured's death. Refund may not be based on short-rate table.	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.23	Civil Union	750 ILCS 75/1 CB 2011-06	The Religious Freedom Protection Act and Civil Union Act (750 ILCS 75/) allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. A party to a civil union shall be included in any definition or use of the terms “spouse,” “family,” “immediate family,” “dependent,” “next of kin,” and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms “marriage” or “married,” or variations thereon. All contracts of insurance issued by Illinois-licensed insurers on Illinois risks must comply with the Act.	
1.B.24	Discrimination	215 ILCS 5/364 50 IAC 2603	215 ILCS 5/364 prohibits discrimination for rates, benefits, terms and conditions between individuals in the same class of risk. Terms "physician" or "doctor" must include licensed dentists. Discriminating practices against people with disabilities, blind or partially blind individuals is prohibited except when based upon sound actuarial principals. 50 IAC 2603 Prohibits Gender Identity Discrimination.	
1.B.25	Form of Policy	215 ILCS 5/356a	No policy of accident and health insurance shall be delivered or issued for delivery to any person in this state unless it contains the enumerated information including: the entire money and other considerations therefor are expressed therein (for example premium that is required, deductibles, copays, coinsurance, non-eligible expenses, etc.); the time at which the insurance takes effect and terminates is expressed therein; and it purports to insure only one person subject to exceptions; the style, arrangement, and appearance of the policy give no undue prominence to any portion of the text; the exceptions and reductions of indemnity are set forth; etc; each such form, shall be identified by a form number; and it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer pare of the policy, subject to exceptions.	
1.B.26	Pre-Existing Conditions	50 IAC 2005.30 50 IAC 2007.70(b)(1)(H) 50 IAC 2007.80 (a)(5)	If a policy contains any limitations with respect to preexisting conditions, those limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations". 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."	
1.B.27	Use of Information Derived from Genetic Testing	215 ILCS 5/356v 410 ILCS 513/20	An insurer may not seek information derived from genetic testing for use in connection with a policy of accident and health insurance. An insurer that receives information derived from genetic testing, regardless of the source of that information, may not use the information for a nontherapeutic purpose as it relates to a policy of accident and health insurance. An insurer shall not use or disclose protected health information that is genetic information for underwriting purposes	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.28	Discretionary Clauses Prohibited	50 IAC 2001.3	No policy, contract, certificate, endorsement, rider application or agreement offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or of a disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State.	
1.B.29	Use of SSN on ID Cards	815 ILCS 505/2QQ 815 ILCS 505/2RR	A person or entity may not print an individual's social security number on an insurance card. 815 ILCS 505/2RR prevents a person, including insurers, from printing an individual's SSN on any materials mailed to an individual unless required by state or federal law.	
1.B.30	Assignment of Benefits	215 ILCS 5/370a	Insurers may not prohibit an insured from making an assignment of all or any part of his/her rights and privileges under the policy.	Affirmed ☐
1.B.31	Dependent Children - Adopted (and Pending) *REQUIRED IF:*	215 ILCS 5/356h	If a policy covers the insured's immediate family or children it may not exclude or limit coverage of an adopted child or a child not residing with the insured (foster child). A child in the custody of the insured pursuant to an interim court order of adoption is considered an adopted child.	

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SECTION C - BENEFIT REQUIREMENTS				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.1	Wellness Programs ***REQUIRED IF:***	215 ILCS 5/356z.17	If offered, the plan must: (1) Give participants the opportunity to qualify for offered incentives at least once a year; and (2) allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards; (3) not provide a total incentive that exceeds 20% of the cost of employee-only coverage. Plans may seek physician verification that health factors make it unreasonably difficult or medically inadvisable for the participant to satisfy the standards. The size of the incentive is limited by law and rule to a defined percentage based on the type of program offered.	
1.C.2	Human Papillomavirus Vaccine (HPV)	215 ILCS 5/356z.9	Policies must provide coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the federal Food and Drug Administration.	
1.C.3	Mammography - Screening	215 ILCS 5/356g.5	Every insurer shall provide coverage for complete and thorough clinical breast examinations as indicated by guidelines of practice, performed by a physician licensed to practice medicine in all its branches, a licensed advanced practice nurse, or a licensed physician assistant, to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows: (1) at least every 3 years for women at least 20 years of age but less than 40 years of age; and(2) annually for women 40 years of age or older.	
1.C.4	Shingles Vaccine (Herpes Zoster)	215 ILCS 5/356z.13	Policies must provide coverage for a vaccine for shingles that is approved for marketing by the federal Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine in all its branches and the enrollee is 60 years of age or older.	
1.C.5	Organ Transplant Medication Notification Act	215 ILCS 175/15	Benefits are available for medically necessary immunosuppressant drugs with a written prescription after an approved human organ transplant. In accordance with the Pharmacy Practice Act, when a prescribing physician has indicated on a prescription "may not substitute", a health insurance policy or health care service plan that covers immunosuppressant drugs may not require or cause a pharmacist to interchange another immunosuppressant drug or formulation issued on behalf of a person to inhibit or prevent the activity of the immune system of a patient to prevent the rejection of transplanted organs and tissues without notification and the documented consent of the prescribing physician and the patient.	
1.C.6	Maternity - Post-Parturition Care ***REQUIRED IF:***	215 ILCS 5/356s	If offered, the plan must provide minimum of 48 hours inpatient care for vaginal delivery and 96 hours for caesarian section for the mother and newborn. Shorter lengths of stays are permitted based on decision of attending physician.	

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SECTION C - BENEFIT REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.7	Prescription Drugs - Cancer Treatment *REQUIRED IF:*	215 ILCS 5/356z.7	If offered, the plan shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the U.S. Food and Drug Administration if proper documentation, as outlined, is provided.	Affirmed ☐
1.C.8	Optometric Services *REQUIRED IF:*	215 ILCS 5/364.1	If offered, the plan shall, upon issuance or delivery, be accompanied by a written notice to the policyholder that such policyholder may elect for optometric services received to be reimbursed to either a physician licensed to practice medicine in all its branches or to an optometrist licensed in this State.	
1.C.9	Cancer Drug Parity *REQUIRED IF:*	215 ILCS 5/356z.20	If offered, the financial requirements and treatment limitations applicable to orally-administered cancer medications may be no more restrictive than those same requirements applied to intravenously administered or injected cancer medications.	
1.C.10	Eye Drops - Topical Medication *REQUIRED IF:*	215 ILCS 156/5	If offered, the plan shall not deny coverage for the refilling of a prescription for topical eye medication when: (1) the medication is to treat a chronic condition of the eye; (2) the refill is requested by the insured prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and (3) the prescribing physician licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the insured do not exceed the total number of refills prescribed.	
1.C.11	Immune Gamma Globulin Therapy *OPTIONAL*	215 ILCS 5/356z.24	If included, the policy must contain statutory required language. Plans covering immune gamma globulin therapy for persons diagnosed with a primary immunodeficiency, when prescribed as medically necessary by a physician, initial authorization shall be for no less than 3 months; reauthorization may occur every 6 months thereafter. For persons who have been in treatment for 2 years, reauthorization shall be no less than every 12 months, unless more frequently indicated by physician.	
1.C.12	Opioid Antagonist *REQUIRED IF:*	215 ILCS 5/356z.23	If offered, the plan must provide coverage for at least one opioid antagonist, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist. This coverage must include refills for expired or utilized opioid antagonists. "Opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.	

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PART 2 - MINIMUM STANDARDS OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE

SECTION A - GENERAL RULES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.A.1	Renewability	50 IAC 2007.70(b)(1)(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.	
2.A.2	Age Calculation	50 IAC 2007.70(b)(1)(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 the definition.	
2.A.3	Military Status	50 IAC 2007.70(b)(1)(D)	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.	
2.A.4	Pregnancy	50 IAC 2007.70(b)(1)(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.	
2.A.5	Extended Care	50 IAC 2007.70(b)(1)(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.	
2.A.6	Transplants	50 IAC 2007.70(b)(1)(G)	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.	
2.A.7	Continuous Loss Calculations	50 IAC 2007.70(b)(1)(L)	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.	

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SECTION A - GENERAL RULES - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
2.A.8	Total Disability (Totally Disabled)	50 IAC 2007.70(b)(1)(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.	
2.A.9	Extension and Limitation of Coverage	50 IAC 2007.70(b)(1)(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.	
2.A.10	Refunds	50 IAC 2007.70(b)(1)(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.A.11	Allowable Exclusions	50 IAC 2007.60(e)(1)-(18)	The Rule provides an extensive list of allowable exclusions. If a policy includes exclusions, they need to be checked against this list.	

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SECTION B - REQUIRED DISCLOSURES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.B.1	Renewal Provisions	50 IAC 2007.80(a)(1)	Each individual policy of accident and health insurance shall include a renewal, continuation or nonrenewal provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, when limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.	
2.B.2	Additional Rider/ Endorsement Premiums	50 IAC 2007.80(a)(3)	When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.	
2.B.3	Usual and Customary	50 IAC 2007.80(a)(4)	A policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of those terms and an explanation of those terms in its accompanying outline of coverage.	
2.B.4	Preexisting Conditions	50 IAC 2007.80(a)(5)	If a policy contains any limitations with respect to preexisting conditions, those limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".	
2.B.5	Free Look	50 IAC 2007.80(a)(7)	All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within 10 days after its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.	
2.B.6	Maximum Aggregate Benefits	50 IAC 2007.80(a)(8)	If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, that fact must be prominently set forth in the outline of coverage.	
2.B.7	Conversion	50 IAC 2007.80(a)(9)	If a policy contains a conversion privilege, the caption of the provision shall be "Conversion Privilege", or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised.	
2.B.8	Accidental Circumstances	50 IAC 2007.60(g)	No policy, rider or endorsement providing benefits for loss due to an accident or accidental injury shall contain a provision or clause limiting, reducing or excluding liability for a loss resulting from purely accidental circumstances (e.g., involuntary or unintentional ingestion of poison or inhalation of poisonous gases or fumes). This restriction shall not preclude approval of a benefit for loss from defined accidents, such as travel, sport and student accident insurance.	

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SECTION B - REQUIRED DISCLOSURES - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
2.B.9	Emergency Medical Condition	215 ILCS 5/155.36 215 ILCS 134/10	All policies must comply with the definition in the Managed Care Reform and Patient Rights Act: "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.	
2.B.10	Notice of Department of Insurance	215 ILCS 5/143c	Policy must provide a written notice of: (1) the address of the complaint department of the insurance company; and (2) the address of the Public Service Division of the Department of Insurance or its successor.	

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PART 3 - COVERAGE TYPE

SECTION A - BASIC HOSPITAL EXPENSE COVERAGE

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.A.1	Basic Hospital Expense Coverage	50 IAC 2007.70(b)(2)	"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.	
3.A.2	Hospital Room and Board	50 IAC 2007.70(b)(2)(A)	Coverage for 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.	
3.A.3	Hospital Services and Supplies	50 IAC 2007.70(b)(2)(B)	Coverage for 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.	
3.A.4	Deductible Limits	50 IAC 2007.70(b)(2)(D)	Benefits provided for Hospital Room and Board, Hospital Services and Supplies, may be provided subject to a combined deductible amount not in excess of $100.	
3.A.5	Hospital Outpatient	50 IAC 2007.70(b)(2)(C)	Coverage for 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.	

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SECTION B - BASIC MEDICAL-SURGICAL EXPENSE COVERAGE				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.B.1	Basic Medical-Surgical Expense Coverage - Defined	50 IAC 2007(b)(3)	"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.	
3.B.2	Coverage for Surgical Services	50 IAC 2007(b)(3)(A)	Coverage shall be 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 not less than 80% of the reasonable charges.	
3.B.3	Coverage for Anesthesia Services	50 IAC 2007(b)(3)(B)	Coverage for 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, shall be in an amount not less than 80% of the reasonable charges; or 15% of the surgical service benefit.	
3.B.4	Coverage for In-hospital Medical Services	50 IAC 2007(b)(3)(C)	Coverage for 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, shall be 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.	
3.B.5	Excepted Benefit	50 IAC 2007(b)(3)(D)	In order to be an excepted benefit, basic medical-Surgical expense coverage can not be combined with basic hospital expense coverage.	

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SECTION C - HOSPITAL CONFINEMENT INDEMNITY COVERAGE				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.C.1	Hospital Confinement Indemnity Coverage	50 IAC 2007.70(b)(4)	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.	
3.C.2	Return of Premium - Cash Value Benefit	50 IAC 2007.60(c)	May contain a "return of premium" or "cash value" benefit so long as: (1) policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less; (2) policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death; (3) surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term; (4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations; (5) surrender value percentages are calculated assuming 0% future claim offset; (6) surrender value percentages are defined for all policy years; (7) interim surrender value percentages are defined when premiums are paid within a contract year; (8) policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.	
3.C.3	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Hospital Confinement Indemnity to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.C.4	Fixed Indemnity Notice Requirement	50 IAC 2007.80(a)(11)(A) 50 IAC 2007.80(a)(11)(B)	The fixed indemnity insurer must provide notice within the application indicating that the fixed indemnity is not MEC that satisfies the ACA individual mandate. That notice must contain the following verbiage displayed prominently in the plan materials in at least 14-point type that has the following language: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."	

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SECTION D - DISABILITY INCOME PROTECTION COVERAGE				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.D.1	Disability Income Protection Coverage	50 IAC 2007.70(b)(6)	"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.	
3.D.2	Return of Premium - Cash Value Benefit	50 IAC 2007.60(c)	May contain a "return of premium" or "cash value" benefit so long as: (1) policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less; (2) policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death; (3) surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term; (4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations; (5) surrender value percentages are calculated assuming 0% future claim offset; (6) surrender value percentages are defined for all policy years; (7) interim surrender value percentages are defined when premiums are paid within a contract year; (8) policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.	

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SECTION E - ACCIDENT ONLY COVERAGE

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.E.1	Accident Only Coverage	50 IAC 2007.70(b)(7)	"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.	
3.E.2	Probationary or Waiting Periods	50 IAC 2007.60(a)	Accident policies shall not contain a probationary or waiting period.	
3.E.3	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Accident Only Coverage to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.E.4	Varying Benefits by Accident	50 IAC 2007.70(b)(1)(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.	
3.E.5	Accident Only	50 IAC 2007.80(a)(6)	Accident only policies shall contain a prominent statement on the first page or attached to the policy in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."	
3.E.6	Accidental Death and Dismemberment	50 IAC 2007.70(b)(1)(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.	
3.E.7	Specific Dismemberment Benefits	50 IAC 2007.70(b)(1)(J)	Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.	

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SECTION F - SPECIFIED DISEASE - Expense Incurred				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.F.1	Return of Premium - Cash Value Benefit	50 IAC 2007.60(c)	May contain a return of premium or cash value benefit so long as: (1) policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100, but greater than 50, is permissible if the return of premium or cash value benefit has been in force for 10 years or less; (2) policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death; (3) surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term; (4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations; (5) surrender value percentages are calculated assuming 0% future claim offset; (6) surrender value percentages are defined for all policy years; (7) interim surrender value percentages are defined when premiums are paid within a contract year; (8) policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.	
3.F.2	Diagnosis	50 IAC 2007.70(b)(8)(A)(iii)	Any policy 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.	
3.F.3	Related Treatment	50 IAC 2007.70(b)(8)(A)(iv)	Specified disease policies shall provide benefits to a covered person not only for a 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.	
3.F.4	Guaranteed Renewable	50 IAC 2007.70(b)(8)(A)(v)	Policies containing specified disease coverage shall be at least Guaranteed Renewable.	
3.F.5	Waiting Period	50 IAC 2007.70(b)(8)(A)(vi)	No policy shall contain a waiting or probationary period greater than 30 days.	
3.F.6	Medical Necessity	50 IAC 2007.70(b)(8)(A)(vii)	Payment may be conditioned upon a covered person receiving medically necessary care or treatment	
3.F.7	Other Insurance	50 IAC 2007.70(b)(8)(A)(viii)	Benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.	
3.F.8	Benefit Trigger	50 IAC 2007.70(b)(8)(A)(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.	
3.F.9	Skin Cancer	50 IAC 2007.70(b)(8)(A)(x)	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.	

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SECTION F - SPECIFIED DISEASE - Expense Incurred - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.F.10	Prohibition on Preexisting Condition	50 IAC 2007.70(b)(8)(A)(ix) 215 ILCS 5/143(1)	First diagnosis or lump sum benefit policies cannot use pre-existing condition language or "manifest" language. Such language would be ambiguous and misleading.	
3.F.11	Policy Requirements	50 IAC 2007.70(b)(8)(B)	A policy that provides coverage for each person insured under the policy for a specifically named disease(s) with a deductible amount not in excess of $250; an overall aggregate benefit limit, per person, of not less than $10,000; and a benefit period of not less than two years for 1) Hospital room and board and any other hospital furnished medical services or supplies; 2) Treatment by a legally qualified physician or surgeon; 3) Private duty services of a registered nurse (R.N.); 4) X-ray, radium, cobalt, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment; 5) Professional ambulance for local service to or from a local hospital; 6) Blood transfusions, including expense incurred for blood donors; 7) Drugs and medicines prescribed by a physician; 8) The rental of an iron lung or similar mechanical apparatus; 9) Braces, crutches and wheel chairs as are deemed necessary by the attending physician; 10) 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; 11) May include coverage of any other expenses necessarily incurred for treatment of the disease.	
3.F.12	Limited Policies	50 IAC 2007.80(a)(10)	All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement such as: "This is a limited policy. Read it carefully."	
3.F.13	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Specified Disease to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.F.14	Limited Policy Notice	50 IAC 2007.80(a)(10)	All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement such as: "This is a limited policy. Read it carefully."	

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SECTION G - CANCER-ONLY OR CANCER/SPECIFIED DISEASE COMBINATION - Expense Incurred				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.G.1	Diagnosis	50 IAC 2007.70(b)(8)(A)(iii)	Any policy 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.	
3.G.2	Related Treatment	50 IAC 2007.70(b)(8)(A)(iv)	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.	
3.G.3	Guaranteed Renewable	50 IAC 2007.70(b)(8)(A)(v)	Policies containing specified disease coverage shall be at least Guaranteed Renewable.	
3.G.4	Waiting Period	50 IAC 2007.70(b)(8)(A)(vi)	No policy issued pursuant to this Section shall contain a waiting or probationary period greater than 30 days.	
3.G.5	Medical Necessity	50 IAC 2007.70(b)(8)(A)(vii)	Payment may be conditioned upon a covered person receiving medically necessary care or treatment	
3.G.6	Other Insurance	50 IAC 2007.70(b)(8)(A)(viii)	Benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.	
3.G.7	Benefit Trigger	50 IAC 2007.70(b)(8)(A)(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.	
3.G.8	Skin Cancer	50 IAC 2007.70(b)(8)(A)(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.	

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SECTION G - CANCER-ONLY OR CANCER/SPECIFIED DISEASE COMBINATION - Expense Incurred - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.G.9	Policy Requirements	50 IAC 2007.70(b)(8)(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: 1) reatment by, or under the direction of, a legally qualified physician or surgeon; 2) X-ray, radium, cobalt, chemotherapy, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment; 3) Hospital room and board and any other hospital furnished medical services or supplies; 4) Blood transfusions and their administration, including expense incurred for blood donors; 5) Drugs and medicines prescribed by a physician; 6) Professional ambulance for local service to or from a local hospital; 7) Private duty services of a registered nurse (R.N.) provided in a hospital; 8) May include coverage of any other expenses necessarily incurred in the treatment of the disease; 9) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; 10) 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; 11) 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; 12) Physical, speech, hearing and occupational therapy; 13) Special equipment including hospital bed, toilette, pulleys, aspirator, incontinence pants, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances; 14) Reconstructive surgery when deemed necessary by the attending physician; 15) Prosthetic devices; and 16) Nursing home care for non-custodial services.	
3.G.10	Return of Premium - Cash Value Benefit	50 IAC 2007.60(c)	May contain a "return of premium" or "cash value" benefit so long as: (1) policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less; (2) policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death; (3) surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term; (4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations; (5) surrender value percentages are calculated assuming 0% future claim offset; (6) surrender value percentages are defined for all policy years; (7) interim surrender value percentages are defined when premiums are paid within a contract year; (8) policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.	

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SECTION G - CANCER-ONLY OR CANCER/SPECIFIED DISEASE COMBINATION - Expense Incurred - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.G.11	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Specified Disease to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.G.12	Limited Policy Notice	50 IAC 2007.80(a)(10)	All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement such as: "This is a limited policy. Read it carefully."	

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SECTION H - SPECIFIED DISEASE - Per Diem Indemnity				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.H.1	Diagnosis	50 IAC 2007.70(b)(8)(A)(iii)	Any policy 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.	
3.H.2	Related Treatment	50 IAC 2007.70(b)(8)(A)(iv)	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.	
3.H.3	Guaranteed Renewable	50 IAC 2007.70(b)(8)(A)(v)	Policies containing specified disease coverage shall be at least Guaranteed Renewable.	
3.H.4	Waiting Period	50 IAC 2007.70(b)(8)(A)(vi)	No policy issued pursuant to this Section shall contain a waiting or probationary period greater than 30 days.	
3.H.5	Medical Necessity	50 IAC 2007.70(b)(8)(A)(vii)	Payment may be conditioned upon a covered person receiving medically necessary care or treatment.	
3.H.6	Other Insurance	50 IAC 2007.70(b)(8)(A)(viii)	Benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.	
3.H.7	Benefit Trigger	50 IAC 2007.70(b)(8)(A)(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.	
3.H.8	Skin Cancer	50 IAC 2007.70(b)(8)(A)(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.	
3.H.9	Hospital Confinement	50 IAC 2007.70(b)(8)(D)(i)	A fixed sum payment of at least $100 for each day of the hospital confinement for at least 365 days.	
3.H.10	Surgery	50 IAC 2007.70(b)(8)(D)(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.	

SECTION H - SPECIFIED DISEASE - Per Diem Indemnity - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.H.11	Skilled Nursing	50 IAC 2007.70(b)(8)(D)(iii)	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.	
3.H.12	Return of Premium - Cash Value Benefit	50 IAC 2007.60(c)	May contain a "return of premium" or "cash value" benefit so long as: (1) policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less; (2) policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death; (3) surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term; (4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations; (5) surrender value percentages are calculated assuming 0% future claim offset; (6) surrender value percentages are defined for all policy years; (7) interim surrender value percentages are defined when premiums are paid within a contract year; (8) policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.	
3.H.13	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Specified Disease to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.H.14	Fixed Indemnity Notice Requirement	50 IAC 2007.80(a)(11)(A) 50 IAC 2007.80(a)(11)(B)	The fixed indemnity insurer must provide notice within the application indicating that the fixed indemnity is not MEC that satisfies the ACA individual mandate. That notice must contain the following verbiage displayed prominently in the plan materials in at least 14-point type that has the following language: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."	
3.H.15	Limited Policy Notice	50 IAC 2007.80(a)(10)	All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement such as: "This is a limited policy. Read it carefully."	

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SECTION I - SPECIFIED ACCIDENT				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.I.1	Diagnosis	50 IAC 2007.70(b)(8)(A)(iii)	Any policy 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.	
3.I.2	Related Treatment	50 IAC 2007.70(b)(8)(A)(iv)	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.	
3.I.3	Guaranteed Renewable	50 IAC 2007.70(b)(8)(A)(v)	Policies containing specified disease coverage shall be at least Guaranteed Renewable.	
3.I.4	Waiting Period	50 IAC 2007.70(b)(8)(A)(vi)	No policy issued pursuant to this Section shall contain a waiting or probationary period greater than 30 days.	
3.I.5	Medical Necessity	50 IAC 2007.70(b)(8)(A)(vii)	Payment may be conditioned upon a covered person receiving medically necessary care or treatment.	
3.I.6	Other Insurance	50 IAC 2007.70(b)(8)(A)(viii)	Benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.	
3.I.7	Benefit Trigger	50 IAC 2007.70(b)(8)(A)(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.	
3.I.8	Skin Cancer	50 IAC 2007.70(b)(8)(A)(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.	
3.I.9	Specified Accident	50 IAC 2007.70(b)(8)(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.	
3.I.10	Probationary or Waiting Periods	50 IAC 2007.60(a)	Accident policies shall not contain a probationary or waiting period.	

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SECTION I - SPECIFIED ACCIDENT - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.I.11	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Specified Disease to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	
3.I.12	Accidental Death and Dismemberment	50 IAC 2007.70(b)(1)(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.	
3.I.13	Specific Dismemberment Benefits	50 IAC 2007.70(b)(1)(J)	Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.	

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SECTION J - LIMITED BENEFIT HEALTH INSURANCE COVERAGE

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.J.1	Limited Benefit Health Insurance Coverage	50 IAC 2007.70(b)(9)	"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 Basic Hospital Expense Coverage, Basic Medical-Surgical Expense Coverage, Hospital Confinement Indemnity Coverage, Major Medical Expense Coverage, Disability Income Protection Coverage, or Accident Only Coverage.	
3.J.2	Medicare Supplement Disclaimer	215 ILCS 5/363a(6)(d)	Outlines of coverage delivered in connection with policies defined in 215 ILCS 355a(4) as Limited Benefit Health Insurance to persons eligible for Medicare shall contain the following and shall be printed on or attached to the first page of the outline: "This policy, certificate or subscriber contract IS NOT A MEDICARE SUPPLEMENT policy or certificate. It does not fully supplement your federal Medicare health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	

IMPORTANT NOTICE: This Checklist does not include all of the requirements of Illinois laws, regulations or bulletins. Companies are responsible for reviewing Illinois laws, regulations and bulletins to ensure that forms are fully compliant before filing the forms.

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