Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

ACA Individual, Small Group, and Catastrophic Checklist

TO BE COMPLETED BY COMPANY

Company Name:

SERFF TOI:

SERFF SUB TOI:

SERFF Tracking #:

Plan Type (check one)		ELECTRONIC REFERENCES - FEDERAL
☐	ACA Individual	Code of Federal Regulations
☐	ACA Small Group	United States Code
☐	Catastrophic	U.S. Preventive Services Task Force

Line of Business (check one)		ELECTRONIC REFERENCES – ILLINOIS
☐	PPO and Indemnity	Illinois Insurance Code
☐	HMO	Administrative Rules
☐	HMO / POS	Illinois Company Bulletins
		Illinois Benchmark Plan 2017

Illinois is providing health insurance issuers a Web Portal through which rate filings and actuarial memorandum must be electronically reported. This reporting process does not replace any other reporting requirements.	Web Portal 2.1 User Guide Link

IMPORTANT NOTICE: This Checklist does not include all 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.

Contact Person: Sara Stanberry, Illinois Department of Insurance Health Advisor
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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) compliance with prohibited language; or
  2) 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.**

Index Directions

PPO/Indemnity filings must include the requirements listed in "Part 1" and "Part 2."
HMO filings must include the requirements listed in "Part 1" and "Part 3."
HMO/POS filings must include the requirements listed in "Part 1," "Part 3" and "Part 4."
PPO/Indemnity Catastrophic policy filings must include the requirements listed in "Part 1" and "Part 2" and "Part 5."
HMO Catastrophic policy filings must include the requirements listed in "Part 1" and "Part 3" and "Part 5."

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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 Checklists	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 number and form number for each entry.	Affirmed ☐
1.A.2	Prescription Drug Formulary	215 ILCS 5/355a(5)(c)(i)	No network based plan shall be offered for sale directly to consumers through the health insurance marketplace unless the most recently published prescription drug formulary is made available to the consumer when comparing policies and premiums.	Affirmed ☐
1.A.3	Consumer Directories	215 ILCS 5/355a(5)(c)(ii) 215 ILCS 124/25	No network based plan shall be offered for sale directly to consumers unless the most recently published provider directory is made available to the consumer when comparing policies and premiums. The Directory must be made available electronically and must be updated at least monthly. Plan shall provide print copies of the provider request upon request by the beneficiary.	Affirmed ☐
1.A.4	Electronic Notices and Devices	215 ILCS 5/143.34 (from PA 99-0167)	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. Do you intend to deliver documents electronically? Yes ☐ No ☐ (If yes, please affirm. If no, please state N/A)	Affirmed or N/A ☐
1.A.5	Rate Review Checklist	Health Premium Rates Checklist	All filings must be accompanied by the requirements contained in the Rate Review Checklist.	Affirmed ☐
1.A.6	Rate Filing	215 ILCS 5/355 215 ILCS 5/143 215 ILCS 125/4-13 50 IAC 4521.60 50 IAC 4521.112	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 approved by the Director. Provide SERFF tracking number	
1.A.7	Health Carrier Required External Review Form Filing Identification	50 IAC 4530.40	Companies must file the following forms as required by Part 4530.40: 1. 215 ILCS 180/20 - Notice of right to external review. 2. 215 ILCS 180/25 - Request for external review. 3. 215 ILCS 180/35 - Standard external review. 4. 215 ILCS 180/40 - Expedited external review. 5. 215 ILCS 180/42 - External review of experimental or investigational treatment adverse determinations. Provide SERFF tracking number	
1.A.8	Certificate of Compliance	50 IAC 916.50 50 IAC 4521.112	Each company doing business in the State of Illinois shall submit with each filing a Certificate of Compliance, as described in Section 916.50 and Exhibit A. Provide SERFF tracking number	
1.A.9	Letter of Submission	50 IAC 916.40(b) 50 IAC 2001.130(a)(3) 50 IAC 4521.112	1). Each form must bear an identifying form number in the lower left corner of the first page. 2). The insurer shall file a letter of submission, or provide the following information in the "Filing Description" field under the "General Information" tab in the SERFF, containing: The name of the form, if any, and identifying form #; Whether the submission is a new form; If the form is intended to supersede another, the 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.10	Proposed Enrollment Template	Proposed Enrollment Template Checklist	All companies filing a policy for approval as a QHP must file a completed Proposed Enrollment Template and attach it to the QHP Binder.	Affirmed ☐
1.A.11	Outline of Coverage	215 ILCS 5/355a(5)(a) 215 ILCS 5/355a(5)(b) 50 IAC 2007.80(b) & (g)	INDIVIDUAL ONLY No policy shall be delivered or issued for delivery in this State unless an outline of coverage either accompanies the policy, or is delivered to the applicant at the time the application is made, and an acknowledgment signed by the insured, of receipt of delivery of the outline is provided to the insurer	

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SECTION B - CONTRACTUAL POLICY REQUIREMENTS				
1.B.1	Definition of Usual and Customary	50 IAC 2007.80(a)(4) 215 ILCS 5/356z.3 215 ILCS 5/143 215 ILCS 125/5-3(a)	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 (such as maximum allowed, eligible charge, allowed charge, recognized charge) shall include a definition of those terms and an explanation of those terms in its accompanying outline of coverage.	
1.B.2	Summary of Benefits & Coverage Required Federal Format	50 IAC 2001.10 50 IAC 4521.110(x) 50 IAC 4521.110(b) Required Summary of Benefits and Coverage Template	Health plans and issuers are required to use the April 2017 edition of the Summary of Benefits and Coverage template and associated documents.	
1.B.3	Uniform Glossary Required Federal Format	Uniform Glossary - Required Federal Format	Health plans and issuers are required to use the April 2017 edition of the SBC template and associated documents.	
1.B.4	Civil Union	750 ILCS 75/10 750 ILCS 75/20 Company Bulletin 2011-06	Any definition or use of the terms “spouse,” “family,” “immediate family,” “dependent,” “next of kin,” and other terms descriptive of spousal relationships must include the term "Civil Union." 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.5	Discrimination	215 ILCS 5/364 50 IAC 2603 215 ILCS 125/5-3(a) 50 IAC 4521.110(v)	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.6	Form of Policy	215 ILCS 5/356(1) 50 IAC 4521.110	INDIVIDUAL ONLY - 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; the exceptions and reductions of indemnity are set forth; etc.	
1.B.7	Free-Look/Right to Examine Policy Individual Only	215 ILCS 5/355a(5)(a) 50 IAC 4521.110(n)	The policy must include on the first page a notice that the policyholder has the right to return the policy within 10 days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason. (The Department requests that language include an explanation of possible ramifications of returning the policy if open enrollment or special enrollment period has expired at the time policy is returned; i.e., individual will not be able to purchase another policy until next open enrollment or special enrollment period.)	
1.B.8	Pre-Existing Conditions	45 CFR 147.108(a) 45 CFR 146.111 26 CFR 54.9801-3 50 IAC 2001.5 50 IAC 4521.110(x) 215 ILCS 356z.25	Pre-existing condition exclusions are no longer permitted. Language which restricts coverage for a loss which occurs while policy is in force is not allowed. Lifetime maximum for completed oocyte retrievals for Infertility is not allowed.	Affirmed ☐
1.B.9	Prohibition on Rescissions	50 IAC 2001.7 50 IAC 4521.110(x) 29 CFR 2590.715-2712	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such policy with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with 30 days-notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).	Affirmed ☐

1.B.10	**Use of Information Derived from Genetic Testing**	215 ILCS 5/356v 215 ILCS 97/20(B) 410 ILCS 513/20 215 ILCS 125/5-3(a)	**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.**	**Affirmed** ☐
1.B.11	**Discretionary Clauses Prohibited**	50 IAC 2001.3 50 IAC 4521.110(x)	**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 healthcare 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.**	**Affirmed** ☐
1.B.12	**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.**	**Affirmed** ☐
SECTION C - NETWORK POLICY REQUIREMENTS				
1.C.1	**Emergency Services Incurred with Non-Participating Providers**	50 IAC 2051.310(a)(6)(J) 50 IAC 4520.110(g) 215 ILCS 124/10(b)(7)	**Policy must state that benefits for emergency care received from non-participating provider must be paid at no greater out-of-pocket to the member than had a participating provider been utilized.**	
1.C.2	**Provider Termination - Transition of Care**	45 CFR 156.230(d)(2) 215 ILCS 134/25 50 IAC 4520.60 215 ILCS 124/20(a) and (b)	**Policy must contain a provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause or for new members whose provider is not a member of the plan's network. Must allow an enrollee in active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. See referenced statute and rules for definition of on-going course of treatment. Managed Care Rule allows HMOs to require notice from enrollee within 30 days of notification of provider leaving network, and within 15 days for new enrollees whose provider is not in the network.**	
1.C.3	**Women's Principal HealthCare Provider**	215 ILCS 5/356r 215 ILCS 125/5-3.1(a)	**Insurer that requires insured to select PCP must allow female insureds the right to select a participating woman's principal health care provider. Notification required.**	
1.C.4	**Notice of Provider Nonrenewal or Termination**	215 ILCS 124/15(a) 215 ILCS 134/20	**A health care plan is required to provide 60 days' notice of nonrenewal or termination of a health care provider to both the provider and to his/her enrollees.** ***Applies to all plans with provider networks with effective dates of 01/01/2019 or later pursuant to passage of the Network Adequacy and Transparency Act (215 ILCS 124)**	
1.C.5	**Network Adequacy and Transparency Requirements**	215 ILCS 124/25	**Please advise SERFF Tracking # of Network Adequacy Filing. Provide SERFF tracking number**	
SECTION D - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS				
1.D.1	**Dependent Children - Adopted (and Pending)**	215 ILCS 5/356h 215 ILCS 125/4-9 26 USC 152(f)(c) 42 USC 300gg-91(d)(12)	**A policy that covers the insured's immediate family or children must provide the same coverage for an adopted child or a child not residing with the insured. An adopted child includes a child who has been "placed for adoption" which is defined as "means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation."**	
1.D.2	**Dependent Children - Disabled**	215 ILCS 5/356b 215 ILCS 5/367b 215 ILCS 125/4-9.1 50 IAC 4521.110(t)	**If a policy contains a provision for a limiting age for dependents, that provision will not be applicable to a disabling condition that occurred before the attainment of the limiting age.**	

1.D.3	**Dependent Children - Newborn**	215 ILCS 5/356c 215 ILCS 125/4-8	**A policy of accident and health insurance shall cover the hospital or medical expenses of newborn infants from and after the moment of birth. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period and may require payment of the appropriate premium.**	
1.D.4	**Dependent Children Covered to Age 26 or 30**	215 ILCS 5/356z.12 215 ILCS 125/5-3(a) 45 CFR 144 45 CFR 147.120 Section 2714 ACA	**A policy that includes dependent coverage must offer coverage to all dependents up to age 26, regardless of marital status, financial dependency on parents or residence. Policies must include coverage for military veteran dependents up to age 30 (may restrict to unmarried and require that the dependent be a resident of Illinois). The IRS defines "child" to include son, daughter, step-child, legally adopted or placed for adoption child, and eligible foster child. The law does not change HIPAA special enrollment requirements.**	
1.D.5	**Discontinuance of Coverage - HIPAA**	50 IAC 2025 215 ILCS 97/30(C) 50 IAC 2001.4(g)(h) & (j) 50 IAC 4521.110(x)	**Insurers must comply with the uniform notification requirements for discontinuing all coverage in the state. Notification requirements must appear in certificate. 1). The health insurance issuer may only discontinue a particular type of health insurance coverage upon the renewal date of the coverage with ninety (90) days' notice to insureds. 2). The health insurance issuer must offer to be purchased all products being marketed in that market. The health insurance issuer may not limit which products are to be offered for purchase. (For group, this may be in the group agreement)**	
1.D.6	**Guaranteed Renewability - HIPAA**	215 ILCS 97/30 (A) & (B) - Group 215 ILCS 97/50(A) & (B) - Individual 50 IAC 2001.4(f) & (g) 50 IAC 4521.110(x)	**A health insurer issuing individual coverage must renew or continue in force coverage at the option of the individual except for: 1. Nonpayment of premium; 2. Termination of the plan; 3. Fraud; 4. Movement outside the service area; or 5. Association membership ceases. (For group, this may be in the group agreement)**	
1.D.7	**Modification of Coverage – HIPAA**	50 ILCS 2025 215 ILCS 97/30(D) - Group 215 ILCS 97/50(D) - Individual 50 IAC 2001.4(j) - Group 50 IAC 4521.110(x)	**An insurer may only modify a contract at renewal as long as the modification is consistent with Illinois law and consistent on a uniform basis among all individuals with that policy form. (For group, this may be in the group agreement)**	**Affirmed** ☐
1.D.8	**Continuation of Coverage**	215 ILCS 5/367e 215 ILCS 125/4-9.2	**GROUP ONLY - A group policy insures employees or members shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership or because of a reduction in hours below the minimum required by the group plan shall be entitled to continue their coverage for themselves and their eligible dependents.**	
1.D.9	**Spousal Continuation Privilege**	215 ILCS 5/367.2 215 ILCS 125/5-3(a)	**GROUP ONLY - Policy must provide for a continuation of the existing insurance benefits for an employee's spouse and dependent children who are insured under the provisions of that group policy or certificate thereunder, notwithstanding that the marriage is dissolved by judgment or terminated by the death of the employee or, after the effective date of this amendatory Act of the 93rd General Assembly, notwithstanding the retirement of the employee provided that the employee's spouse is at least 55 years of age, in each case without any other eligibility requirements.**	
1.D.10	**Dependent Child Continuation Privilege**	215 ILCS 5/367.2-5 215 ILCS 125/5-3(a)	**GROUP ONLY - Policy must provide for a continuation of the existing insurance benefits for an employee's dependent child who is insured under the provisions of that group policy or certificate in the event of the death of the employee and the child is not eligible for coverage as a dependent under the provisions of Section 367.2 (Spousal Continuation Privilege) or the dependent child has attained the limiting age under the policy.**	
1.D.11	**Discontinuance and Replacement**	215 ILCS 5/367i 215 ILCS 125/5-3(a) 50 IAC 2013	**GROUP ONLY - Group health insurance policies issued, amended, delivered or renewed on and after the effective date of this amendatory Act of 1989, shall provide a reasonable extension of benefits in the event of total disability on the date the policy is discontinued for any reason.**	

SECTION E - PREMIUMS / GRACE PERIODS				
1.E.1	**Grace Period for Advance Premium Tax Credit Recipients**	45 CFR 155.430 45 CFR 156.270 50 IAC 4521.110(l)	**ON EXCHANGE ONLY - INDIVIDUAL ONLY - A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in 45 CFR 155.430(d)(4), provided that the QHP issuer meets the notice requirement specified in paragraph (b) of that section. During the grace period, the QHP issuer must: 1). Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; 2). Notify HHS of such non-payment; and, 3). Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.**	
SECTION F - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
1.F.1	**Out-Of- Pocket Expense**	Section 1302 of the ACA 42 USC 300gg-6	**Policy must state all out-of-pocket limitations. The ACA sets the annual limitation on cost sharing. (For instance, the 2018 maximum annual limitation on cost sharing is $7,900 for individual coverage and $15,800 for family coverage.)**	
1.F.2	**Precertification Penalties**	50 IAC 2051.310(a)(6)(K) 215 ILCS 5/143(1) 215 ILCS 124/10(b)(8)	**If a plan intends to impose penalties for failure to pre-certify a hospital admission, the penalty must be defined in the policy and may not exceed $1,000. The penalty may be no more frequent than a per confinement basis.**	
1.F.3	**Claims - Timely Payment**	215 ILCS 5/368a(c) 215 ILCS 5/357.9 215 ILCS 125/5-3(a)	**STATUTORY LANGUAGE REQUIRED - Claims shall be paid within 30 days following receipt of written due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day. For payors other than PPO/Indemnity insurers, the payee entitled to interest may include an insured, insured's assignee, health care professional, or health care facility.**	
1.F.4	**Coordination of Benefits**	215 ILCS 5/367(11a) 215 ILCS 5/367(11b) 50 IAC 4521.110(s) 50 IAC 2009 - Exhibit A	**Policies are permitted, but not required, to contain coordination of benefits (COB) provisions consistent with the requirements of 50 IAC 2009.**	
SECTION G - APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS				
1.G.1	**Notice of Department of Insurance**	215 ILCS 5/143c 50 IAC 4520.70 50 IAC 4521.110(m) 50 IAC 919.40 50 IAC 919.50	**Policy must provide address of complaint department of the insurance company and the address of the Illinois Department of Insurance. If a settlement of a claim is less than the amount claimed, or if the claim is denied, the plan shall provide to the insured a reasonable written explanation of the basis of the lower offer or denial within 30 days after the investigation and determination of liability is completed. This explanation shall clearly set forth the policy definition, limitation, exclusion or condition upon which denial was based. The explanation shall clearly inform the enrollee of the right to appeal the claim reduction or denial, the process by which the enrollee (or the enrollee's designee or guardian) may initiate the appeal process and the plan's phone number to call to receive more information concerning the appeal process. Notice of Availability of the Department shall accompany this explanation.** **The Appeal/Complaint Section must include Notice of DOI:** **The Illinois Department of Insurance** **Office of Consumer Health Insurance** **320 West Washington Street** **Springfield, IL 62767** **(877)527-9431 Toll-free number** **(217) 558-2083 Fax Number** **Email address - complaints@ins.state.il.us** **Message Center - https://mc.insurance.illinois.gov/messagecenter.nsf** **Note: This info is different from the external review notice of department**	

1.G.2	External Review	External Review Checklist	Please provide SERFF tracking number of your external review filing. Provide SERFF tracking number	
SECTION H - BENEFITS - ESSENTIAL HEALTH BENEFITS / ILLINOIS MANDATES				
1.H.1	Essential Health Benefits	Section 1302 of the ACA 42 USC Section 18022(e)(1)(B) 45 CFR 156.155(a)(3) 50 IAC 2001.11 50 IAC 4521.130(l)	Federal EHB Requirements: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, (including oral and vision care).	Affirmed ☐
1.H.2	Inpatient Hospital Services (e.g., Hospital Stay)	Benchmark p. 46 CMS EHB Benchmark Summary requirement	Note to Issuers - Benchmark Example: The following are covered services when you receive them as an inpatient in a hospital. Inpatient covered services 1). Bed, board and general nursing care when you are in: a) a semi-private room b) a private room c) an intensive care unit 2). Ancillary services (such as operating rooms, drugs, surgical dressings and lab work) 3). Preadmission testing. Private room benefits may be limited to the Hospital's rate for its most common type of room with two or more beds.	
1.H.3	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Benchmark pp. 47 & 48 CMS EHB Benchmark Summary requirement	Note to Issuers - Benchmark Example: 1). Surgery and any related Diagnostic Service (including imaging and laboratory - CMS Summary) received on the same day as the Surgery 2). Radiation Therapy Treatments 3). Chemotherapy 4). Electroconvulsive Therapy 5). Renal Dialysis Treatments 6). Diagnostic Service (including imaging and laboratory - CMS Summary) 7). Urgent Care 8). Emergency Accident Care 9). Emergency Medical Care	
1.H.4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Benchmark p. 67 CMS EHB Benchmark Summary requirement	Note to Issuers - Benchmark Example: Benefits for all Covered Services are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.	
1.H.5	Emergency Medical Condition	215 ILCS 5/155.36 215 ILCS 134/10	"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.	
1.H.6	Emergency Transportation/ Ambulance	215 ILCS 125/4-15 Benchmark pp. 6 & 59 CMS EHB Benchmark Summary requirement	Note to Issuers - Benchmark Example: "Ambulance Transportation" means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a hospital, between hospital and hospital, between hospital and skilled nursing facility or from a skilled nursing facility or hospital to your home. If there are no facilities in the local area equipped to provide the care needed, ambulance transportation then means the transportation to the closest facility that can provide the necessary service. Benefit not provided for convenience. Benefits will not be provided for use of an ambulance because it is more convenient than other transportation.	
1.H.7	Emergency Room Services	Benchmark p. 13 CMS EHB Benchmark Summary requirement	Note to Issuers - Benchmark Example: "Emergency services" means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient. Managed Care Reform and Patient Rights Act: "Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.	
1.H.8	Emergency Medical Care - Criminal Sexual Assault	215 ILCS 5/367(8) 215 ILCS 5/356e 215 ILCS 125/4-4	Policy must state that it will provide coverage for charges for testing and examination for victims of criminal sexual assault for actual expenses incurred, without offset or reduction for benefit deductibles or coinsurance amounts.	
1.H.9	Partial Hospitalization	Benchmark p. 46	Benefits provided for partial hospitalization program.	

1.H.10	**Home Health Care**	Benchmark p. 47	**Benefits will be provided for services under a Coordinated Home Care Program**	
1.H.11	**Hospice**	Benchmark p. 77 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: Hospital coverage also includes benefits for Hospice Care Program Service. Benefits will be provided for the Hospice Care Program Service described below when these services are rendered by a Hospice Care Program Provider. However, for benefits to be available the enrollee must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, with no continued benefit from standard medical care or have chosen to receive hospice care rather than standard care. A family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home. The following services are covered under the Hospice Care Program: Coordinated Home Care; Medical supplies and dressings; Medication; Nursing Services - Skilled and non-Skilled; Occupational Therapy; Pain management services; Physical Therapy; Physician visits; Social and spiritual services; and Respite Care Service.**	
1.H.12	**Skilled Nursing Facility**	Benchmark pp. 23 & 66 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: The following are covered services when you receive them in a skilled nursing facility: 1). Bed, board and general nursing care; 2). Ancillary services (such as drugs and surgical dressings or supplies). No benefits will be provided for admissions to a skilled nursing facility which are for the convenience of the patient or physician or because care in the home is not available or the home is unsuitable for such care. "Skilled Nursing Service" means those services provided by a registered nurse (RN) or licensed practical nurse (LPN) which require the clinical skill and professional training of an RN or LPN and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for skilled nursing service will not be provided due to the lack of willing or available non-professional personnel. Skilled nursing service does not include "custodial care service".**	
1.H.13	**Physician Services Primary Care Visit to Treat an Injury or Illness**	Benchmark pp. 17 & 51 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: Benefits are available for medical care visits (ordinary & usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury) when you are: 1). inpatient in a hospital, substance use disorder treatment facility or skilled nursing facility; 2). a patient in a partial hospitalization treatment program or coordinated home care program; or 3). you visit a physician's office or a physician comes to your home.**	
1.H.14	**Physician Services Specialist Visit**	Benchmark p. 51 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: When you receive Covered Services in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Participating Provider's specialist office Copayment amount (if applicable). Benefits will then be provided at the specialist's office payment level.**	
1.H.15	**Referrals and Second Opinions/Additional Surgical Opinion**	215 ILCS 5/370i(a) 50 IAC 4521.130(a) Benchmark p. 51 CMS EHB Benchmark Summary requirement	**Plan must contain a description of any limitation for referrals and access to second opinions to ensure access and availability of health care services for the insured is not restricted. Coverage includes benefits for an additional surgical opinion following a recommendation for elective surgery.**	
1.H.16	**Physician Services Surgical**	Benchmark p. 50	**Surgery performed by a physician, dentist or podiatrist. Services by dentist or podiatrist are limited to those surgical procedures they may legally render and which are payable under the policy.**	
1.H.17	**Assist at Surgery**	Benchmark p. 50	**Assist at Surgery by Physician, Dentist, Podiatrist, Registered Surgical Assistant, Advanced Practice Nurse OR Physician Assistant under direct supervision of a Physician, Dentist or Podiatrist**	
1.H.18	**Anesthesia Services**	Benchmark p. 50	**Anesthesia services for a covered surgical procedure in Hospital or Ambulatory Surgical Facility if administered at the same time as covered surgical procedure by a physician other than operating physician or by a Certified Registered Nurse Anesthetist**	

1.H.19	**Anesthesia Services - Dental**	215 ILCS 5/356z.2 215 ILCS 125/5-3(a)	**Statute: a) A policy shall cover charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or an ambulatory surgical treatment center if any of the following applies: 1). the individual is a child age 6 or under; 2). the individual has a medical condition that requires hospitalization or general anesthesia for dental care; or 3). the individual is a person with a disability. (a-5) A policy shall cover charges incurred, and anesthetics provided by a dentist in a dental office, oral surgeon's office, hospital, or ambulatory surgical treatment center if the individual is under age 19 and has been diagnosed with an autism spectrum disorder or a developmental disability as defined by the statute.**	
1.H.20	**Anesthesia Services – Oral Surgery**	Benchmark p. 50	**Benefits are provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.**	
1.H.21	**Allergy Testing and Treatment (Serum)**	Benchmark p. 51 CMS EHB Benchmark Summary requirement 50 IAC 4521.130(g)	**Note to Issuers - Benchmark Example: Covered services include allergy injections and allergy testing**	
1.H.22	**Amino Acid-Based Elemental Formulas**	215 ILCS 5/356z.10 215 ILCS 125/5-3(a)	**Coverage must include reimbursement for amino acid-based elemental formulas, regardless of delivery method, for diagnosis and treatment of eosinophilic disorders and short bowel syndrome.**	
1.H.23	**Bariatric Surgery (Obesity)**	Benchmark p. 67 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: Benefits for Covered Services received for bariatric surgery will be provided under the hospital benefits and physician benefits section of this Certificate, the same as for any other condition.**	
1.H.24	**Breast - Fibrocystic Breast Condition**	215 ILCS 356n 215 ILCS 125/4-16	**Policy must provide coverage for fibrocystic breast condition.**	
1.H.25	**Breast - Post Mastectomy Care**	215 ILCS 5/356t 215 ILCS 125/4-6.5	**Coverage must provide inpatient treatment following a mastectomy for a length of time to be determined by the attending physician; and must also provide for availability of post-discharge physician office visit or in-home nurse visit within 48 hours of discharge.**	
1.H.26	**Breast Cancer Pain Medication and Therapy**	215 ILCS 5/356g.5-1 215 ILCS 125/5-3(a)	**Coverage must include all medically necessary pain medication and pain therapy related to the treatment of breast cancer under the same terms and condition applicable to treatment of other conditions. The term "pain therapy" is defined.**	
1.H.27	**Breast Implant Removal**	215 ILCS 356p 215 ILCS 125/4-6.2	**Coverage must include-medically necessary breast implant removal for a sickness or injury. This provision does not apply to the removal of breast implants that were done solely for cosmetic purposes.**	
1.H.28	**Breast Reconstruction After Mastectomy**	215 ILCS 5/356g(b) 50 IAC 2016 215 ILCS 125/4-6.1(b) 50 IAC 4521.132 CMS EHB Benchmark Summary requirement	**Coverage must provide for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include: 1). reconstruction of the breast upon which the mastectomy has been performed; 2). surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3). prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.**	
1.H.29	**Cancer - Qualified Clinical Cancer Trials**	215 ILCS 5/364.01 215 ILCS 125/5-3(a)	**Policy must cover routine patient care for an insured participating in a qualified clinical cancer trial if the policy covers that same care for insureds not so enrolled. "Routine patient care" means all health care services provided in the qualified clinical cancer trial that are otherwise generally covered under the policy if those items or services were not provided in connection with a qualified clinical cancer trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial.**	
1.H.30	**Chiropractic & Osteopathic Manipulation**	Benchmark p. 53 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Benefits for chiropractic and osteopathic manipulation may be limited to a maximum of twenty-five (25) visits per benefit period.**	

1.H.31	**Dental Care Due to Accidental Injury – Adult and Child**	Benchmark p. 59 CMS EHB Benchmark Summary requirement	**Coverage includes services rendered by a Dentist or Physician which are required as the result of an accidental injury.**	
1.H.32	**Dental Care - Oral Surgery (moved from 1.H.8)**	Benchmark p. 50 CMS EHB Benchmark Summary requirement	**Benefits for oral Surgery are limited to the following services: (1) surgical removal of complete bony impacted teeth; (2) excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (3) surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (4) excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.**	
1.H.33	**Dental Care - TMJ Services and Devices**	215 ILCS 5/356q CMS EHB Benchmark Summary requirement	**Policies shall provide coverage for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder.**	
1.H.34	**Diabetes - Self Management, Education and Nutrition**	215 ILCS 5/356w 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**Benefits will be provided for outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management.**	
1.H.35	**Diabetes - Preventive Foot Care**	215 ILCS 5/356w 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**Policy must provide for foot care and foot examinations for persons with diabetes.**	
1.H.36	**Diabetes Supplies**	215 ILCS 5/356w 215 ILCS 125/5-3(a) 50 IAC 2019	**a). Coverage for durable medical equipment shall be subject to the same deductible, copayment, and coinsurance provisions provided for other durable medical equipment, depending on whether such coverage is provided under the policy or a durable medical equipment rider to the policy. Such minimum benefit shall not apply to a group policy of accident and health insurance that does not provide durable medical equipment. b). Coverage for pharmaceuticals and supplies shall be subject to the same coverage, deductible, co-payment, and co-insurance provisions provided for other pharmaceuticals, depending on whether such coverage is provided under the policy or a drug rider to the policy. Such minimum benefit shall not apply to a group policy of accident and health insurance that does not provide drug coverage.**	
1.H.37	**Durable Medical Equipment**	Benchmark p. 53 CMS EHB Benchmark Summary requirement	**Note to Issuers - Benchmark Example: Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of DME required for temporary therapeutic use (such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, walkers, and other medically necessary equipment prescribed by a health care provider-from CMS definition) provided that this equipment is primarily and customarily used to serve a medical purpose. From www.healthcare.gov - Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.**	

1.H.38	**Habilitative and Rehabilitative Services and Devices**	45 CFR 156.110 45 CFR 156.115(a)(5) Benchmark pp. 14 & 51 CMS EHB Benchmark Summary requirement	**Provision of EHB means that a health plan provides benefits: (5). With respect to habilitative services and devices: (i). Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings; (ii). Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and (iii). Do not impose combined limits on habilitative and rehabilitative services and devices. (Rehabilitative and habilitative services & devices means professional, counseling, guidance services, and treatment programs, that are intended to develop, maintain, and restore the functioning of an individual. Examples, besides those specifically referenced elsewhere in this checklist, include, but are not limited to pulmonary rehabilitation therapy and cardiac transplant rehabilitation services.)**	
1.H.39	**Habilitative Services for Children**	215 ILCS 5/356z.15 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**Plan must provide coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder (not limited to autism – see statute) so long as all of the following conditions are met: 1). A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder. 2.) treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches. 3). initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational. "Habilitative services" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder.**	
1.H.40	**Habilitative and Rehabilitative Services for Children with Autism**	215 ILCS 5/356z.14 215 ILCS 125/5-3(a)	**Policies shall include benefits for habilitative and rehabilitative services, including applied behavioral analysis, prescribed, provided, or ordered for an individual under 21 years of age diagnosed with an autism spectrum disorder - See 1.J.3 for specific requirements. Coverage shall not be subject to any limits on the number of visits to a service provider.**	
1.H.41	**Hearing Aids/ Cochlear Implants**	Benchmark pp. 53, 59 & 91 CMS EHB Benchmark Summary requirement	**Coverage for medically necessary bone anchored hearing aids/Osseo integrated auditory implants and cochlear implants must be written in the policy for adults and children. Benefits for hearing aids for children may limited to two every 36 months.**	
1.H.42	**Infertility (Fertility) Treatment**	215 ILCS 5/356m 50 IAC 2015 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**Infertility benefits must be covered the same as benefits for any other condition for covered services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Lifetime limits for completed oocyte retrievals are prohibited due to pre-existing condition prohibition. See 1.B.8 (45 CFR 146.111 26 CFR 54.9801-3)**	
1.H.43	**Maternity and Newborn Care**	45 CFR 156.110 50 IAC 2007.60e(3) 215 ILCS 5/356c 215 ILCS 125/4-8 215 ILCS 5/356s 215 ILCS 125/4-6.4 CMS EHB Benchmark Summary requirement	**Benefits for maternity service are the same as benefits for any other condition. Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. The maternity benefit must provide a minimum of 48 hours inpatient care for normal delivery and 96 hours for caesarian section for mom and newborn. Shorter lengths of stays are permitted based on decision of attending physician if coverage and availability of a post-discharge physician office visit or in-home nurse visit. A distinct deductible and coinsurance may be applied to newborn charges only after the initial 48 or 96-hour period.**	
1.H.44	**PANDAS/PANS**	215 ILCS 5/356z.25	**Plan shall provide coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.**	

1.H.45	**Physical Therapy - Multiple Sclerosis Patients**	215 ILCS 5/356z.8	**Coverage must provide for medically necessary preventative physical therapy for insureds diagnosed with this disease. A definition of "preventative physical therapy" is included. Coverage limitations, deductibles, coinsurance features, etc. must be provided the same as any other illness.**	
1.H.46	**Private-Duty Nursing**	Benchmark p. 35 CMS EHB Benchmark Summary requirement	**Note to Issuers -Benchmark Example: Private duty nursing service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any. Private duty nursing service must have prior approval. Whenever private duty nursing service is recommended by your physician, you must, in order to receive maximum benefits under the policy, obtain prior approval.**	
1.H.47	**Prosthetics/Orthotics**	215 ILCS 5/356z.18 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**Shall include coverage for repairs and replacements, and shall be subject to the other general exclusions, limitations, and financial requirements of the policy. "Prosthetic Device" means an artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as medically necessary. "Customized Orthotic Device" means a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the repair or replacement of the device based on the patient's physical condition as medically necessary (EXCLUDING foot orthotics defined as an "in-shoe" device designed to support the structural components of the foot during weight-bearing activities.)**	
1.H.48	**Reconstructive Surgery (other than related to mastectomy)**	Benchmark p. 90	**The policy must provide coverage for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases.**	
1.H.49	**Transplants - Human Organ Transplants**	215 ILCS 5/356k 215 ILCS 5/367(13) 215 ILCS 125/4-5 CMS EHB Benchmark Summary requirement	**Plan must provide coverage for expenses incurred for any organ transplantation procedure and may not deny coverage solely on the basis that such procedure is deemed experimental or investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research (now known as the Technology Assessment Program within the Agency for Healthcare Research and Quality) within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.**	
1.H.50	**Transplants - Human Organ Transplants Transportation and Lodging**	Benchmark p. 62	**Benefits must be provided for transportation and lodging for covered patient receiving transplant and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, the patient's place of residency must be more than 50 miles from the Hospital where the transplant will be performed. Benefits for transportation and lodging may be limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging may be limited to $50 per person per day.**	
SECTION I - BENEFITS - PREVENTIVE				
1.I.1	**Preventive Services ACA**	Public Law 111-148-PPACA 50 IAC 2001.8 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement	**The Department requires the complete list of preventive covered services to appear in the certificate of insurance. The Department will not accept referring an insured to a web site or a 1-800 phone number. Benefits shall be provided at no cost sharing to the member when these services are delivered by a network provider.**	
1.I.2	**Preventive Services - Immunizations - Adults**	50 IAC 2001.8(a)(1)(B) 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement	**Plans are required to cover immunizations recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment or coinsurance. The list of covered immunizations that must be included in the contract can be found using the web link provided (Preventive Services - Immunizations - Adults). NO COST SHARING IN-NETWORK**	
1.I.3	**Preventive Services - Immunizations - Children**	50 IAC 2001.8(a)(1)(B) 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement	**Plans are required to cover immunizations recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment or coinsurance. The list of covered immunizations that must be included in the contract can be found using the web link provided (Preventive Services - Immunizations - Children). NO COST SHARING IN-NETWORK**	

1.I.4	**Preventive Services - Adults**	50 IAC 2001.8 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement	**Plans are required to cover preventive services recommended by the U.S. Preventive Services Task Force without charging a deductible, copayment or coinsurance. The list of covered preventive services that must be included in the contract can be found using the web link provided (Preventive Services - Adults). NO COST SHARING IN-NETWORK**	
1.I.5	**Preventive Services - Women**	50 IAC 2001.8 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement Company Bulletin 2012-05	**Plans are required to cover women's preventive services guidelines supported by the Health Resources & Services Administration without charging a deductible, copayment or coinsurance. The list of covered preventive services that must be included in the contract can be found using the web link provided (Preventive Services - Women). NO COST SHARING IN-NETWORK**	
1.I.6	**Preventive Services - Children**	50 IAC 2001.8 50 IAC 4521.110(x) CMS EHB Benchmark Summary requirement Benchmark p. 52	**Plans are required to cover preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) without charging a deductible, copayment or coinsurance. The list of covered preventive services that must be included in the contract can be found using the web link provided (Preventive Services - Children). Benefits must include routine hearing screenings/examinations. NO COST SHARING IN-NETWORK**	
1.I.7	**Osteoporosis - Bone Mass Measurement**	215 ILCS 5/356z.6 215 ILCS 125/5-3(a)	**Policies must provide coverage for medically necessary bone mass measurement and for the diagnosis of osteoporosis. NO COST SHARING IN-NETWORK**	
1.I.8	**Breast Exam - Clinical**	215 ILCS 5/356g.5 215 ILCS 125/4-6.5 Benchmark p. 52 CMS EHB Benchmark Summary requirement	**Coverage is required for clinical breast examinations. NO COST SHARING IN-NETWORK**	
1.I.9	**Breast Feeding (Lactation) Support, Supplies and Counseling - Breast Pumps**	50 IAC 2001.8 50 IAC 4521.110(x) Company Bulletin 2012-05	**Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment, in conjunction with each birth. Coverage of breast pump must be included in the policy, including type (manual or electric) covered at no cost-sharing. NO COST SHARING IN-NETWORK**	
1.I.10	**Colorectal Cancer Examination and Screening**	215 ILCS 5/356x 215 ILCS 125/5-3(a)	**Plan must provide coverage for all colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. NO COST SHARING IN-NETWORK**	
1.I.11	**Contraceptive/Birth Control Services**	215 ILCS 5/356z.4 215 ILCS 125/5-3(a)	**Policies must provide coverage for the insured and any dependent of the insured covered by the policy for all outpatient contraceptive services (consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy) and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration including over-the-counter products with the exception of male condoms. Coverage must provide for dispensing of 12 months' worth of contraception at one time. NO COST SHARING IN-NETWORK Sterilization coverage is required – see below.**	
1.I.12	**HIV screening - pregnant women**	215 ILCS 5/356z.1 215 ILCS 125/4-6.5	**Plan must provide coverage for prenatal HIV testing ordered by an attending physician licensed to practice medicine in all its branches, or by a physician assistant or advanced practice registered nurse, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. NO COST SHARING IN-NETWORK**	
1.I.13	**Human Papillomavirus Vaccine (HPV)**	215 ILCS 5/356z.9 215 ILCS 125/5-3(a)	**Plan must provide coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the federal Food and Drug Administration. NO COST SHARING IN-NETWORK**	

1.I.14	**Mammography - Screening**	215 ILCS 5/356g(a) 215 ILCS 5/356g.5 215 ILCS 125/4-6.1	**Plan must provide coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer within the provisions of the policy, contract, or certificate. Coverage shall be as follows: 1). a baseline mammogram for women 35 to 39 years of age; 2). An annual mammogram for women 40 years of age or older; 3). a mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors; 4). a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches; 5). a screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches. Low-dose mammography includes digital mammography and includes breast tomosynthesis. Out of network shall be at least as favorable as for other radiological examinations covered by the policy or contract. NO COST SHARING IN-NETWORK**	
1.I.15	**Pap Tests/ Prostate-Specific Antigen Tests/ Ovarian Cancer Surveillance Test**	215 ILCS 5/356u - Group Only 215 ILCS 125/4-6.5 - Group Only	**Plans shall provide coverage for all of the following: 1). An annual cervical smear or pap smear test for female insureds; 2). An annual digital rectal examination and a prostate-specific antigen test, for male insureds upon the recommendation of a physician licensed to practice medicine in all its branches for: a). asymptomatic men age 50 and over; b). African-American men age 40 and over; c). men age 40 and over with a family history of prostate cancer; 3). Surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer. Refer to Preventive Services - Adults and Preventive Services - Women for cost-sharing requirements.**	
1.I.16	**Shingles Vaccine (Herpes Zoster)**	215 ILCS 5/356z.13 215 ILCS 125/5-3(a)	**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. NO COST SHARING IN-NETWORK**	
1.I.17	**Tobacco Smoking Cessation Program**	215 ILCS 5/356z.21 215 ILCS 125/5-3(a)	**Insurers must provide coverage for a tobacco use cessation program for persons enrolled in the plan. NO COST SHARING IN-NETWORK**	
1.I.18	**Sterilization**	215 ILCS 5/356z.4(a)(3)(B) 215 ILCS 125/5-3(a)	**A policy shall provide coverage for voluntary sterilization procedures for males and females and shall not impose a deductible, coinsurance, copayment, or any other cost- sharing requirement on the coverage provided. NO COST SHARING IN-NETWORK**	
1.I.19	**Wellness Programs**	215 ILCS 5/356z.17 215 ILCS 125/5-3(a) 50 IAC 2001.9(b)(2)(B) & (c)(3) & (f)(g)(h)(i)(j)(k)	**OPTIONAL - Individual - Activity and outcome based wellness programs are not allowed in individual plans; however, participatory programs are allowed. Group - If the insurance plan includes Wellness Programs, they may be Activity and outcome based or participatory. If a plan offers wellness coverage, it should describe what type is being offered and it must: 1). Give participants the opportunity to qualify for offered incentives at least once a year; 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). Plans may seek physician verification that health factors make it unreasonably difficult or medically inadvisable for the participant to satisfy the standards; 4). The size of the incentive is limited by law and rule to a defined percentage based on the type of program offered**	
SECTION J - BENEFITS - MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES/BEHAVIORAL HEALTH TREATMENT				
1.J.1	**Autism Spectrum Disorder**	215 ILCS 5/356z.14 215 ILCS 125/5-3(a)	**Policies must provide coverage for individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders. "Autism Spectrum Disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified. Diagnosis must be made by a physician or a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.**	
1.J.2	**Autism - Prohibition on Coverage Termination**	215 ILCS 5/356z.14(h-10) 215 ILCS 125/5-3(a)	**An insurer may not restrict coverage under an individual contract on the basis that the individual declined an alternative medication or covered service under certain circumstances.**	**Affirmed** ☐

1.J.3	**Autism Spectrum Disorder - Treatment**	215 ILCS 5/356z.14 215 ILCS 125/5-3(a)	**Policies shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by: 1). a physician licensed to practice medicine in all its branches or 2). a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches: a). Psychiatric care, b). Psychological care, c). habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. d). Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: i). self care and feeding, ii). pragmatic, receptive, and expressive language, iii). cognitive functioning, iv). applied behavior analysis, intervention, and modification, v). motor planning, and vi). sensory processing. Coverage shall not be subject to any limits on the number of visits to a service provider.**	
1.J.4	**Mental Health and Addiction Parity**	45 CFR 156.110(a)(5) 45 CFR 146.136 215 ILCS 5/370c.1 215 ILCS 125/5-3(a)	**Policies shall ensure that: 1). financial requirements applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and 2). treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.** **Note to Issuers: Nonquantitative treatment limitations (NQTLs): A health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. NQTLs can include, but are not limited to:** **(1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative** **(2) Formulary design for prescription drugs** **(3) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design** **(4) Standards for provider admission to participate in a network, including reimbursement rates** **(5) Plan methods for determining usual, customary, and reasonable charges** **(6) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)** **(7) Exclusions based on failure to complete a course of treatment** **(8) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage**	

1.J.5	**Mental Health/Substance Use Disorder – Supporting Documentation Template**	Mental Health Parity Checklist	**Issuers must complete and attach the Mental Health/Substance Use Disorder – Supporting Documentation Template under the Supporting Documentation tab of this filing.**	**Affirmed** ☐
1.J.6	**Mental Health Parity Methodology**	45 CFR 146.136	**Carriers must provide methodology for determination of parity of benefits with the filing under the appropriate section of the supporting documentation. These documents may be marked as proprietary information.**	**Affirmed** ☐
1.J.7	**Mental (Behavioral) Health Treatment**	215 ILCS 5/370c(a)&(b) 215 ILCS 125/5-3(a) CMS EHB Benchmark Summary requirement	**A group plan must provide coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions. Any condition defined by the plan or coverage as being or as not being a mental health condition, must be defined to be consistent with generally recognized independent standards of current medical practice (example, most current version of the Diagnostic and Statistical Manual of Mental Disorders, or most current version of the ICD, or State guidelines). All group and individual plans must provide coverage for "serious mental illness." "Serious Mental Illness" means the following mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association: 1). Schizophrenia; 2). Paranoid and other psychotic disorders; 3). Bipolar disorders (hypomanic, manic, depressive & mixed); 4). Major depressive disorders (single episode or recurrent); 5). Schizoaffective disorders (bipolar or depressive); 6). Pervasive developmental disorders; 7). Obsessive-compulsive disorders; 8). Depression in childhood & adolescence; 9). Panic disorder; 10). Post-traumatic stress disorders (acute, chronic, or with delayed onset); 11). Anorexia nervosa and bulimia nervosa.**	
1.J.8	**Substance Use Disorders - Acute Treatment and Stabilization**	215 ILCS 5/370c(b)(1) 215 ILCS 5/370c(b)(2.5) 215 ILCS 5/370c(b)(3) 215 ILCS 5/370c(b)(5.5) 215 ILCS 125/5-3(a)	**Policies shall provide coverage for medically necessary acute treatment services, medically necessary clinical stabilization services, and substance use disorders. All medical necessity determinations for substance use disorders must be made in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria. "Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual & group counseling, psychoeducational groups, and discharge planning. "Clinical stabilization services" means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families & significant others, and aftercare planning for individuals beginning to engage in recovery from addiction. "Substance use disorder" means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association: 1). substance abuse disorders; 2). substance dependence disorders; and 3). substance induced disorders.**	
1.J.9	**Substance Use Disorders Inpatient Treatment**	215 ILCS 370c(b)(9) 215 ILCS 125/5-3(a)	**With respect to substance use disorders, coverage for inpatient treatment shall include coverage for treatment in a residential treatment center licensed by the Department of Public Health or the Department of Human Services.**	

SECTION K - BENEFITS - PRESCRIPTION DRUGS - ALL POLICIES				
1.K.1	**Prescription Drug Coverage**	45 CFR 156.110 45 CFR 156.122 45 CFR 156.122(d) 45 CFR 156.122(e) CMS EHB Benchmark Summary requirement 215 ILCS 5/155.37 215 ILCS 125/4-6.5	**1). Prescription drug coverage must be provided as an essential health benefit; 2). Benefits may be provided by Retail and Mail Order (Plan cannot require use of Mail Order only); 3). Plans are allowed to develop Drug Formularies with Tiers that may include generic, brand name and specialty drugs; 4). The Department requests that plan documents include information regarding frequency of Formulary changes within the contract/benefit period; 5). The CMS EHB Benchmark Summary requires coverage for Generic, Preferred Brand, Non-preferred Brand, and Specialty Drugs.** ***Please see CMS' Illinois Benchmark Plan Summary Information for benchmark plan benefits by category and class. Visit https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Illinois-Benchmark-Summary.pdf for additional information.** **Note to Issuers: A health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public.** **Note to Issuers: A health plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless: the drug is subject to restricted distribution by the U.S. Food and Drug Administration or the drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. A health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing under 45 CFR 156.130 and must be accounted for in the plan's actuarial value calculated under 45 CFR 156.135.**	
1.K.2	**Contraceptive/Birth Control Services**	215 ILCS 5/356z.4 215 ILCS 125/5-3(a)	**Policies must provide coverage for the insured and any dependent of the insured covered by the policy for all outpatient contraceptive drugs and devices approved by the Food and Drug Administration including over-the-counter products with the exception of male condoms. Coverage must provide for dispensing of 12 months' worth of contraception at one time. NO COST SHARING IN-NETWORK**	
1.K.3	**Diabetes Drugs**	215 ILCS 5/356w 215 ILCS 125/5-3(a) 50 IAC 2019	**Coverage for pharmaceuticals and supplies, including (1) insulin; (2) syringes and needles; (3) test strips for glucose monitors; (4) FDA approve oral agents used to control blood sugar; and (5) glucagon emergency kits, shall be subject to the same coverage, deductible, co-payment, and co-insurance provisions provided for other pharmaceuticals.**	
1.K.4	**Inhalants - Prescription**	215 ILCS 5/356z.5 215 ILCS 125/5-3(a)	**Plans may not deny or limit coverage for prescription inhalants to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are medically appropriate.**	
1.K.5	**Immunosuppressant Drugs - Organ Transplant Medication Notification Act**	215 ILCS 175/15	**Plans must cover medically necessary immunosuppressant drugs with a written prescription after an approved human organ transplant. When a prescribing physician has indicated on a prescription "MAY NOT SUBSTITUTE", a health insurance policy or healthcare 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 the patient to prevent the rejection of the transplanted organs & tissues without notification and the documented consent of the prescribing physician and the patient.**	

1.K.6	**Prescription Drug Exception**	45 CFR 156.122(c) 215 ILCS 134/45.1 215 ILCS 5/155.36	**Note to Issuers: A health plan must have a process in place for standard exception requests, expedited exception requests, and external exception request reviews as stipulated in 215 ILCS 134/45.1 and 45 CFR 156.22(c). Plans must advise enrollees of the process for making exceptions for non-covered prescription drugs when: 1). the drug is not covered based on the health benefit plans formulary; 2). the health benefit plan is discontinuing coverage of the drug; 3). the prescription drug alternatives required to be used in accordance with a step therapy requirement, a). has been ineffective in the treatment or b). has caused an adverse reaction or harm to the enrollee; or 4). the number of doses available under a dose restriction for the prescription drug, a). has been ineffective in the treatment of the enrollee's disease or medical condition or b). the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.**	
1.K.7	**Prescription Drugs - Cancer Treatment**	215 ILCS 5/356z.7 - Group PPO/Indemnity 215 ILCS 125/4-6.3 – Group & Individual HMO	**Coverage for prescribed drugs for certain types of cancer 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 federal Food and Drug Administration if proper documentation, as outlined, is provided.**	
1.K.8	**Synchronization**	PA 100-0138 **215 ILCS 356z.25** **215 ILCS 125/5-3**	**Policy that provides for coverage of prescription drugs shall provide for synchronization of prescription drug refills (on at least one occasion per insured per year). "Synchronization" means the coordination of medication refills for a patient taking 2 or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. The following must be reflected in the policy: (1) definition (or, an example) of synchronization; (2) the prescription drugs are maintenance medications as defined by the policy; (3) the medications are not Schedule II, III, or IV controlled substances; (4) the prescription drugs do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription; (5) the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; (6) prorated daily cost-sharing rates to permit synchronization and, if applicable, non-prorated dispensing fees based on the number of prescriptions filled or refilled. Issuer may include the following in the policy: (a) the prescription drugs are covered by the policy's clinical coverage policy; (b) the insured meets all utilization management criteria specific to the prescription drugs at the time of synchronization.**	
PART 2 - PPO/INDEMNITY ONLY REQUIREMENTS				
SECTION A - GENERAL FILING REQUIREMENTS				
2.A.1	**Network Filing Required**	215 ILCS 5/370i 50 IAC 2051.310 50 IAC 2051.330(a)&(b) 215 ILCS 124(10)	**Carriers are permitted to offer incentives to members for utilizing preferred providers. The filing must include information for the network the carrier intends to use or reference a previously filed network within the cover letter. The policy must explain how the incentives work (explain that there is a preferred provider network, the incentives for using the network, and how to access the Directory of providers). The network must be registered with DOI, though a licensed insurance company network is only subject to the requirements of 215 ILCS 124 and not also 50 IAC 2051. Provide SERFF tracking number**	
SECTION B - CONTRACTUAL POLICY REQUIREMENTS				
2.B.1	**Entire Contract**	215 ILCS 5/357.2 215 ILCS 5/367(2)(a)	**STATUTORY LANGUAGE REQUIRED - The policy, including the application and any amendments and riders, constitutes the entire contract of insurance and no change is valid unless approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto.**	
2.B.2	**Change of Beneficiary**	215 ILCS 5/357.13	**STATUTORY LANGUAGE REQUIRED - If included, policy must contain statutory required language. "The individual designating a beneficiary retains the right to change that designation unless he/she makes that designation irrevocable."**	
2.B.3	**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.**	

2.B.4	**Premium – Unpaid**	215 ILCS 5/357.21	**OPTIONAL - 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.**	
2.B.5	**Physical Examinations and Autopsy**	215 ILCS 5/357.11	**STATUTORY LANGUAGE REQUIRED - If included, policy must contain statutory language. Insurers, at their own expense, have the right and opportunity to examine the insured when, and as reasonably often as required, during a claim's pending period. It may also conduct an autopsy in the case of death when law does not forbid it.**	
2.B.6	**Time Limit on Certain Defenses**	215 ILCS 5/357.3 42 USC 300gg-12	**STATUTORY LANGUAGE REQUIRED - A policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.**	
2.B.7	**Prohibition on Rescissions**	42 USC 300gg-12	**A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee.**	
2.B.8	**Relation of Earnings to Insurance**	215 ILCS 5/357.20	**OPTIONAL - 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."**	
2.B.9	**Cancellation**	215 ILCS 5/357.22	**OPTIONAL - 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.)**	
2.B.10	**Notice of Claim**	215 ILCS 5/357.6	**STATUTORY LANGUAGE REQUIRED - If notice of claim is required within a specific time-period, this information must be stated in the policy and can be no less than 20 days from date of loss.**	
2.B.11	**Disclosure of Conformity with State Statutes**	215 ILCS 5/357.23	**OPTIONAL - 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.**	
2.B.12	**Legal Action**	215 ILCS 5/357.12	**STATUTORY LANGUAGE REQUIRED - No such action shall be brought to recover before 60 days after written proof of loss or after 3 years from the date of due proof of loss is required to be furnished.**	

2.B.13	**Other Insurance in Company**	215 ILCS 5/357.17	**OPTIONAL - If included, policy must contain statutory required language. Other Insurance In This Company: 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.**	
2.B.14	**Misstatement of Age**	215 ILCS 5/357.16	**OPTIONAL - 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.**	
SECTION C - NETWORK POLICY REQUIREMENTS				
2.C.1	**Accessibility or Availability of In-Network Providers**	50 IAC 2051.310 (a)(6)(H) 215 ILCS 124/25	**Policy must have a provision ensuring that when a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider.**	
2.C.2	**Limited Benefit Disclosure**	215 ILCS 5/356z.3	**Policies must include the following disclosure: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of the Illinois Insurance Code. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card." This must be on cover or first page of policy and schedule.**	
SECTION D - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS				
2.D.1	**Reinstatement for Military Service Member**	215 ILCS 5/368f	**INDIVIDUAL ONLY - No Illinois resident activated for military service (and no spouse or dependent of that resident) who becomes eligible for a federal government-sponsored program as a result of that activation may be denied reinstatement to that same individual coverage with the health insurer after discharge unless the discharge is under less than honorable conditions.**	
2.D.2	**Continuation of Coverage upon Death of Employee**	215 ILCS 5/367(5)	**GROUP ONLY - No policy of group accident and health insurance may be issued or delivered in this State unless it provides that upon the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.**	
2.D.3	**Grace Period Requirement for ALL Non-Advance Premium Tax Credit Recipient Policies**	215 ILCS 5/357.4	**STATUTORY LANGUAGE REQUIRED - Requires policies to contain language defining the grace period for the policy as follows: "GRACE PERIOD: 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." Should be in group agreement for group policies.**	

SECTION E - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
2.E.1	Insurance with Other Companies	215 ILCS 5/357.18 215 ILCS 5/357.19	OPTIONAL - If included, policy must contain statutory required language. "No policy shall reduce benefits solely on account of the existence of similar benefits provided under other group policy where such reduction would reduce total benefits payable below an amount equal to 100% of total allowable expenses provided under the policies. Establishes the "birthday rule" for dependents covered under the policies."	
2.E.2	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 ☐
2.E.3	Claims - Proof of Loss	215 ILCS 5/357.8	STATUTORY LANGUAGE REQUIRED - If written proof of loss is required to be submitted within a specific time period, this information must be stated in the policy and can be no less than 90 days from date of loss.	
2.E.4	Claims - Payment of Claims to Beneficiary, Estate, etc.	215 ILCS 5/357.10	STATUTORY LANGUAGE REQUIRED - Indemnity for loss of life will be payable in accordance with the beneficiary designation and 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." At the option of the issuer, benefits may be paid to another person if included in the policy, benefit amounts are limited to $1000.	
2.E.5	Claims - Claim Forms	215 ILCS 5/357.7	STATUTORY LANGUAGE REQUIRED - Claim form to be furnished within 15 days upon receipt of notice of claim from member.	Affirmed ☐
2.E.6	Reimbursement Provisions	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.40	OPTIONAL - 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."	
2.E.7	Subrogation Provision	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.50	OPTIONAL - If included, policy must contain statutory required language. 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 F - BENEFITS - ESSENTIAL HEALTH BENEFITS/ ILLINOIS MANDATES				
2.F.1	Emergency Coverage Under the Influence of Alcohol or Narcotics	215 ILCS 5/367k	Plan shall not, solely on the basis of the insured being intoxicated or under the influence of a narcotic, exclude coverage for any emergency or other medical, hospital, or surgical expenses incurred by an insured as a result of and related to an injury acquired while the insured is intoxicated or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.	Affirmed ☐

2.F.2	Optometric Services	215 ILCS 5/364.1	Every policy which provides coverage for services coming within the practice of optometry 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.	Affirmed ☐
SECTION G - BENEFITS - PRESCRIPTION DRUGS				
2.G.1	Cancer Drug Parity	215 ILCS 5/356z.20	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.	
2.G.2	Eye Drops - Topical Medication	215 ILCS 156/5	Plan must provide coverage for the refill 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.	
2.G.3	Immune Gamma Globulin Therapy	215 ILCS 5/356z.24	OPTIONAL - If the policy includes this provision it must contain statutory required language. For 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.	
2.G.4	Opioid Antagonist	215 ILCS 5/356z.23	Plans 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.	
PART 3 - HMO ONLY REQUIREMENTS				
SECTION A - GENERAL FILING REQUIREMENTS				
3.A.1	Network Filing Required	77 IAC 240.40	Illinois Department of Public Health Personnel, Organization and Provider Requirements. Provide SERFF tracking number	
3.A.2	Entire Contract	50 IAC 4521.110(d)	The group contract, evidence of coverage and individual contract shall contain a statement that the group contract evidence of coverage and individual contract, all applications, and any amendments shall constitute the entire agreement between the parties.	
SECTION B - NETWORK POLICY REQUIREMENTS				
3.B.1	Out of Area Benefits and Services	50 IAC 4521.110(h)	The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available out of the HMO's designated service area.	
3.B.2	Standing Referral to a Specialist	215 ILCS 134/40(b)	A health care plan shall establish a procedure by which an enrollee who requires the treatment of a specialist physician or other health care provider may obtain a standing referral to that individual. Such a referral may be effective for up to one year and may be renewed and re-renewed.	
3.B.3	Utilization of Health Care Facilities	215 ILCS 134/43	A health care plan must provide its enrollees with a description of their rights and responsibilities for obtaining referrals and for making appropriate use of health care facilities when their PCP is not available.	
SECTION C - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS				
3.C.1	Eligibility Requirements	50 IAC 4521.110(e)	The group contract, evidence of coverage and individual contract must contain eligibility requirements that explain the conditions that must be met to enroll in the plan, the limiting age for enrollees and eligible dependents, including the effects of Medicare eligibility, and a clear statement regarding newborn coverage.	

3.C.2	**Prohibition on Medicaid Language**	215 ILCS 125/4-2(b)	**An HMO contract may not contain any provision which limits or excludes payments of health care services to or on behalf of the enrollee because the enrollee or any covered dependent is eligible for or is receiving Medicaid benefits in this or any other state.**	**Affirmed** ☐
3.C.3	**Reinstatement**	50 IAC 4521.110(k)	**The group contract, evidence of coverage, and individual contract shall contain the conditions of the enrollee's right to reinstatement**	
3.C.4	**Grace Period**	50 IAC 4521.110(l)	**A group contract or individual contract not involving the use of a premium tax credit shall provide for a grace period for the payment of any premium, except the first, during which coverage shall remain in effect if payment is made during the grace period. The grace period for a group contract shall not be less than 10 days. The grace period for an individual contract shall not be less than 31 days.**	
SECTION D - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
3.D.1	**Emergency Services Prior to Stabilization**	215 ILCS 134/65 50 IAC 4520.110(b)	**The plan shall cover emergency services in a manner that those services will be provided without imposing a requirement under the plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the plan for the providing of services.**	
3.D.2	**Post Stabilization Services**	215 ILCS 134/70 50 IAC 4520.120	**If prior authorization for covered post-stabilization services is required by the healthcare plan, the plan shall provide access 24 hours a day, 7 days a week to persons designated by the plan to make such determinations. The health care plan shall provide reimbursement for covered post-stabilization medical services if: 1). authorization to render them is received from the healthcare plan or its delegated health care provider, or 2). after two documented good faith efforts, the treating health care provider has attempted to contact the enrollee's health care plan and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request.**	
3.D.3	**Refunds/ Additional Premiums**	215 ILCS 125/5-3(f)	**HMO GROUP ONLY - If an HMO and a group policy holder (employer or other enrollment unit) agree to refund arrangements or charge additional premiums, the following terms and conditions must be met: 1). the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); 2). the amount of the refund or additional premium shall not exceed 20% of the HMO's profitable or unprofitable experience with respect to the group or other enrollment unit for the period.**	
3.D.4	**Deductibles and Copayments**	50 IAC 4521.110(i)	**An HMO may require deductibles and copayments of enrollees as a condition for the receipt of specific health care services, including basic health care services. Deductibles and copayments shall be the only allowable charge, other than premiums, assessed enrollees. Copayments and deductibles appearing in the policy shall be for specific dollar amounts or for specific percentages of the cost of the health care services.**	
SECTION E - APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS				
3.E.1	**Administrative Complaints and Appeals**	215 ILCS 134/50 215 ILCS 125/4-6 50 IAC 4530.40 50 IAC 4521.110(p)	**1). Healthcare plans must accept and review appeals of determinations and complaints related to administrative issues (not healthcare services, procedures & treatments) initiated by enrollees or healthcare providers; 2). Complainants not satisfied with the plan's resolution of any complaint may appeal that final plan decision to the Department. Administrative complaints and appeals may not be submitted for external review.**	
SECTION F - BENEFITS - ESSENTIAL HEALTH BENEFITS/ ILLINOIS MANDATES				
3.F.1	**Basic Health Care Services**	50 IAC 4521.130	**Except when superseded by other law or ACA EHB requirements, HMO's must provide coverage for Basic Health Care Services as provided by 50 IAC 4521.130.**	
3.F.2	**Ambulance - emergency transportation**	215 ILCS 125/4-15	**May not exclude coverage for emergency transportation by ambulance for life threatening condition or situation or a need for immediate medical attention as otherwise reasonably determined by a physician, public safety official or other emergency medical personnel.**	
3.F.3	**Rehabilitation Benefits**	50 IAC 4521.130(j)	**Outpatient rehabilitation therapy, including but not limited to, speech therapy, physical therapy, and occupational therapy directed at improving physician functioning of a member must be provided up to 60 treatments per year for conditions which are expected to result in significant improvement within two months as determined by the PCP and HMO Medical Director.**	

PART 4 - HMO / POS REQUIREMENTS				
SECTION A - GENERAL FILING REQUIREMENTS				
4.A.1	**Filing of POS Product**	215 ILCS 125/4.5-1 50 IAC 4521.113	**The filing must include separate filings for the HMO portion (base) and the indemnity portion. Illinois does not permit a POS plan with a preferred provider organization (PPO) base and an HMO 'tail' (out-of-network piece). Both the HMO base filing and the indemnity portion of the filing must have a POS sub-TOI. Provide name SERFF filing number for Out of Network Benefits**	
4.A.2		50 IAC 4521.113(a)(1)	**Filing must include copy of member handbook used to integrate the services provided by the HMO and the benefits provided by the indemnity carrier.**	
4.A.3		215 ILCS 125/4.5-1(a)(3) 50 IAC 4521.113	**May not offer services out-of-plan without providing those services on an in-plan basis**	
4.A.4		50 IAC 4521.113(a)(7)	**Filing must include a comparison of benefits offered by the HMO carrier and the indemnity carrier.**	
4.A.5		50 IAC 4521.113(a)(2)	**Filing must include enrollment application and member identification card disclosing the names of both the HMO and indemnity carrier.**	
4.A.6		215 ILCS 125/4.5-1(a)(7)	**HMO must include the following disclosure on its point-of-service contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card."**	
PART 4.5 INDEMNITY/PPO POS REQUIRMENTS (WRAP AROUND POLICY FOR THE HMO PRODUCT)				
4.5.A.1	**Filing of POS Product**	215 ILCS 125/4.5-1 50 IAC 4521.113	**The filing must include separate filings for the HMO portion (base) and the indemnity portion. Illinois does not permit a POS plan with a preferred provider organization (PPO) base and an HMO 'tail' (out-of-network piece). Provide SERFF filing number for HMO portion that includes all items in Part 4 of checklist**	
4.5.A.2			**Out of network benefits must meet all requirements stated within Part 1 of this checklist. If the out-of-network piece is a PPO policy, Part 2 requirements must also be met.**	
PART 5 - CATASTROPHIC REQUIREMENTS				
SECTION A - GENERAL FILING REQUIREMENTS				
5.A.1	**Individual Market Only**	42 USC 18022(e)(3)	**A health insurance issuer may only offer Catastrophic Plans in the individual market.**	**Affirmed** ☐
5.A.2	**Metal Level Requirements**	42 USC 18022(e)(1) 45 CFR 156.155(a)(2)	**A catastrophic plan may not provide a bronze, silver, gold, or platinum level of coverage.**	**Affirmed** ☐
5.A.3	**Individual Eligibility**	42 USC 18022(e)(2) 26 USC 5000A 45 CFR 156.155(a)(5)	**Plans are only available to an individual who: has not attained the age of 30 before the beginning of the plan year; or has a certification in effect for any plan year that the individual is exempt from the requirement under section 26 USC 5000A.**	**Affirmed** ☐
5.A.4	**Family Eligibility**	45 CFR 156.155(c)	**For other than self-only coverage, each individual enrolled in catastrophic plan must be under 30 years of age or have received a certificate of exemption.**	**Affirmed** ☐

5.A.5	**Essential Health Benefits**	42 USC 18022(e)(1)(B)(i) 45 CFR 156.155(a)(3)	**A catastrophic plan must provide coverage for essential health benefits.**	**Affirmed** ☐
5.A.6	**Out-of-Pocket**	42 USC 18022(e)(1)(B)(i) 45 CFR 156.155(a)(3)	**Plans may not provide benefits for coverage of essential health benefits in any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation.**	
5.A.7	**Preventive Services**	42 USC 18022(e)(1)(B)(i) 45 CFR 156.155(b)	**A catastrophic plan must provide preventive services coverage without consideration of any other cost-sharing requirements and at no cost to the individual when an in-network provider is used.**	
5.A.8	**Primary Care Visit Requirements**	42 USC 18022(e)(1)(B)(ii) 45 CFR 156.155(a)(4)	**A catastrophic plan must provide coverage for at least three primary care visits without consideration of any cost sharing requirements.**	
5.A.9	**Individual Plan Requirements**	45 CFR 156.155(a)(1)	**A catastrophic plan must meet all applicable requirements for health insurance coverage in the individual market.**	**Affirmed** ☐