

TITLE 50: INSURANCE
PART 2051 PREFERRED PROVIDER PROGRAMS
CHAPTER 1: DEPARTMENT OF INSURANCE

Section 2051.310 Network Availability and Adequacy Requirements

- a) Administrators and insurers must file a description of the services to be offered through the preferred provider program. The description shall include:
- 1) The method of marketing the program;
 - 2) A geographic map of the area proposed to be served by the program by county and zip code, including marked locations for preferred providers;
 - 3) The names, addresses and specialties of the providers who have entered into preferred provider agreements under the program;
 - 4) The number of beneficiaries anticipated to be covered by the providers listed in
 - 5) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access regarding up-to-date lists of preferred providers, additional information about the discounted health care services plan, as well as any other information necessary to conform to this Part. A plan shall identify specific providers in a beneficiary's area, confirm specific provider participation or provide a listing of preferred providers by mail. Preferred provider lists requested by phone must be sent within 3 working days. The up-to-date provider list applies to all providers that have entered arrangements to provide services under the program either directly, or indirectly through another administrator. Administrators' and insurers' Internet website addresses shall be prominently displayed on all advertisements, marketing materials, brochures, benefit cards and identification cards; and
 - 6) A description of how health care services to be rendered under the preferred provider program are reasonably accessible and available to beneficiaries. Standards shall address:
 - A) The type of health care services to be provided by the administrator;
 - B) The ratio of providers to beneficiaries, by specialty and including primary care physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;
 - C) The greatest distance or time that the beneficiary may be required to travel to access:

- i) Preferred provider hospital services when applicable under the contract;
 - ii) Primary care and woman's principal health care physician services when applicable under the contract;
 - iii) Any applicable health care service providers;
- D) Written policies and procedures for determining when the program is closed to new providers desiring to enter into preferred provider arrangements;
- E) Written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient to provider ratio, changes in medical and health care capabilities, and increased demand for services;
- F) The provision of 24 hour, 7 day per week access to network affiliated primary care and woman's principal health care providers. This subsection (a)(6)(F) does not apply to administrators offering only a discounted health care services plan;
- G) The procedures for making referrals within and outside the network. This subsection (a)(6)(G) does not apply to administrators offering only a discounted health care services plan;
- H) A provision ensuring that whenever a beneficiary has made a good faith effort to utilize network 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 payor 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. This subsection (a)(6)(H) does not apply to a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the administrator's panel of participating providers. In these circumstances, the contractual requirements for non-preferred provider reimbursements will apply. This subsection (a)(6)(H) does not apply to administrators offering only a discounted health care services plan;
- I) The procedures for paying benefits when particular physician specialties are not represented within the provider network, or the services of such providers are not available at the time care is sought. In any case in which a beneficiary has made a good faith effort to utilize network providers, by satisfying contractual obligation specified in the benefit contract or certificate, for a covered service and the administrator does not have the appropriate preferred specialty providers (including but not limited to radiologists, anesthesiologists, pathologists and emergency room physicians) under contract due to the inability of the administrator to contract with the specialists, or due to the insufficient number or type of, or travel distance to, specialists, the administrator shall ensure 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. This subsection (a)(6)(I) does not apply to a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the administrator's panel of participating providers. In these circumstances, the contractual requirements for non-preferred provider

reimbursements will apply. This subsection (a)(6)(I) does not apply to administrators offering only a discounted health care services plan;

- J) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a plan provider. For purposes of this subsection (a)(6)(J), "the same benefit level" means 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. This subsection (a)(6)(J) does not apply to administrators offering only a discounted health care services plan;
 - K) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed \$1,000 per occurrence;
 - L) Efforts to address the needs of beneficiaries with limited English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
 - M) A sample beneficiary identification card in conformity with the Uniform Health Care Service Benefits Information Card Act [215 ILCS 139], and the Uniform Prescription Drug Information Card Act [215 ILCS 138] when pharmaceutical services are provided as part of the program's health care services;
 - N.) When a gatekeeper option is included as part of the program, a requirement that the administrator make a good faith effort to provide written notice of termination of the gatekeeper to all beneficiaries who are patients seen on a regular basis by the gatekeeper whose contract is terminating. In a gatekeeper option, when a contract termination involves a primary care physician, all beneficiaries who are patients of that primary care physician shall also be notified. This subsection (a)(6)(N) does not apply to administrators offering only a discounted health care services plan.
- b) If an administrator is leasing, buying or otherwise using another administrator's or insurer's program, and the required information has previously been filed by the other administrator or insurer, then only the administrative agreement and verification that the providers have consented to the agreement pursuant to Section 2051.300(d) need to be filed. A clause within the provider contract allowing assignment will be deemed consent in the absence of material modification of the provider's obligations under the contract.
- c) Enrollees are not responsible for any costs associated with medical record transmission or duplication in order to have a claim adjudicated. This subsection (c) does not apply to administrators offering only a discounted health care services plan.