Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

Individual Short-Term, Limited Duration Checklist

TO BE COMPLETED BY COMPANY

Company Name:

SERFF TOI:

SERFF SUB TOI:

SERFF Tracking #:

Line of Business (check one)		ELECTRONIC REFERENCES - ILLINOIS
	PPO and Indemnity	Illinois Insurance Code
	HMO	Administrative Rules
	HMO / POS	Illinois Company Bulletins

Checklist Directions

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

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

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.”

Page	Part	Title
	Part 1	**ALL POLICIES**
3	Section A	GENERAL FILING REQUIREMENTS
4	Section B	CONTRACTUAL POLICY REQUIREMENTS
5	Section C	NETWORK POLICY REQUIREMENTS
6	Section D	MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS
7	Section E	CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES
8	Section F	APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS
10	Section G	BENEFITS - ILLINOIS MANDATES
13	Section H	BENEFITS - PREVENTIVE
15	Section I	BENEFITS - MENTAL HEALTH/ SUBSTANCE USE DISORDER SERVICES/ BEHAVIORAL HEALTH TREATMENT
17	Section J	BENEFITS - PRESCRIPTION DRUGS
	Part 2	**PPO/INDEMNITY ONLY REQUIREMENTS**
18	Section A	GENERAL FILING REQUIREMENTS
19	Section B	CONTRACTUAL POLICY REQUIREMENTS
21	Section C	NETWORK POLICY REQUIREMENTS
22	Section D	MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS
23	Section E	CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES
25	Section F	BENEFITS - ILLINOIS MANDATES
26	Section G	BENEFITS - PRESCRIPTION DRUGS
	Part 3	**HMO ONLY REQUIREMENTS**
27	Section A	GENERAL FILING REQUIREMENTS
28	Section B	NETWORK POLICY REQUIREMENTS
29	Section C	MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS
30	Section D	CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES
31	Section E	APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS
32	Section F	BENEFITS - ILLINOIS MANDATES
	Part 4	**HMO / POS REQUIREMENTS**
33	Section A	GENERAL FILING REQUIREMENTS

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

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	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.	Affirmed
1.A.3	Rate Filing	215 ILCS 5/355	No policy shall be issued until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director.	SERFF Tracking #
1.A.4	Health Carrier Required External Review Form Filing Identification	50 IAC 5430.40	Companies must file the following forms as required by Part 5430.40: 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.	SERFF Tracking #
1.A.5	Certificate of Compliance	50 IAC 916.40(b) 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.	SERFF Tracking #
1.A.6	Letter of Submission	50 IAC 2001.130(a)(3)	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.7	Notice Requirement Required Short-Term, Limited-Duration Policies	45 CFR 144.103	Short-Term, Limited-Duration policies must display prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following: "This is not qualifying health coverage ("minimum essential coverage") that satisfies the health coverage requirement of the affordable care act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes."	
1.A.8	Policy Duration	45 CFR 144.103 45 CFR 148.102	Short-term, limited-duration insurance must specify that the expiration date (taking into account any extensions that may be elected by the policyholder with or without the issuers consent) may not exceed 3 months after the original effective date of the contract.	
1.A.9	Outline of Coverage	50 IAC 2007.80(b)	All policies must contain the appropriate outline as described in 50 IAC 2007.80.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION B - CONTRACTUAL POLICY REQUIREMENTS				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.1	Definition of Usual and Customary	50 IAC 2007.80 (a)(4)	A policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or of similar import shall include a definition of those terms and an explanation of those terms in its accompanying outline of coverage.	
1.B.2	Civil Union	750 ILCS 75/1 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.3	Discrimination	215 ILCS 5/364 50 IAC 2603.35 215 ILCS 125/5-3(a)	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. IAC 2603.35 Prohibits Gender Identity Discrimination.	
1.B.4	Entire Contract *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.2 215 ILCS 5/367(2)(a) 50 IAC 4521.110(d)	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.	
1.B.5	Form of Policy	215 ILCS 5/356a 50 IAC 4521.110	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.6	Use of Information Derived from Genetic Testing	215 ILCS 5/356v 215 ILCS 97/20(A)(1) 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.7	Discretionary Clauses Prohibited	50 IAC 2001.3	No policy, contract, certificate, endorsement, rider application or agreement, offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of 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.8	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

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION C - NETWORK POLICY REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.C.1	Emergency Services Incurred - Non-Participating Providers	50 IAC 2051.310(a)(6)(J) 50 IAC 4520.110	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	Women's Principal Health Care 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.3	Network Adequacy Checklist	215 ILCS 5/401 215 ILCS 5/370i 215 ILCS 5/356z.22	State Network Requirements.	

SECTION D - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.D.1	Dependent Children - Adopted (and Pending)	215 ILCS 5/356h 215 ILCS 125/4-9	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 (foster child). A child in the custody of the insured pursuant to an interim court order of adoption is considered an adopted child.	
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	29 CFR 2590.715-2714 215 ILCS 5/356z.12 215 ILCS 125/5-3(a)	A policy that includes dependent coverage must allow dependents under the age of 26 to apply for coverage. Additionally, polices must allow military veteran dependents under the age of 30 to apply for coverage if the veteran is an Illinois resident, not married; has served in the active or a reserve components of the U.S. Armed Forces (including the National Guard) and has received a release or discharge other than dishonorable. The law does not change HIPAA special enrollment requirements.	
1.D.5	Dependent Students; Medical Leave of Absence Continuation	215 ILCS 5/356z.11 215 ILCS 125/5-3(a)	A policy must continue to provide coverage for a dependent college student who has taken a medical leave of absence or reduced hours to part-time status due to a catastrophic illness or injury. Continuation is subject to all of the policy's terms and conditions applicable to that form of insurance and shall terminate 12 months after the notice of the illness or injury or until coverage would have otherwise lapsed.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION E - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.E.1	Precertification Penalties	50 IAC 2051.310(a)(6)(K) 215 ILCS 5/143(1)	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.E.2	Claims - Timely Payment *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/ 368a(c) 215 ILCS 5/357.9 215 ILCS 125/5-3(a)	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.	
1.E.3	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 IL Adm. Code 2009.	

SECTION F - APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.F.1	Notice of Department of Insurance	215 ILCS 5/143c 50 IAC 4521.110(m)	Must provide a written notice of the address of the complaint department of the insurance company and the address of the Public Service Division of the Department of Insurance or its successor	
1.F.2	Health Care Services Complaints and Appeals	215 ILCS 134/45 215 ILCS 5/155.36 215 ILCS 180/20 215 ILCS 125/4-6 50 IAC 5430.40 50 IAC 4521.110(p)	1). Expedited - Must allow appeals for health care services, procedures and treatments, the denial of which could significantly increase the risk to an enrollee's health, either orally or in writing and must render a decision within 24 hours of receiving proper documentation. Appeals can be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. 2). Standard - Must establish procedures for appeals for health care services, procedures and treatments, the denial of which would not significantly increase the risk to an enrollee's health and must notify the party filing an appeal, within 3 business days, of all information the plan requires to evaluate the appeal and must render a decision on the appeal within 15 business days after receipt of the required information. Appeals can be filed by the enrollee, enrollee's designee or guardian, enrollee's primary care physician, or the enrollee's health care provider. 3). Denials of expedited and standard appeals can be appealed to an external independent review.	
1.F.3	Health Care External Review Act	215 ILCS 5/155.36 215 ILCS 180/ 215 ILCS 180/75 215 ILCS 5/134.45	Each health carrier shall include a description of the external review procedures in, or attached to, the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. The description shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the Director. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.	
1.F.4	External Review	External Review Checklist	For Reference Only	
1.F.5	Autism/Alternative Medication or Covered Service	215 ILCS 5/356z.14(h-10)	An insurer may not deny or refuse to provide covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract, for a person diagnosed with an autism spectrum disorder on the basis that the individual declined an alternative medication or covered service when the individual's health care provider has determined that such medication or covered service may exacerbate clinical symptomatology and is medically contraindicated for the individual and the individual has requested and received a medical drug exception.	Affirmed

SECTION F - APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.F.6	Prescription Drug Exception	215 ILCS 134/45.1 215 ILCS 5/155.36	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.	

SECTION G - BENEFITS - ILLINOIS MANDATES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.G.1	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.G.2	Habilitative Services for Children	215 ILCS 5/356z.15 215 ILCS 125/5-3(a)	Plan must provide coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder 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 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.G.3	Emergency Medical Care - Sexual Assault	215 ILCS 5/367(8) 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. Covered at 100% with no cost-sharing.	
1.G.4	Referrals and Second Opinions	215 ILCS 5/370i(a) 50 IAC 4521.130(a)	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.	
1.G.5	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.G.6	Breast - Fibrocystic Breast Condition	215 ILCS 356n 215 ILCS 125/4-16	Policy must state that coverage includes coverage for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the enrollee's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.	
1.G.7	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.G.8	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.	

SECTION G - BENEFITS - ILLINOIS MANDATES - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.G.9	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.G.10	Breast Reconstruction After Mastectomy	215 ILCS 5/356g(b) 50 IAC 2016 215 ILCS 125/4-6.1(b) 50 IAC 4521.132	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.G.11	Cancer - Qualified Clinical Cancer Trials	215 ILCS 5/364.01 215 ILCS 125/5-3(a)	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.G.12	Dental Care - Adjunctive Services	215 ILCS 5/356z.2 215 ILCS 125/5-3(a)	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.	
1.G.13	Infertility (Fertility) Treatment	215 ILCS 5/356m 50 IAC 2015 215 ILCS 125/5-3(a)	Infertility benefits must be covered the same as 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. The ACA does not allow for the exclusion of preexisting conditions. No lifetime limits for completed oocyte retrievals.	
1.G.14	Maternity - Post-Parturition Care	215 ILCS 5/356s 215 ILCS 125/4-6.4	Coverage must provide minimum of 48 hours inpatient care for normal delivery and 96 hours for caesarian section. Shorter lengths of stays are permitted based on decision of attending physician.	

SECTION G - BENEFITS - ILLINOIS MANDATES - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.G.15	Maternity - Prenatal HIV testing	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.	
1.G.16	Physical Therapy - Multiple Sclerosis Patients	215 ILCS 5/356z.8 215 ILCS 125/5-3(a)	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.G.17	Prosthetics/Orthotics	215 ILCS 5/356z.18 215 ILCS 125/5-3(a)	Shall include coverage for repairs and replacements, and shall be subject to the 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 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.G.18	Transplants - Human Organ Transplants	215 ILCS 5/356K 215 ILCS 5/367(13) 215 ILCS 125/4-5	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 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.	

SECTION H - BENEFITS - PREVENTIVE

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.H.1	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 and treatment of osteoporosis.	
1.H.2	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.	
1.H.3	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. Sterilization covered below.	
1.H.4	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.	
1.H.5	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 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.	

SECTION H - BENEFITS - PREVENTIVE - *CONTINUED*

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.H.6	Pap Tests, Prostate Specific Antigen Tests, and Ovarian Cancer Surveillance Test	215 ILCS 5/356u 215 ILCS 125/4-6.5	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; and 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.	
1.H.7	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.	
1.H.8	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.	
1.H.9	Sterilization	215 ILCS 5/356z.4(a)(3)(B)	A policy shall provide coverage for voluntary sterilization procedures and shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided.	
1.H.10	Wellness Programs *OPTIONAL*	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)	If a plan offers wellness coverage, 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 I - BENEFITS - MENTAL HEALTH/ SUBSTANCE USE DISORDER SERVICES/ BEHAVIORAL HEALTH TREATMENT				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.I.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.I.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.	
1.I.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. 3). Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: a). self care and feeding, b). pragmatic, receptive, and expressive language, c). cognitive functioning, d). applied behavior analysis, intervention, and modification, e). motor planning, and f). sensory processing.	
1.I.4	Mental Health and Addiction Parity	45 CFR 156.110(a)(5) 215 ILCS 5/370c.1 215 ILCS 125/5-3(a) Company Bulletin 99-6	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.	

SECTION I - BENEFITS - MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES/BEHAVIORAL HEALTH TREATMENT - ***CONTINUED***				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.I.5	Mental (Behavioral) Health Treatment	215 ILCS 5/370c(b)(2) 215 ILCS 125/5-3(a)	Plan must provide coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, including "serious mental illness". 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). "<u>Serious Mental Illness</u>" 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.I.6	Substance Use Disorders - Acute Treatment and Stabilization	215 ILCS 5/370c(b)(2.5) 215 ILCS 5/370c(b)(5.5) 215 ILCS 125/5 – 3(a)	Policies shall provide coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. 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. "<u>Acute treatment services</u>" 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. "<u>Clinical stabilization services</u>" 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. "<u>Substance use disorder</u>" 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.I.7	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.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION J - BENEFITS - PRESCRIPTION DRUGS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.J.1	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.	Affirmed
1.J.2	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.	Affirmed
1.J.3	Prescription Drugs - Cancer Treatment	215 ILCS 5/356z.7 215 ILCS 125/4-6.3	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 U.S. Food and Drug Administration if proper documentation, as outlined, is provided.	Affirmed

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

PART 2 - PPO/INDEMNITY ONLY REQUIREMENTS

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.A.1	Network Filing Required	215 ILCS 5/370i 50 IAC 2051.310 50 IAC 2051.330(a)&(b)	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 incentives work (explain that there is a preferred provider network, incentives for using the network, and how to access the Directory of providers). Network must be registered with DOI unless it is a licensed insurance company network.	SERFF Tracking #
2.A.2	Illinois Network Adequacy (Tiered) Collection Template		Illinois Network Adequacy (Tiered) Collection Template on DOI website	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION B - CONTRACTUAL POLICY REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.B.1	Change of Beneficiary *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.13	The individual designating a beneficiary retains the right to change that designation unless he/she makes that designation irrevocable.	
2.B.2	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.3	Premium – Unpaid *OPTIONAL*	215 ILCS 5/357.21	If included, policy must contain statutory required language. Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted.	
2.B.4	Physical Examinations and Autopsy *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.11	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.5	Time Limit on Certain Defenses *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.3	A policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.	
2.B.6	Relation of Earnings to Insurance *OPTIONAL*	215 ILCS 5/357.20	If included, policy must contain statutory required language. "If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is 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 or the sum of monthly benefits specified in such coverages, whichever is lesser, nor shall it operate to reduce benefits other than those payable for loss of time."	

SECTION B - CONTRACTUAL POLICY REQUIREMENTS - CONTINUED

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.B.7	Cancellation OPTIONAL	215 ILCS 5/357.22	If included, policy must contain statutory required language. "The company may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the company, stating when, not less than 30 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the company, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the company will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the company cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." (Notice to the policy holder of the cancellable nature of his policy shall be set forth on the face of the policy.)	
2.B.8	Notice of Claim STATUTORY LANGUAGE REQUIRED	215 ILCS 5/357.6	Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.	
2.B.9	Disclosure - Conformity with State Statutes OPTIONAL	215 ILCS 5/357.23	If included, policy must contain statutory required language. Any provision of the policy, which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.	
2.B.10	Legal Action STATUTORY LANGUAGE REQUIRED	215 ILCS 5/357.12	No civil 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.11	Other Insurance in Company OPTIONAL	215 ILCS 5/357.17	If included, policy must contain statutory required language. If an accident or health or accident and health policy or policies previously issued by the company to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage or coverages) in excess of $..(insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate." or, in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies.	
2.B.12	Misstatement of Age OPTIONAL	215 ILCS 5/357.16	If included, policy must contain statutory required language. If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.	

SECTION C - NETWORK POLICY REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.C.1	Preferred Provider Registration	50 IAC 2051.330(a) and (b)	Insurers incorporating a preferred provider program must either registered that program or provide required information for a previously incorporated program.	SERFF Tracking #
2.C.2	Accessibility or Availability of In-Network Providers	50 IAC 2051.310 (a)(6)(H)	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.3	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.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION D - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.D.1	Reinstatement for Military Service Member *INDIVIDUAL ONLY*	215 ILCS 5/368f	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	Grace Period *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.4	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."	
2.D.3	Reinstatement *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.5	If a company allows for reinstatement, policies must contain language describing requirements for reinstatement. A policy may be reinstated with or without an application as provided.	
2.D.4	Conversion Privileges - Insured Former Spouses	215 ILCS 5/356d	Policies of accident and health must contain a conversion provision, made available without evidence of insurability, for dependent spouses upon a valid judgment of dissolution of the marriage if such application is made within 60 days following the date of judgment.	

SECTION E - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
2.E.1	Insurance with Other Companies *OPTIONAL*	215 ILCS 5/357.18 215 ILCS 5/357.19	If included, policy must contain statutory required language. 357.18 If there be other valid coverage, not with this company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage." 357.19 If there be other valid coverage, not with this company, providing benefits for the same loss on other than an expense incurred basis and of which this company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the company had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined."	
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 *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.8	Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."	Affirmed
2.E.4	Claims - Payment of Claims to Beneficiary, Estate, etc. *STATUTORY LANGUAGE REQUIRED*	215 ILCS 5/357.10	Indemnity for loss of life will be payable in accordance with the beneficiary designation and 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.	

SECTION E - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES - ***CONTINUED***				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
2.E.5	Claims - Claim Forms ***STATUTORY LANGUAGE REQUIRED***	215 ILCS 5/357.7	The company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.	Affirmed
2.E.6	Reimbursement Provisions ***OPTIONAL***	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.40	If included, policy must contain statutory required language. 1). "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability." 2). "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, covered person's parents if the covered person is a minor, or covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability."	
2.E.7	Subrogation Provision ***OPTIONAL***	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.50	If included, policy must contain statutory required language. 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."	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION F - BENEFITS - ILLINOIS MANDATES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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	Alcoholism	215 ILCS 5/367(7)	Plans must cover the treatment of alcoholism.	
2.F.3	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
2.F.4	Dental Care - Oral Surgery/TMJ Services and Devices	215 ILCS 5/356q	Policies providing coverage for hospital, medical, or surgical treatment on an expense-incurred basis shall offer, for an additional premium and subject to the insurer's standard of insurability, optional coverage for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder. Benefits may be subject to the same pre-existing conditions, limitations, deductibles, co-payments and co-insurance that generally apply to any other sickness. The maximum lifetime benefits for temporomandibular joint disorder and craniomandibular treatment shall be no less than $2,500.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION G - BENEFITS - PRESCRIPTION DRUGS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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 *OPTIONAL*	215 ILCS 5/356z.24	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.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

PART 3 - HMO ONLY REQUIREMENTS

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
3.A.1	Network Filing Required	77 IAC 240.40	Illinois Department of Public Health Personnel, Organization and Provider Requirements.	SERFF Tracking #

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION B - NETWORK POLICY REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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.	Affirmed
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.	
3.B.4	Notice of Provider Nonrenewal or Termination	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.	Affirmed
3.B.5	Provider Termination - Continuation of Care	215 ILCS 134/25 50 IAC 4520.60	Policy must contain a provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause. 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 for definition of on-going course of treatment.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION C - MEMBERSHIP/ELIGIBILITY/WHEN COVERAGE BEGINS/WHEN COVERAGE ENDS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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.	
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 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.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION D - CLAIMS/ DEDUCTIBLES/ COPAYMENTS/ COINSURANCE/ OUT-OF-POCKET/ ELGIBLE EXPENSES				
Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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.	Affirmed
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.	Affirmed
3.D.3	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.	Affirmed

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION E - APPEALS, COMPLAINTS, GREIVANCES, EXTERNAL REVIEWS				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
3.E.1	Administrative Complaints and Appeals	215 ILCS 134/50 215 ILCS 125/4-6 50 IAC 5430.40 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.***	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

SECTION F - BENEFITS - ILLINOIS MANDATES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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	Newborn Care	215 ILCS 125/4-8	Benefits shall be granted immediately with respect to newborn infants from the moment of birth and that such coverage shall include illness, injury, congenital defects, birth abnormalities and premature birth. Benefits will be available from the moment of birth up to the first 31 days, thereafter, you must add the child to your policy. You may apply for family coverage within 31 days of the date of the birth. Family coverage will then be effective from the date of the birth.	

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

PART 4 - HMO / POS REQUIREMENTS

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
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).	Affirmed

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

Contact Person: Sandra Ross, Assistant Deputy Director of Health Products
217-558-3749 Sandra.Ross@Illinois.gov