Contact Person:	**Illinois Division of Insurance**	**320 West Washington Street**
Cindy Colonius	**Review Requirements Checklist**	**Springfield, IL 62767-0001**
217- 782-4572		
Cindy.Colonius@Illinois.gov		**Effective as of / / /**

Line(s) of Business	**Line(s) of Insurance**
Group Accident/ Health	**Large and Small group Accident/Health (POS products must be filed with an HMO base. The Accident/Health portion may only be the out-of-network benefits.)**

Illinois Insurance Code Link	Illinois Compiled Statutes Online		
Illinois Administrative Code Link	Administrative Regulations Online		
Product Coding Matrix	**Product Coding Matrix**		
REVIEW REQUIREMENTS	**REFERENCE**	**DESCRIPTION OF REVIEW** **STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
		NOTE: These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Department of Insurance.	
FORM FILING REQUIREMENTS	**REFERENCE**	**STANDARDS FOR FILING**	
Form Filing Requirements for Certificates intended for out-of-state use.	215 ILCS 5/352(c) 50 IL Adm. Code 2021.40	Policies sitused in Illinois, but intended for insureds who neither work in nor reside in Illinois, must be filed on an informational basis to claim exemption from Illinois mandates and other required provisions. Insurers not specifically filing under the exemption provided by 215 ILCS 5/352(c) must submit such filings for approval.	
Review Requirements Checklist	Go to Review Requirements Checklists on DOI web site. See next column	Each filing must include a completed Review Requirements Checklist that must contain a completed “Location of Standard in Filing” column for each required element of the filing. Please indicate the proper page # and form # for each entry.	
Cover Letter and Letter of Submission	50 IL Adm. Code 1405.20 (e) 50 IL Adm. Code 2001.30 (a) (3) 50 IL Adm. Code 916.40 (b)	In addition to referencing any previously approved form number(s) as required by 50 IL Adm. Code 1405.20(e), those references must also include the filing number and SERFF tracking number (if applicable and available) for the referenced forms. Letters of submission must generally describe the intent and use of the form being filed and, if applicable, how it will be used with any previously approved form(s).	
Rate Filings	215 ILCS 5/355 Company Bulletin	The Federal Patient Protection and Affordable Care Act (PPACA) has established premium reporting and review processes for all health	

	2010-08	insurance issuers. The Rate Filing Actuarial Memorandum and Rate Data Collection Form are available on the Department's web site under Company Bulletin 2010-08. Rates must be submitted with a uniform transmittal document and contain a unique filing number.	
GENERAL REQUIREMENTS FOR ALL FILINGS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Entire Contract	215 ILCS 5/367(2)(a)	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.	
Time Limit on Certain Defenses	215 ILCS 5/357.3 215 ILCS 5/367(2)	A policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.	
Timely Payment of Claims	215 ILCS 5/357.9	Claims must be paid within 30 days following receipt of written due proof of loss.	
Timely Payment of Health Care Services	215 ILCS 5/368a	Periodic payments must be made within 60 days of insured's selection of a provider or effective date of selection, whichever is later. In case of retrospective enrollment only 30 days after notice by employer to insurer. Subsequent payments must be in monthly periodic cycle. Penalty payment of 9% per year. Payments other than periodic must be made within 30 days after receipt of due proof of loss. Same penalty provisions.	
Continuation of coverage	215 ILCS 5/367e	Continuation of coverage under this provision is now 12 months instead of 9 as required by the federal American Recovery and Reinvestment Act of 2009.	
Conversion	215 ILCS 5/367e.1	Conversion must be made available to anyone who has been continuously insured under the group policy for three months and whose insurance has been terminated for any reason other than discontinuance of the group policy in its entirety.	
Continuation of Coverage upon employee death	215 ILCS 5/367(5)	Coverage must continue for dependents for at least 90 days after death of the insured. Insurers may charge additional premium.	
Spousal continuation	215 ILCS 5/367.2	Spousal and dependent continuation rights in case of death, divorce or retirement.	
Dependent continuation	215 ILCS 5/367.2-5	Continuation rights for an insured's dependent child in the event of the death of the insured and the child is not eligible for coverage as a	

		dependent under 215 ILCS 5/367.2.	
Extended age dependent continuation	215 ILCS 5/356z.12	Effective June 1, 2009 a policy that includes dependent coverage must allow unmarried 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. Policies in force as of June 1, 2009 must provide for a 90 day open enrollment period for all dependents that meet the criteria described above beginning on the policy renewal date, but no later than May 31, 2010. Insurers may not apply requirements for creditable coverage, continuous coverage or breaks in coverage during the initial enrollment period. However, preexisting condition limitations may be applied if creditable coverage has not been established. Policies issued on or after June 1, 2009 must also provide for a 90 day open enrollment applicable to policies issued on or before May 31, 2010. Insurers must provide an annual 30 day open enrollment period. The law does not change HIPAA special enrollment requirements. The attached link provides FAQ information from our web site.	
Dependent students; medical leave of absence continuation	215 ILCS 5/356z.11	Effective June 1, 2009 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. This coverage mirrors the requirements of H.R. 285, known as Michelle's Law, signed by the President on October 9, 2008.	
Coordination of Benefits	215 ILCS 5/367(11a &b) 50 IL Adm Code 2009	Based on same premise as NAIC Model with some language variance.	
Discontinuance and replacement of coverage	215 ILCS 5/367i 50 IL Adm Code 2013	A policy shall provide a reasonable extension of benefits (up to 12 months) in the event of total disability on the date the policy is discontinued. In case of discontinuance the prior plan shall be liable only to the extent of its accrued liabilities and extension of benefits.	
Newborn Coverage	215 ILCS 5/356c	The policy must state newborns covered from the moment of birth. If additional premium is required insurer may require notification within 31 days in order to have coverage continue.	
Pending & Adopted Children	215 ILCS 5/356h	No policy that covers the insured's immediate family or children may	

		exclude or limit coverage of an adopted child or a child not residing with the insured (foster child). A child residing with an insured pursuant to an interim court order of adoption is considered an adopted child.	
Disabled Dependents	215 ILCS 5/367b	Provides continuation for handicapped dependent that has attained the limiting age of the policy.	
Assignment of Benefits	215 ILCS 5/370a	No provision of the Illinois Insurance Code, or any other law, prohibits an insured from making an assignment of all or any part of his/her rights and privileges under the policy.	
REQUIREMENTS RELATING TO POLICY FORM REVIEW	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Alcoholism	215 ILCS 5/367(7)	For inpatient coverage alcoholism must be treated the same as any other illness. The Department of Insurance relies on the premise that since it may not be excluded from the coverage it must be treated as any other medical condition.	
Emergency Coverage Under the Influence of Alcohol or Narcotics	215 ILCS 5/367k	No policy may exclude coverage for any emergency or other medical, hospital or surgical expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered.	
Definition of Emergency Medical Condition	215 ILCS 5/155.36 215 ILCS 134/10	Insurers must use this definition that includes “prudent lay person” language.	
Preventive Services Covered Under the Affordable Care Act	Public Law 111-148-Patient Protection and Affordable Care Act	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. This requirement applies only when these services are delivered by a network provider. The list also includes covered preventive services for women as well.	
Preventive Health Care for Women	Company Bulletin 2012-05	The federal Affordable Care Act (ACA) requires health care plans to include women’s preventive health care such as mammograms, screening for cervical cancer, prenatal care and other services to be covered without cost sharing (when delivered by a network provider) by non-grandfathered group plans beginning on or after September 23, 2010 and by individual insurance plans beginning on or after the same date. Additionally, health care plans must now comply with the guidelines released by the Health Resources and Services Administration (HRSA) on August 1, 2011. Non-grandfathered plans and issuers are required to provide coverage without cost sharing consistent with these guidelines	

		in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012. The HRSA web site is located at: http://www.hrsa.gov/womensguidelines/.	
Criminal Sexual Assault	215 ILCS 5/367(8)	No policy for hospital or medical expenses issued on an expense-incurred basis may exclude coverage for charges for examination and testing of sexual criminal assault.	
Infertility Coverage	215 ILCS 5/356m 50 IL Adm Code 2015	The treatment of infertility is only required for employer groups with more than 25 employees.	
Mammography	215 ILCS 5/356g(a)	Coverage of screening by low-dose mammography for all women over 35; Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older. For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered medically necessary. Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described. Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit. When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the policy or contract.	
Clinical Breast Exam	215 ILCS 5/356g.5	Clinical breast examinations must be covered: (1) at a minimum every three years for women over 20 years of age but less than 40; and, (2) annually for women 40 years of age and older.	
Reconstructive breast surgery	215 ILCS 5/356g(b) 215 ILCS 5/367(12) 50 IL Adm Code 2016	Coverage requires: reconstruction of breast upon which mastectomy performed; surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment for physical complications at all stages of mastectomy, including lymphdemas.	
Breast Cancer Pain Medication and Therapy	215 ILCS 5/356g.5-1	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.	
Post Mastectomy Care	215 ILCS 5/356t	Coverage must provide inpatient treatment following mastectomy for length of time to be determined by attending physician; must also provide for availability of post-discharge physician office visit or in-home nurse visit within 48 hours of discharge.	

Organ Transplant	215 ILCS 5/367(13)	No accident and health insurer may deny reimbursement for an organ transplant as experimental or investigational unless supported by appropriate, required documentation.	
Mental, Emotional or Nervous Disorders/Serious Mental Illness Mental Health Parity	215 ILCS 370c and c.1 Bulletin 99-6	The coverage must meet the minimum requirements of the Mental Health Parity Act. Please see Division Bulletin 99-6 The benefit for serious mental illness, based on medical necessity, in addition to requiring 45 days of inpatient treatment also requires 60 outpatient visits and an additional 20 outpatient visits for speech therapy for the treatment of pervasive developmental disorders. Benefits for serious mental illness are not applicable for small group. The sunset provision for serious mental illness has been removed.	
Post-Parturition Care	215 ILCS 5/356s	If coverage provides maternity benefit it 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.	
Pap and Prostate tests	215 ILCS 5/356u	Coverage must include annual cervical smear or Pap smear test for female insureds, including surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer; and, Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of physician. Must include asymptomatic men age 50 and over; African-American men age 40 and over; and men age 40 and over with family history of prostate cancer.	
Colorectal Cancer Screening	215 ILCS 5/356x	Must cover all colorectal cancer exams and lab tests for colorectal cancer as prescribed by physician according to stated guidelines; may not impose greater copays, ded or waiting periods.	
Qualified Clinical Cancer Trials	215 ILCS 5/364.01 (c)-(j)	No group policy of accident and health insurance shall exclude coverage for any 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.	
Cancer Drug Parity	215 ILCS 5/356z.20	The financial requirements applicable to orally-administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.	
Diabetes Supplies and Testing	215 ILCS 5/356w 50 Il Adm. Code 2019	Coverage must be provided for outpatient self-management training and education, equipment and supplies. Guidelines are provided.	
Prenatal HIV testing	215 ILCS 5/356z.1	Must be provided if coverage includes maternity benefit.	
Adjunctive Services in Dental Care	215 ILCS 5/356z.2	This coverage is limited to children age 6 or under; to individuals with medical conditions that require hospitalization and general anesthesia for dental care; and for disabled individuals.	
Prescription Inhalants	215 ILCS 5/356z.5	If policy provides RX coverage it may not deny or limit coverage for prescription inhalants when diagnosis is asthma or other life-threatening bronchial ailments; additional guidelines provided.	

Coverage for contraceptives	215 ILCS 5/356z.4	If policy provides coverage for OP services and RX or devices it must provide insured and dependent coverage for all OP and contraceptive drugs and devices approved by the FDA; may not impose greater copays, ded or waiting periods.	
Bone Mass Measurement/Osteoporosis	215 ILCS 5/356z.6	Coverage must include medically necessary bone mass measurement and diagnosis and treatment of osteoporosis the same as any other illness.	
Multiple Sclerosis Preventative Physical Therapy	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.	
Amino acid-based elemental formulas	215 ILCS 5/356z.10	Coverage must include reimbursement for amino acid-based elemental formulas, regardless of delivery method, for diagnosis and treatment of conditions described herein.	
Coverage for Human Papillomavirus Vaccine	215 ILCS 5/356z.9	Coverage must include benefit for FDA approved human papillomarivus vaccine (HPV).	
Shingles Vaccine	215 ILCS 5/356z.13	Coverage must include a vaccine for shingles that is approved by the federal Food and Drug Administration if it is ordered by a physician for an insured/enrollee who is 60 years of age or older.	
Autism Spectrum Disorders	215 ILCS 5/356z.14	Coverage must be provided for individuals under age 21 for the diagnosis and treatment of autism spectrum disorders to the extent that such care is not already covered by the policy.	
Habilitative Services for Children	215 ILCS 5/356z.15	A group or individual policy of accident and health or a managed care plan must provide coverage for habilitative services for children less than 19 years of age with congenital, genetic, or early acquired disorders as described.	
Prosthetic and customized orthotic devices	215 ILCS 5/356z.18	A group or individual major medical policy of accident or health insurance or a managed care plan must provide coverage for prosthetic and orthotic devices subject to other general exclusions, limitations and financial requirements of the policy.	
Health Care Services Appeals, Complaints, and External Independent Reviews	215 ILCS 5/155.36 50 IL Adm. Code 134/45	Managed Care Act appeals, complaints and external review provisions have now been added to insurer requirements as well.	
Health Care External Review Act	215 ILCS 5/155.36 215 ILCS 180/ 215 ILCS 180/75 215 ILCS 134/45	The Act provides uniform standards for the establishment and maintenance of external review procedures. Please note the disclosure provisions of section 75.	
Health Care External Review Act Time Frame Requirements	215 ILCS 180/35 215 ILCS 180/40 215 ILCS 180/42 (PDF of chart goes here)	Please note the statutory references for the time lines for external review as well as a chart to aid for compliance purposes.	
Health Care External Review Carrier Obligations	215 ILCS 180/20 50 IL Adm. Code	Health carriers must file for approval sample copies of:	

for Filing Notices and Forms	5430.40	• Notices and forms required to file for a right to external review • Descriptions for both standard and expedited external review procedures • Statements informing the insured and any authorized representative that a standard or expedited external review request deemed ineligible by the plan may be appealed to the Department of Insurance by filing a complaint • Notification (until July 1, 2013) that if an external independent review upholds an adverse determination the insured has a right to appeal that decision to the Department of Insurance	
REQUIREMENTS SPECIFIC TO HIPAA	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Small employer (Definition)	215 ILCS 97/5	"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.	
Creditable Coverage	215 ILCS 97/20 (C)(D)(E)	a.) A group health plan; b.) Health insurance coverage; c.) Part A or part B of title XVIII of the Social Security Act; d.) Title XIX of the Social Security Act other than coverage consisting solely of benefits under Section 1928; e.) Chapter 55 of title 10 of the United States Code; f.) A medical care program of the Indian Health Service or of a tribal organization; g.) A state health benefits risk pool; h.) A health plan offered under chapter 89 of title 5, United States Code; i.) A public health plan (as defined in regulations); j.) A health benefit plan under Section 5(e) of the Peace Corps Act; k.) Title XXI of the federal Social Security Act, a State Children's Health Insurance Program.	
Pre-Existing Conditions	215 ILCS 97/20	Pre-existing condition exclusions are limited to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The exclusion may extend for no more than 12 months or 18 months for a late enrollee.	
Small Group Guarantee Issue	215 ILCS 97/40(A)	Insurers must accept every small employer that applies for such coverage. Insurers must also accept every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll in the coverage.	
Network Plans Exceptions	215 ILCS 97/40(B)(C)(D)(E)	Insurer may limit guarantee availability. May deny coverage to small group if it can demonstrate that it does not have the capacity to deliver services adequately to enrollees of any additional groups because of obligations to other existing groups and enrollees. This exception must be applied uniformly. If this exception is invoked, insurer is barred from writing coverage in small group market in that particular service area for 180 days.	
Guaranteed Renewability	215 ILCS 97/30(A)(B)	Insurers in the small group or large group market must renew or continue in force a group's coverage at the option of the plan sponsor.	

		Such guaranteed renewability is not applicable in cases of nonpayment of premium, fraud or misrepresentation, and violation of minimum participation requirements. For insurers ceasing to market to small or large group market or both, network plans may nonrenew coverage if there are no enrollees of the group who live, reside or work in the service area. Coverage through a bona fide association may be nonrenewed if the employer ceases to be a member of the association.	
Uniform Termination of Coverage Notification Requirements	215 ILCS 97/30 (C)	Insurers must comply with the uniform notification requirements for discontinuing a particular type of coverage and discontinuing all coverage in the state. Notification requirements must appear in certificate.	
Notice Requirement	215 ILCS 97/60	An insurer electing to uniformly modify, terminate or discontinue coverage in accordance with Section 30 or 50 of Act 97 (HIPAA) must provide 90 days advance notice to the Division by certified mail.	
Portability	215 ILCS 97/20	Individuals moving within the group market and from individual coverage to group coverage (not group to individual coverage; unless to the alternative mechanism) will have pre-existing exclusions reduced by creditable coverage under prior plans if there is no more than a 63 day break in coverage.	
GENERAL INFORMATION	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Civil Unions	Company Bulletin 2011-06	The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75/, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.	
Discretionary Authority	215 ILCS 5/143(1) 50 IL Adm. Code 2001.3	Insurers are not permitted to place discretionary authority language in contracts of accident and health.	
Standardized Individual and Small Employer Application Form	215 ILCS 5/359b 50 Il Adm. Code 2030 Company Bulletin 2010-10	All health insurance carriers offering health benefit plans in either the individual or small group market must use the standard health application beginning on January 1, 2011.	
Blanket Group Policies	215 ILCS 5/367a	Provides guidelines for covering special groups of people as listed.	
Discretionary Group Policies	215 ILCS 5/367.3	Filings will only be approved if the Division determines that the issuance of the policy is not contrary to the public interest; the issuance will result in economies of acquisition and administration; and, the benefits under	

		the policy are reasonable in relation to the premium charged. Informational filings are required.	
Optional Coverage for TMJ	215 ILCS 5/356q	Insurers providing hospital, medical or surgical care must offer coverage for TMJ and craniomandibular disorder.	
Optional Coverage for Tobacco Use Cessation Programs	215 ILCS 5/356z.21	Insurers providing hospital or medical treatment or services must offer coverage of up to $500 annually for a tobacco use cessation program for persons enrolled in the plan who are 18 years of age or older.	
Women's Principal Health Care Provider	215 ILCS 5/356r	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.	
Prescription Drugs; Cancer Treatment	215 ILCS 5/356z.7	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.	
Discrimination	50 IL Adm Code 2603	Guidelines for Unfair Discrimination based on sex, sexual preference or marital status. Forbids excluding coverage for dependent child maternity.	
Right of Reimbursement and Subrogation	50 IL Adm Code 2020	Provides guidelines for reimbursement and subrogation rights due to negligence of a third party.	
Optometric Services Election	215 ILCS 5/364.1	A policy that covers optometry must include an informational notice to the policyholder that it has the option to have such services reimbursed to either a physician or optometrist.	
Dental Coverage Reimbursement Rates	215 ILCS 5/355.2	All group or individual accident and health coverage that also includes dental and bases reimbursement on usual and customary fees must disclose specific information.	
HIV/AIDS Questions on Application	215 ILCS 5/143(1)	Questions designed to elicit information regarding AIDS, ARC and HIV must be specifically related to the testing, diagnosis or treatment done by a physician or an appropriately licensed clinical professional acting within the scope of his/her license.	
Use of SSN on ID Cards	815 ILCS 505 2QQ 215 ILCS 138/15	The focus of HB 4712 is on any card required for an individual to access products or services, while SB 2545 is more limited in that it just focuses on insurance cards. HB 4712 prevents a person from: • Publicly posting or displaying an individual's SSN; • Printing an individual's SSN on any card required for the individual to access products or services, however, an entity	

		providing an insurance card must print on the card a unique identification number as required by 215 ILCS 138/15. • Being required to transmit an SSN over the Internet to access a web site unless the connection is secure or the SSN is encrypted; • Requiring the individual to use his/her SSN to access a web site unless a PIN number or other authentication device is also used; and, • Printing an individual's SSN on any materials mailed to an individual unless required by state or federal law. Insurers must comply with both provisions.	
Qualified Clinical Cancer Trials	215 ILCS 5/364.01 (a),(b)	No insurer may cancel or non-renew any individual's coverage due to participation in a qualified clinical cancer trial.	
Wellness Coverage	215 ILCS 5/356z.17	Individual and group accident and health insurers and HMOs may offer reasonably designed programs for wellness coverage.	
Organ Transplant Medication Notification Act	215 ILCS 175	Provides guidelines for health insurance policies and health care service plans that cover immunosuppressant drugs.	
Use of Information Derived from Genetic Testing	215 ILCS 5/356v 215 ILCS 97/20(A)(1)	Insurers must comply with the Genetic Information Privacy Act as well as the provisions found in 215 ILCS 97/20(A)(1).	
Cardiovascular Disease	215 ILCS 5/356z.19	Insurers and managed care plans must develop and implement procedures to communicate on an annual basis with adult enrollees regarding the importance and value of early detection and proactive management of cardiovascular disease.	
DEPARTMENT POSITIONS	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	
Hospital Definition	215 ILCS 5/143(1)	The definition of hospital must allow for those hospitals providing surgery, etc., on a formal arrangement basis with another institution.	
Prohibited Terms	215 ILCS 5/143(1) 50 IL Adm Code 2001.20 h) 2)	Policies may not use terms such as "external" and "violent" in connection with the definition of accident and health.	
Intoxication Definition	215 ILCS 5/143(1)	An intoxication definition must be included in the policy if it is listed as exclusion. A reasonable example would be, "Intoxication means that which is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred."	
Prohibited Exclusion	50 IL Adm Code 2001.20 q)	General Body System exclusions are not permissible.	