

TITLE 50: INSURANCE
PART 5421 HEALTH MAINTENANCE ORGANIZATION
CHAPTER I: DEPARTMENT OF INSURANCE
SECTION 5421.131 BASIC OUTPATIENT PREVENTIVE AND PRIMARY HEALTH CARE SERVICES

Section 5421.131 Basic Outpatient Preventive and Primary Health Care Services for Children

- a) Eligibility.
 - 1) A health maintenance organization may undertake to provide or arrange for and to pay for or reimburse the cost of basic outpatient preventive and primary health care services for children in Illinois who:
 - A) are without health care coverage:
 - i) through a parent's employment;
 - ii) through failure to qualify for medical assistance under the Illinois Public Aid Code or failure to qualify for coverage under the State Children's Health Insurance Program of the Social Security Act as amended by the Balanced Budget Act of 1997, P.L. 105-33;
 - iii) through any other health plan. For purposes of this Section, health plan means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health plan does not include accident-only, credit, dental, vision, Medicare supplement, partnership or traditional long-term care, or disability income insurance coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance or short-term and catastrophic health insurance policies, or a policy that pays on a cost-incurred basis, or student insurance;
 - iv) due to a loss of medical assistance when a parent has moved from welfare to work and does not find employment that offers health care coverage;
 - B) are 18 years of age or under;
 - C) have resided in the State of Illinois for at least 30 days and continue to reside in the State of Illinois.
 - 2) Said coverage will be made available to an adult on behalf of an enrollee. For purposes of this Section, enrollee is defined as an eligible child on whose behalf the policy is purchased. The financially responsible party (FRP) is the person or entity paying the premium on behalf of the enrollee. The certificate and/or policy will be issued to the parent or legal guardian of the enrollee. If the FRP and parent or legal guardian are different, both shall be listed on the face page of the certificate and/or policy. The name of the enrollee shall also be listed on the face page of the certificate and/or policy.
- b) Required Basic Minimum Outpatient Preventive and Primary Health Care Services for Children to be provided. The following minimum standards shall meet the requirements for basic outpatient preventive and primary health care services to be provided under this subsection, provided that such services are medically necessary as determined by the

enrollee's primary care physician, and if required by the HMO, are authorized on a prospective and timely basis by the HMO's medical director.

- 1) Preventive health services provided by the enrollee's primary care physician in the office, as appropriate for the patient population, including a health evaluation program and immunizations to prevent or arrest the further manifestation of human illness or injury including, but not limited to, allergy injections and allergy serum. Such health evaluation program shall include at least periodic physical examinations and medical history, blood pressure testing, and uterine cervical cytological testing as required by Section 356u of the Illinois Insurance Code [215 ILCS 5/356u] as well as health education concerning appropriate health care practices;
 - 2) Basic or general physician services for illness or injury, provided by the enrollee's primary care physician in the office;
 - 3) Emergency services for accidental injury or emergency illness 24 hours per day, 7 days per week. Such emergency services are covered benefits inside and out of the plan's service area;
 - 4) Outpatient diagnostic x-rays and laboratory services provided, arranged or authorized by the enrollee's primary care physician.
- c) Supplemental Basic Health Care Services which may be provided in addition to Basic Outpatient Preventive and Primary Health Care Services for Children. In addition to the minimum required health services listed in subsection (b) above, the HMO may offer Supplemental Basic Health Care Services, provided that such services are medically necessary as determined by the enrollee's primary care physician; and if required by the HMO, are authorized on a prospective and timely basis by the HMO's Medical Director. Supplemental Basic Health Care Services includes any services listed in Section 5421.130 of this Part. To the extent that Supplemental Basic Health Care Services are provided under this subsection, the minimum requirements of Section 5421.130 of this Part must be met for those services.
- d) Supplemental Services which may be provided in addition to Basic Outpatient Preventive and Primary Health Care Services for Children. In addition to the Supplemental Basic Health Care Services provided in Section 5421.131(c) of this Section, the HMO may offer the following Supplemental Services:
- 1) preventive dental services including diagnostic services, x-rays and restorations (fillings);
 - 2) vision screening, including one pair of eyeglasses per year;
 - 3) prescription drugs.
- e) Copayments, deductibles and benefit maximums for Basic Outpatient Preventive Services, Primary Health Care Services, Supplemental Basic Health Care Services and Supplemental Services for Children. An HMO may require copayments of enrollees as a condition for the receipt of specific health care services under this Part. Deductibles and copayments shall be the only allowable charge, other than premiums. Copayments shall be for a specific dollar amount. Deductibles shall be either for a specific dollar amount or for a specific percentage of the cost of the health care service. No single deductible or copayment for health services may exceed 25% of the usual and customary fee of the service to the HMO and must be waived when, in a calendar year, deductibles and copayments paid for the receipt of health care services exceed \$500 per enrollee. This

subsection does not preclude the provider from charging reasonable administrative fees such as service fees for checks returned for non-sufficient funds and missed appointments.

- f) Necessary Disclosure Requirements.
 - 1) The policy or certificate issued under this Section shall prominently disclose all limitations, exclusions, copayments and deductibles. Such disclosure shall include, but is not limited to:
 - A) A prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, as follows:

"Notice to Buyer. This is a limited benefit (policy) (certificate). Benefits provided are not intended to cover all of your medical expenses."
 - B) Exclusion of inpatient hospital services.
 - C) Statement that pre-existing conditions may not be excluded or limited.
 - D) Exclusion of services which are not provided, arranged or authorized by the primary care physician, and if required by the HMO, are subject to authorization on a prospective and timely basis by the HMO's medical director, except for emergency services.
 - 2) In the event services are offered under this Section by the HMO and purchased on behalf of the enrollee, full disclosure of the scope of those limited benefits shall be prominently stated within the policy or certificate.
 - 3) Eligibility requirements shall be prominently disclosed in the policy or certificate.
 - 4) Terms of cancellation shall be prominently disclosed pursuant to Section 5421.111 of this Part.
- g) Advertising. All advertising materials used to market policies pursuant to 50 Ill. Adm. Code 916 and/or certificates pursuant to this Part shall be filed and accepted by the Director in accordance with the requirements of Section 4-17 of the Act prior to use.
- h) Grace Period Extension. For purposes of this Part, the grace periods of Section 5421.110(m) of this Part apply. In the event an FRP, other than the parent or guardian, fails to pay the premium within the grace period, the parent or guardian will be so notified and be given an additional 30 days in which to pay the premium or obtain another FRP.

(Source: Added at 22 Ill. Reg. 6671, effective March 31, 1998)