

**Illinois Division of Insurance
Review Requirements Checklist**

320 West Washington Street
Springfield, IL 62767-0001

Updated 3/2016

Line(s) of Insurance: **HMO Individual Plans**

(All State Mandates Apply)

Line(s) of Business: **Affordable Care Act
Benchmark Requirements**

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ELECTRONIC REFERENCES

Federal References Link: [Code of Federal Regulations](#)
[United States Code](#)

Illinois References Link: [Illinois Insurance Code](#)
[Administrative Regulations](#)
[Online](#)
[Illinois Company Bulletins](#)

GENERAL FILING REQUIREMENTS

Review Requirements	Reference	General Filing Requirements	Location of Standard in Filing
Filing of Marketing and Advertising Materials	50 IL Admin. Code 5421.100 c)	All brochures, media scripts, marketing and advertising material must be filed with the Division of Insurance prior to use.	
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.	

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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)	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). In addition, 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 reference forms. **The Filing Description field in the General Information Tab in SERFF may be used in place of a cover letter.**	
Rate Filings	50 IL Adm. Code 5421.60 215 ILCS 125/4-12 Company Bulletin 2010-08	An HMO must file its rates with the Department's actuarial unit. The Federal Patient Protection and Affordable Care Act (PPACA) has established premium reporting and review processes for all health insurance. The Rate Filing Actuarial Memorandum and Rate Data Collection Form are available on the Department's web site under Company Bulletin 2010-08.	
Retrospective Rate Filings	215 ILCS 125/5-3 (f)	An HMO may effect refunds or charge additional premium under the circumstances described.	
Health Care External Review Carrier Obligations for Filing Notices and Form	215 ILCS 180/20 50 IL Adm. Code 5430.40	Health carriers must file for approval sample copies of: <ul style="list-style-type: none"> • 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 	
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.	
Medically Necessary Dispute Resolution	215 ILCS 125/4-10	Each HMO must establish a dispute resolution process in which a physician, holding the same class of license as the PCP and not affiliated with the HMO, is jointly selected by the patient and the HMO in the event of a dispute regarding medical necessity of a covered service proposed by the patient's PCP. In the event the reviewing physician determines the covered service is medically necessary the HMO will be required to provide the service.	

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Provision of Information	50 IL Adm. Code 5421.110q) 50 IL Adm. Code 5420.40	An HMO must provide to each enrollee information regarding its functions, organization, and related institutions and describe the appropriate use of its services. This material must also include a description of the grievance procedure, directions on filing a grievance and "Notice of Availability of the Division". HMOs must provide description of coverage worksheets as detailed in 50 IL Adm. Code 5420.40	
ID Card Required	50 IL Adm. Code 5421.110r) 215 ILCS 139/15	HMOs must provide ID cards to their enrollees. Mandatory data elements for the card or other technology include: <ul style="list-style-type: none"> • Processor control number if required for claims adjudication • Group number • Card issuer identifier • Cardholder ID number • Cardholder name The back of the card or other technology is to include the claims submission names and addresses and the help desk telephone numbers and names. Cards must be issued upon enrollment and reissued upon any change in the enrollee's coverage that affects any of the required elements.	
Use of SSN on ID Cards	815 ILCS 505 2QQ 215 ILCS 139/15	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 139/15. 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.	
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.	

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Out-Of- Pocket Expense	§1302(e) of the ACA 26 U.S.C. §36B(c)(3)	Annual Limitation on Cost Sharing: The maximum annual limitation on cost sharing is the product of the dollar limit for calendar year 2014 (\$6,350 for self-only coverage) and the premium adjustment percentage for 2017, rounded down to the next lower \$50. The 2017 maximum annual limitation on cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage.	
Basic Outpatient Preventative and Primary Health Care Services for Children	215 ILCS 125/4-17 50 IL Adm. Code 5421.131	An HMO may choose to provide or arrange to pay for or reimburse the cost of basic outpatient preventive and primary health care services for children who are without health care coverage.	
Dental Coverage Reimbursement Rates	215 ILCS 5/355.2 215 ILCS 125/5-3(a)	A group contract or evidence of 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.	
Prohibition against Substitution of Hospitalist	215 ILCS 5/134/30 (c)	No health care plan, or one of its subcontractors, may require an enrollee who is hospital confined to substitute his/her primary care physician for a hospitalist who is under the control of that entity.	
Organ Transplant Medication Notification Act	215 ILCS 175	Provides guidelines for health insurance policies and health care service plans that covered immunosuppressant drugs.	
Use of Information Derived from Genetic Testing	215 ILCS 5/356v 215 ILCS 97/20(A)(1) 215 ILCS 125/5-3(a)	Insurers must comply with the Genetic Information Privacy Act as well as the provisions found in 215 ILCS 97/20(A)(1).	
Entire Contract	50 IL Adm Code 5421.110 d)	The individual contract shall contain a statement that the individual contract, all applications, and any amendments shall constitute the entire agreement between the parties. No portion of the charter, by-laws or other document of the HMO shall be part of a contract or evidence of coverage unless set forth in full in the document or attached to it.	

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Timely Payment of Health Care Services	215 ILCS 5/368a	Periodic payments must be made within 60 days of an enrollee's selection of a provider, or effective date of selection, whichever is later. In case of retrospective enrollment only 30 days after notice by the employer to the 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.	
Grace period	50 Il Adm Code 5421.110 l)	A individual contract shall provide for a grace period not less than 31 days.	
Grace period for advance premium tax credit recipients	45 CFR 155.430 45 CFR 156.270	A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in 45 CFR 155.430(d)(4), provided that the QHP issuer meets the notice requirement specified in paragraph (b) of that section. During the grace period, the QHP issuer must: ·Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; ·Notify HHS of such non-payment; and, ·Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.	
Eligibility Requirements	50 IL Adm. Code 5421.110 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.	
Cancellation	50 IL Adm. Code 5421.110 j) 50 IL Adm code 5421.111 a)	No HMO may cancel a group or individual contract or evidence of coverage except for one or more of the following reasons: *Failure to pay the premium; *Fraud or material misrepresentation; * Material violation of the terms of the contract or evidence of coverage; *Failure to establish a satisfactory patient-physician relationship; *Failure to meet or continue to meet eligibility requirements under the Basic Outpatient Preventive and Primary Care Services for Children Program offered by 50 IL Adm. Code 5421.131; or, (Such other good cause as appears in the contract.)	

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Extended age dependent continuation	215 ILCS 5/356z.12 215 ILCS 125/5-3(a)	A policy that includes dependent coverage must allow unmarried dependents under the age of 26 to apply for coverage. Additionally, policies 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.	
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. This coverage mirrors the requirements of H.R. 285, known as Michelle's Law, signed by the President on October 9, 2008.	
Newborn Children	215 ILCS 125/4-8	The contract or evidence of coverage must state newborns are covered from the moment of birth. If additional premiums are required the insurer may require notification within 31 days in order to have coverage continue.	
Pending & Adopted Children	215 ILCS 125/4-9	No contract 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 enrollee pursuant to an interim court order of adoption is considered an adopted child.	
Reinstatement	50 IL Adm. Code 5421.110 k)	The group contract, evidence of coverage, and individual contract shall contain the conditions of the enrollee's right to reinstatement.	
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.	
Disabled Dependents	215 ILCS 125/4-9.1 50 IL Adm. Code 5421.110 t)	Provides continuation for handicapped dependents that have attained the limiting age of the contract.	

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Deductibles and Copayments	50 IL Adm. Code 5421.110 i)		
Out of Area Benefits and Services	50 IL Adm. Code 5421.110 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.	
Benefits and Services within the Service Area	50 IL Adm. Code 5421.110 f)	The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available within the HMO's designated service area.	
Grievance Procedure	50 IL Adm. 5421.110 w)	The group contract, evidence of coverage, and individual contract shall set forth a full description of the HMO grievance procedure required by Section 5421.40.	
Limitations and Exclusions	215 ILCS 125/4-14(3) 50 IL Adm. Code 5421.110 b)	There must be a detailed statement in the group contract, evidence of coverage, and individual contract that describes the limitations and exclusions expressed with the same prominence as the description of the benefits.	
Notice of Address of Division of Insurance	50 IL Adm. Code 5421.110	No evidence of coverage may be issued without notice of the complaint department of the HMO and the address of the Managed Care Unit of the Division of Insurance.	
Health Care External Review Act	215 ILCS 5/155.36 215 ILCS 180/ 215 ILCS 180/75 215 ILCS 5/134.45	The Act provides uniform standards for the establishment and maintenance of external review procedures. Please note the disclosure provisions in section 75.	
Health Care External Review Act Time Frame Requirements	215 ILCS 180/35 215 ILCS 180/40 215 ILCS 180/42	Please note the statutory references for the time lines for external review.	
Basic Health Care Services	50 IL Adm. Code 5421.130	This section contains the minimum standards that must be met for basic health care services provided those services are determined to be medically necessary by the enrollee's primary care physician (PCP). Some of these services are outlined in more detail in this section of the checklist.	
Description of in-plan and out-of-plan benefits	50 IL Adm. Code 5421.110 f) h)	The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available both in-plan and out-of-plan.	

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Prescription Drugs, Cancer Treatment: Off-label use	215 ILCS 125/4-6.3	No HMO that provides prescription drug coverage for certain types of cancer may exclude coverage of any drug on the basis that the drug has not been FDA approved for that particular type of cancer if documentation is provided in certain medical reference compendia as to the efficacy of that drug for the form of cancer in question, or if the drug has been recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals here or in Great Britain.	
Outpatient Rehabilitative Therapy	50 IL Adm. Code 5421.130 j)	Coverage must include, but is not limited to, speech, physical and occupational therapy for up to 60 treatments per year.	
POINT OF SERVICE (POS) PLAN REQUIREMENTS			
Filing of POS Product	215 ILCS 125/4.5-1 50 IL Adm. Code 5421.113	The filing must include an HMO portion (base) and an indemnity portion. The HMO filing must be filed with the HMO unit and the indemnity portion with the LAH unit. Illinois does not permit a POS plan with a preferred provider organization (PPO) base and an HMO 'tail' (out-of-network piece).	
MANAGED CARE REFORM AND PATIENT RIGHTS ACT PROVISIONS			
Transition of Services	215 ILCS 134/25 50 IL Adm. Code 5420.60 45 CFR 156.230(d)(2)	A health care plan must provide for continuity of care for an ongoing course of treatment for its enrollees in circumstances in which the enrollee's PCP leaves the network as described. Treatment is available for 90 days from the date of the notice of the physician's termination or if the enrollee has entered the third trimester of pregnancy.	
Emergency Services Prior to Stabilization	215 ILCS 134/65 50 IL Adm. Code 5420.60	A health care plan that provides, or is required to provide, coverage for emergency services may not make payments contingent upon whether the provider is in or out-of plan, or whether prior authorization is obtained.	
Post-Stabilizations Medical Services	215 ILCS 134/70 50 IL Adm. Code 5420.110	A health care plan will be responsible for providing post-stabilization medical services if authorization is received from the health care plan, or one of its delegated providers, or after 2 documented good faith efforts by the treating health care provider as described.	

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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.	
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.	
Administrative Appeals: Complaint Handling Procedures	215 ILCS 134/50 215 ILCS 134/55 215 ILCS 125/4-6 50 IL Adm. Code 5420.90	An HMO is required to establish a procedure to handle complaints regarding administrative issues and procedures, but nothing in these requirements prevents an enrollee from filing a complaint with the Division. An HMO is required to respond to a complaint received from the procedures for requesting an external independent review.	
Appeals and Grievances Relating to Health Care Services	215 ILCS 134/45(a)(b)(c)(d)	An HMO must establish procedures for both expedited appeals of health care services and other appeals for health care services that meet the minimum requirements outline herein. If the case involves an adverse determination the HMO must provide the procedures for requesting an external independent review.	
Notice of 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.	
HIPAA REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	
Pre-Existing Conditions	ACA	Pre-existing condition exclusions are no longer permitted.	
Guaranteed Renewability	215 ILCS 97/50 (A),(B)	Except as provided a health insurer issuing individual coverage must renew or continue in force coverage at the option of the individual except for: 1. Nonpayment of premium 2. Termination of the plan 3. Fraud 4. Movement outside the service area 5. Association membership ceases.	

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Termination of Plan	50 IL Adm. Code 2025 215 ILCS 97/50 (C)(1)	50 IL Adm. Code 2025 215 ILCS 97/50 (C)(1)	
Discontinuance of Coverage	50 IL Adm. Code 2025 215 ILCS 97/50(C)(2)	Insurers must comply with the uniform notification requirements for discontinuing all coverage in the state. Notification requirements must appear in certificate.	
Modification of Coverage	50 IL Adm. Code 2025 215 ILCS 97/50(D)	An insurer may only modify a contract at renewal as long as the modification is consistent with Illinois law and consistent on a uniform basis among all individuals with that policy form.	
Notice Requirement	50 IL Adm. Code 2025 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.	
BENEFIT			
BENEFIT	BENCHMARK REQUIREMENT	CONDITIONS FOR COVERAGE OR LIMITATIONS	
AMBULATORY PATIENT SERVICES			
Primary Care to treat illness/injury	Yes		
Specialist visits	Yes		
Pediatrician office visit	Yes		
Urgent care facility	Yes		
Surgery facility – outpatient procedure at an ambulatory surgical center	Yes		
Assistant Surgeon/ Surgical Assistant	Yes	Registered Surgical Assistant	
Additional Surgical Opinion	Yes	Following a recommendation for elective surgery. Covered at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation.	
Blood and blood components	Yes		
Dental Ancillary Services	Yes	Mandated Only covered in the event of an accident.	

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Chemotherapy	Yes	Both outpatient and in-patient settings.	
Radiation Therapy	Yes	Both outpatient and in-patient settings.	
Biological Drugs	Yes		
Oxygen and its administration	Yes		
Outpatient end stage renal disease treatment	Yes	Both outpatient and in-patient settings.	
Infertility treatment services	Yes 215 ILCS 5/356m 50 IL Adm Code 2015 P.A. 99-0421	Mandated	
Sterilization	Yes		
Home health care	Yes	You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).	
Outpatient Contraceptive Services	Yes	Mandated. Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means 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.	
Dental care required for the direct treatment of a medical condition	No	May be covered if specifically and directly related to the medical condition i.e. dental work needed in order to treat cancer itself or dental care required to be performed in order to treat another underlying medical condition. For example the treatment of malnutrition or digestive disorders in the young and elderly due to underlying dental and oral problems.	
Dental care due to accident or injury	Yes	Coverage only for sound natural teeth.	
Routine Care During Cancer Clinical Trials	Yes	Mandated	

EMERGENCY SERVICES

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Definition of Emergency Medical Condition	215 ILCS 5/155.36 215 ILCS 134/10	Insurers must use this definition that includes “prudent layperson” language.	
Emergency services – facility	Yes		
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.	
Emergency services – physician	Yes		
Criminal Sexual Assault Emergency medical care resulting from a criminal sexual assault or abuse	Yes 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. Covered at 100% with no cost-sharing	
Ambulance service – ground and air	Yes	Not provided for long distance trips because it is more convenient than other transportation.	
HOSPITALIZATION			
Inpatient medical and surgical care	Yes		
Assistant Surgeon/ Surgical Assistant	Yes	Registered Surgical Assistant	

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Human Organ Transplants	215 ILCS 5/356k	<p>No accident and health insurer may deny reimbursement for an organ transplant as experimental or investigational unless supported by appropriate, required documentation.</p> <p>Benefits for transportation and lodging are limited to a maximum of \$10,000 per transplant. Max for lodging per person, per day, is \$50.</p> <p>Benefits are available to both the recipient and donor of a covered transplant as follows:</p> <ul style="list-style-type: none"> • If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own program. • If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits. • If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient. <p>Benefits will be provided for:</p> <ul style="list-style-type: none"> • Inpatient and Outpatient Covered Services related to the transplant Surgery. • The evaluation, preparation and delivery of the donor organ. • The removal of the organ from the donor. • The transportation of the donor organ to the location of the transplant Surgery. <p>Benefits will be limited to the transportation of the donor organ in the United States or Canada.</p> <p>Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.</p>	
Bariatric surgery	Yes	If Medically necessary	
Anesthesia	Yes		

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Oral surgery/TMJ services and devices	Yes	Limited to: surgical removal of complete bony impacted teeth; excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth: surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.	
Breast reconstruction after mastectomy	Yes 215 ILCS 5/356g(b) 50 IL Adm Code 2016	Mandated 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 lymphedemas.	
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.	
Breast Implant Removal	215 ILCS 356p	No contract may deny 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.	
Fibrocystic Breast Condition	215 ILCS 356n	No contract or evidence of coverage may deny or exclude 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.	
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.	
Reconstructive surgery (other than related to mastectomy)	Yes	Limited to correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.	

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Blood transfusions	Yes		
Hospice	Yes	<p>You must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> • Coordinated Home Care • Medical supplies and dressings • Medication • Nursing Services – Skilled and non-Skilled • Occupational Therapy • Pain management services • Physical Therapy • Physician visits • Social and spiritual services • Respite Care Service 	
MATERNITY AND NEWBORN CARE			
Pre and post-natal Care Services	Yes		
Prenatal HIV testing	215 ILCS 5/356s	Must be provided if coverage includes maternity benefits.	
Delivery and inpatient maternity services	Yes		
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.	
Newborn child coverage	Yes		
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT			
Alcoholism and Drug Abuse	215 ILCS 5/330c(2.5) 215 ILCS 5/370c(5.5) HB 1 (effective 9.9.15)	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.	

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<p>Mental, Emotional or Nervous Disorders/Serious Mental Illness Mental Health Parity</p>	<p>215 ILCS 370c 215 ILCS 3701c.1 Bulletin 99-6</p>	<p>The coverage must meet the minimum requirements of the Mental Health Parity Act.</p> <p>Annual or lifetime limits for MH/SUD cannot be less favorable than those applied to medical/surgical benefits (215 ILCS 5/370c.1(b) and (c)). There can be no separate but equal deductibles – MH/SUD and medical/surgical benefits must add up together to the same, combined deductible.</p> <p>Financial requirements such as copayment, coinsurance, and deductibles for MH/SUD benefits can be no more restrictive than the predominant financial requirement for substantially all medical/surgical benefits. Quantitative treatment limitations (such as number of visits, number of days, frequency of treatment) applicable to MH/SUD benefits can be no more restrictive than the predominant quantitative treatment limitations for substantially all medical/surgical benefits (5/370c.1(a)(1) and (2)).</p> <p>Non-quantitative treatment limitations (such as medical management standards, formulary design, determination of usual and customary schedules) cannot be applied more stringently for MH/SUD benefits than they are applied for medical/surgical benefits. 215 ILCS 180/20(g) definition of treatment limitation which refers to the Federal Final Rule https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf</p>	
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Mental/Behavioral Health/Substance Use Disorder - Inpatient Hospital	Yes	Plans subject to Illinois laws and the ACA must cover mental health benefits, including individual and small group. Mental Illness means those illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Serious Mental Health is defined under 5/370c(b)(2) as: Schizophrenia Paranoid and other psychotic disorders; Bipolar disorders; Major depressive disorders; Schizoaffective disorders; Pervasive developmental disorders; Obsessive-compulsive disorders; Depression in childhood and adolescence; Panic disorder; Post-traumatic stress disorders; Anorexia nervosa and bulimia nervosa.	
Mental/Behavioral Health/ Substance Use Disorder – Outpatient		Includes, but is not limited to, psychological testing, neuropsychological testing, electroconvulsive therapy, intensive outpatient programs, partial hospitalization treatment programs, if it is an in-network approved program. NOTE: The same requirement approval requirement has to be in place for medical/surgical approvals in order to meet the parity requirements.	
Acute Treatment Services and Clinical Stabilization services	Shall Offer 215 ILCS 5/370cP.A.	Shall offer for individual and group health and accident policies for coverage for medically necessary services.	
Emergency MH/SUD Admission	Yes		
Partial Hospitalization	Yes		
Intensive Outpatient Treatment	Yes		
Residential Treatment Facility	Yes	Illinois law specifically requires coverage for residential treatment for SUD disorders. (5/370c(9).	
Detoxification	Yes		
Applied Behavior Analysis Based Therapies	Yes	Mandated - Only for Autism Spectrum Disorder	

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Electroconvulsive Therapy	Yes		
Other MH/SUD Exclusions (this is not an exhaustive list)		Exclusions include but may not be limited to: <ul style="list-style-type: none"> • Residential treatment centers, except for SUD • Non-quantitative standards can be no less restrictive for MH/SUD than those used for medical/surgical. SUD must be done in accordance with ASAM (American Society of Addiction Medicine). This includes: <ul style="list-style-type: none"> • Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services • Investigational treatments (see Other Exclusions below) • Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. • Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. • Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. • Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. 	

PRESCRIPTION DRUGS

Retail	Yes		
Mail Order		Plans cannot require the use of mail order only.	
Generic	Yes		
Brand	Yes		
Specialty	Yes		
Self-Injectable medications	Yes		

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Insulin/needles for diabetes	Yes		
Tobacco Cessation Drugs	Yes	Benchmark Drug: Category & Class = Anti-Addiction/Substance Abuse Treatment Agent, Smoking Cessation Agent	
Opioid Antagonist	Yes	215 ILCS 5/356z.23	
Fertility Drugs	Yes	Mandated	
Biological Drugs	Yes		
Growth Hormone Therapy	Yes		
Organ Transplant Medication Notification Act	215 ILCS 175/	Provides guidelines for health insurance policies and health care service plans that cover immunosuppressant drugs.	
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.	
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.	
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 Out Patient services and Out Patient Prescription drugs or devices it must provide insured and dependent coverage for all Out Patient and contraceptive drugs and devices approved by the FDA; may not impose greater co-pays, deductibles or waiting periods.	
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES			
Physical Therapy	Yes	A written plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by Multiple Sclerosis.	

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Preventive Physical Therapy for Multiple Sclerosis Patients	215 ILCS 5/356z.8	Mandated 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.	
Occupational Therapy	Yes		
Speech Therapy	Yes		
Pulmonary Rehabilitation Therapy	Yes	Covered based on medical necessity	
Cardiac Outpatient Rehab Services		Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period. Benefits may be required to provide only in an in-network approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or trans-myocardial revascularization.	
Inpatient Rehabilitation	Yes		
Autism Spectrum Disorder Coverage	Yes 215 ILCS 5/356z.14	Mandated 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	Yes	Mandated Reference: (§ 156.115) (EHB) Definition from the Glossary of Health Coverage and Medical Terms Definition of Habilitative Services Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	
Chiropractic & Osteopathic Manipulation	Yes		
Massage Therapy	Yes		
Skilled Nursing Facility Services	Yes		
Durable Medical Equipment	Yes		

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Prosthetics	Yes. 215 ILCS 5/356z.18	An 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.	
Orthotics	Yes. 215 ILCS 5/356z.18		
Cochlear Implants/Bone Anchored	Yes	Covers Osseo integrated auditory implants	
Hearing Aids	Yes		
LABORATORY SERVICES			
Lab Tests, X-ray services and Pathology – Inpatient/Outpatient	Yes		Inpatient -- Outpatient --
Imaging/Diagnostics (egg. MRI, CT scan, PET scan) – Inpatient/Outpatient	Yes		Inpatient -- Outpatient --
PREVENTATIVE WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT			
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.	
Wellness Coverage	215 ILCS 5/356z.17	Individual and group accident and health insurers and HMOs may offer reasonably designed programs for wellness coverage.	
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.	

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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/	
Preventive Services	Yes		
Immunizations	Yes		
Bone Density Test	Yes 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.	
Colorectal Cancer Screening	Yes 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 co-pays, deductibles or waiting periods, or other cost sharing limitation that is greater than that required for other coverage under the policy.	

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Screening Mammography	Yes 215 ILCS 5/356g(a)	<ul style="list-style-type: none"> • Coverage of screening by low-dose mammography (including 3D mammograms or breast tomosynthesis 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 <p>Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described</p> <ul style="list-style-type: none"> • Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit. <p>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.</p>	
Clinical Breast Exam	215 ILCS 5/356g.5	Clinical breast examinations must be covered: at a minimum every three years for women over 20 years of age but less than 40; and, annually for women 40 years of age and older.	
Qualified Clinical Cancer Trials	215 ILCS 5/364.01 (c)-(j) 215 ILCS 5/364.01 (a),(b)	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. No insurer may cancel or non-renew any individual's coverage due to participation in a qualified clinical cancer trial.	
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.	
Preventive Foot Care	Yes	For persons with diabetes	
Allergy testing and treatment	Yes		
Nutrition	Yes	Diabetes education and Habilitative services	
Diabetes Care Management	Yes		

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Diabetes – Testing Medically necessary equipment and supplies	Yes 215 ILCS 5/356w 50 II Adm. Code 2019	Coverage must be provided for outpatient self-management training and education, equipment and supplies. Guidelines are provided. Insulin pumps are a covered benefit.	
Smoking Cessation Program	Yes 215 ILCS 5/356z.21	Insurers providing hospital or medical treatment or services must offer coverage for a tobacco use cessation program for persons enrolled in the plan who are 18 years of age or older.	
Screening Pap Tests	Yes 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.	
Coverage for Human Papillomavirus Vaccine	215 ILCS 5/356z.9	Coverage must include benefit for FDA approved human papillomavirus vaccine (HPV)	
Prostate Cancer Screening	Yes 215 ILCS 5/356u	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	
Women’s Principal HealthCare 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.	
PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE			
Preventive Care – Physician Services	Yes		
Immunizations	Yes		
Treatment of Illness or Injury - Child	Yes		
Amino acid-based elemental formulas	Yes 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.	

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Adjunctive Services in Dental Care	215 ILCS 5/356z.2; P.A. 99-0141	This coverage is for children under age 19 and has been diagnosed with an autism spectrum disorder as defined in Section 10 of the Autism Spectrum Disorders Reporting Act or a developmental disability. A covered individual shall be required to make 2 visits to the dental care provider prior to accessing other coverage under this subsection.	
Dental Accidents or Injury	Yes	Limited to treatment of sound natural teeth	
Dental care required for the direct treatment of a medical condition	No	May be covered if specifically and directly related to the medical condition i.e. dental work needed in order to treat cancer itself or dental care required to be performed in order to treat another underlying medical condition. For example the treatment of malnutrition or digestive disorders due to underlying dental and oral problems.	
Hearing Aids – child	Yes	2 every 36 months	
Cochlear Implants – Child	Yes	Covers Osseo integrated auditory implants	
Routine Hearing Exams – child	Yes		
Vision Care -- child	Yes		
OPTIONAL PROVISIONS			
Wellness Coverage	215 ILCS 5/356z.17	Individual and group accident and health insurers and HMOs may offer reasonably designed programs for wellness coverage.	
DEPARTMENT POSITIONS			
Intoxication Definition	215 ILCS 5/143(1)	If any policy or contract of insurance uses the term intoxicated or intoxication in the form it must also include a definition of intoxication. 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."	
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.	