



Illinois Insurance Facts

Illinois Department of Financial and Professional Regulation
Division of Insurance

Dependent Coverage – P.A. 095-0958 FAQ For Industry

Revised
February 2011

1) What is the effective date of changes mandated by Public Act 95-0958?

The changes need to be reflected in individual and group health insurance policies and HMO contracts as they are delivered, issued, amended or renewed on and after June 1, 2009. Policies in force prior to June 1, 2009, will have to reflect the changes on the first renewal date or date the policy is first amended after June 1, 2009.

2) Does the law require group and individual policies to provide dependent coverage?

No. The law only applies if dependent coverage is included in the policy.

3) Who must be covered under the law?

Policies that include dependent coverage must allow unmarried dependents under the age of 26 to apply for coverage. In addition, policies must allow military veteran dependents under age 30 to apply for coverage if the military veterans: 1) are Illinois residents; 2) are not married; 3) have served in the active or reserve components of the U.S. Armed Forces (which includes the National Guard); and 4) have received a release or discharge other than a dishonorable discharge.

To prove that they have served in the U.S. Armed Forces and received a release or discharge other than a dishonorable discharge, veterans must submit to insurers a DD2-14 (Member 4 or 6), otherwise known as a "Certificate of Release or Discharge from Active Duty."

A policy shall not condition eligibility for dependent coverage on enrollment in any educational institution.

4) Do covered dependents need to re-apply for coverage?

No. After June 1, 2009, dependents covered under a policy at the time of that policy's delivery, issuance, amendment or renewal do not need to re-apply. After June 1, 2009, dependents not covered at the policy's delivery, issuance, amendment or renewal may need to re-apply for coverage.

5) When will dependents be allowed to enroll?

a) Policies in force as of June 1, 2009 must provide for a 90-day open enrollment period for all dependents that meet the criteria established in (3) beginning on the date the policy is first amended or renewed. During the initial 90-day enrollment period, requirements for creditable coverage, continuous coverage or breaks in coverage may not be applied.

b) Policies issued on or after June 1, 2009 must provide for a 90-day open enrollment period for all dependents that meet the criteria established in (3). During the initial 90-day enrollment period,

requirements for creditable coverage, continuous coverage or breaks in coverage may not be applied.

c) The effective date of coverage for dependents added during the initial 90-day enrollment period shall be consistent with the enrollment terms of the plan or policy (e.g., the effective date of coverage is the first day of the month following enrollment).

d) After the initial 90-day open enrollment period, insurers must provide eligible dependents not already covered under the policy annual enrollment during an open enrollment period. For policies that do not currently provide for an open enrollment period, enrollment must be allowed for the 30-day period prior to the policy's annual renewal date or anniversary date if the policy does not have a renewal date. During this annual enrollment period the insurer may decline coverage if the dependent does not meet the requirement of 90 days of continuous coverage without a break in coverage of more than 63 days.

e) This law does not change enrollment terms or requirements for dependents added outside of the initial 90-day enrollment or subsequent annual enrollment periods, including HIPAA special enrollment requirements. As such, an eligible dependent that meets the limiting age requirements of P.A. 095-0958 may be added to a group policy if a HIPAA special enrollment event occurs. An eligible dependent who meets a company's underwriting guidelines may be added to an individual policy at any time throughout the year.

6) Can the insurer decline coverage for eligible dependents due to health conditions?

During the initial 90-day enrollment, annual enrollment or special enrollment periods, no policy may decline coverage to an eligible dependent due to age (as defined in P.A. 095-0958), health status, or enrollment in an educational institution. The law does not otherwise restrict the definition of dependent. **However, the Division will take appropriate enforcement action if the Division finds that an insurer imposed any eligibility requirement as a proxy for age or student status (e.g., restricting coverage based on IRS dependency rules).**

During the annual enrollment period, the insurer may decline coverage if the dependent does not meet the requirement of 90 days of continuous coverage without a break in coverage of more than 63 days.

7) Can the insurer impose preexisting condition limitations for the coverage of eligible dependents?

a) With respect to dependents added during the **initial 90-day open enrollment period**, rules governing preexisting condition limitations are not changed by P.A. 095-0958. For group policies, any such exclusion period must be reduced by the amount of creditable coverage a dependent has at the time of enrollment, consistent with HIPAA (215 ILCS 97/20 (A)(3)).

b) For dependents added during an **annual enrollment** period, preexisting condition limitations may be applied to the extent that creditable coverage has not been established. Group and individual policies must apply periods of creditable coverage, as defined in HIPAA, to any preexisting condition exclusion periods.

c) For dependents added to an individual policy at a time other than the initial 90-day enrollment or annual enrollment periods, preexisting condition limitations may be applied. However, insurers must apply creditable coverage to any preexisting condition exclusion period at the time of the policy's next annual enrollment period.

d) Individual policies may not contain elimination or exclusionary riders with respect to coverage for eligible dependents.

8) Will companies be required to amend existing policies in order to comply with new enrollment and eligibility requirements?

Yes. Companies must amend an existing policy if the policy does not currently contain a provision for an annual enrollment period or if the definition of “dependent” does not conform with these new requirements. For example, an individual policy that is guaranteed renewable and contains no open enrollment provision and has no renewal date must be amended to establish an enrollment period for the 30-day period preceding the annual anniversary date. In addition, if the policy’s definition of dependent varies from the requirements established by this new law, that definition will need to be amended.

Any required amendments to in-force policies must be incorporated by way of a rider that must be filed with and approved by the Director.

After the effective date of the new law, policies will either need to be refiled or amended to accommodate these new requirements or must be issued with a rider in order to be in compliance.

9) Does the dependent coverage law apply to dental and vision plans?

Effective January 1, 2011, Public Act 096-1034 (215 ILCS 5/356z.16) exempted short-term travel, disability income, long-term care, accident only, or limited or specified disease policies from the Young Adult Dependent Coverage law. Dental and vision policies issued, amended delivered or renewed January 1, 2011 or after are not required to abide by the Young Adult Dependent Coverage law.

For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at www.ins.state.il.us

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