

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
 Springfield, IL 62767-0001

Updated 3/2016

Line(s) of Insurance: **Catastrophic 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](#)

CATASTROPHIC			
	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	
Plan Requirements	42 U.S.C. §18022(e).	The catastrophic plans allowed under the Affordable Care Act are those plans that do not meet one of the four levels of coverage (Bronze, Silver, Gold, or Platinum), and are only available to a limited class of individuals: those under 30 who are exempt from the requirement to maintain minimum essential coverage either because they cannot afford it, or because come hardship has prevented them from obtaining coverage under a QHP. The plans must offer Essential Health benefits once the cost-sharing limit is reached. Deductible do not apply to required preventive services and at least three primary care visits per year.	
LIMITED CLASS OF ELIGIBILITY		Individual must be under 30 beginning the plan year.	

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	26 U.S.C. §5000A	Certification that the applicable individual is exempt from maintaining the minimum essential coverage.	
	26 U.S.C. §5000A(e)(1)	The individual cannot afford coverage because the individual's required contribution for coverage for the month exceeds 8 percent of the individual's household income for the taxable year.	
	26 U.S.C. §5000A(e)(5)	The applicable individual for any month is determined by the Secretary to have suffered a hardship with respect to the capability to obtain under a qualified health plan.	
	45 C.F.R. §156.155(c)	For family coverage, each individual enrolled must meet the above conditions.	
Meet Requirements	45 C.F.R. §156.155	The plan must also meet "all applicable requirements for health insurance coverage in the individual market."	
GENERAL FILING REQUIREMENTS			
Review Requirements	Reference	General Filing Requirements	Location of Standard in Filing
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)	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.**	

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Outline of Coverage	50 IL Adm. Code 2007.80 b)	An Outline of Coverage must be submitted including Outline Of Coverage with policy forms in Supporting Documents Tab.	
Rate Filings	215 ILCS 5/355 Company Bulletin 2010-08	The Federal Patient Protection and Affordable Care Act (PPACA) has established premium reporting and review processes for all health insurance issuers. The Rate Filing Actuarial Memorandum requirements in Company Bulletin 2010-08 are no longer applicable. The revised Actuarial Memorandum requirements are found in the "Actuarial Memorandum" section of the Health Premium Rates Checklist. Rates must be submitted with a uniform transmittal document and contain a unique filing number. http://www.insurance.illinois.gov/LAH_HMO_IS3_Checklists/HealthPremiumRates.asp	
Accident and Health Required Provisions	215 ILCS 5/357.1	Each accident and health policy must contain the provisions contained in 3/357.2-3/357.13.	
Form of Policy	215 ILCS 5/356a	No policy of accident and health insurance may be delivered or issued for delivery to any person in this state unless it adheres to the provisions of this section.	
Entire Contract	215 ILCS 5/357.1 215 ILCS 5/357.2	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 5/357.1 215 ILCS 5/357.3 PHSA Sec. 2712	PPACA prohibits rescission, except in cases where an individual "has performed an act of practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan of coverage." A policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.	
Notice of Claim	215 ILCS 5/357.1 215 ILCS 5/357.6	Written notice of claim should be submitted to the company within 20 days of the occurrence or commencement of any loss.	

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Legal Action	215 ILCS 5/357.1 215 ILCS 5/357.12	No such action shall be brought to recover before 60 days after written proof of loss or after 3 years from the date of due proof of loss is required to be furnished.	
Claim Forms	215 ILCS 5/357.1 215 ILCS 5/357.7	The company shall furnish those forms needed to submit proofs of loss within 15 days.	
Payment of Claims	215 ILCS 5/357.1 215 ILCS 5/357.10	At the option of the issuer, benefits may be paid to another person, if included in the policy, benefit amounts are limited to \$1000.	
Timely Payment of Claims	215 ILCS 5/357.1 215 ILCS 5/357.9	Claims shall be paid within 30 days following receipt of written due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day.	
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. 	

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Grace period for advance premium tax credit recipients	45 CFR 155.430 45 CFR 156.270	<p>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.</p> <p>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.</p>	
Exchange Required Grace period	45 CFR 155.430 45 CFR 156.270	<p>The Exchange may choose to require QHP issuers to provide all enrollees with grace period of three consecutive, regardless of advance payment status. However, it must be remembered that a QHP issuers must apply non-payment of premium policies, irrespective of Exchange standards, uniformly to all enrollees in similar circumstances.</p>	
Proof of Loss	215 ILCS 5/357.1 215 ILCS 5/357.8	Written proofs of loss should be submitted to the company within 90 days of loss.	
Physical examinations and autopsy	215 ILCS 5/357.1 215 ILCS 5/357.11	Insurers, at their own expense, have the right and opportunity to examine the insured when, and as reasonably often as required, during a claim's pending period. It may also conduct an autopsy in the case of death when law does not forbid it.	
Change of Beneficiary	215 ILCS 5/357.1 215 ILCS 5/357.13	The individual designating a beneficiary retains the right to change that designation unless he/she makes that designation irrevocable.	
Reinstatement	215 ILCS 5/357.1 215 ILCS 5/357.5	A policy may be reinstated with or without an application as provided.	

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Reinstatement for Military Service Member	215 ILCS 5/368f	No Illinois resident who is activated for military service (and no spouse or dependent of that resident) and who becomes eligible for a federal government-sponsored program as a result of that activation may be denied reinstatement to that same individual coverage with the health insurer after discharge unless the discharge is under less than honorable conditions.	
Extended age dependent continuation	215 ILCS 5/356z.12	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	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.	
Spousal Conversion	215 ILCS 5/356d	Policies of accident and health must contain a conversion provision, made available without evidence of insurability, for dependent spouses upon a valid judgment of dissolution of the marriage if such application is made within 60 days following the date of judgment.	

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Newborn Children	215 ILCS 5/356c	The policy must state newborns are covered from the moment of birth. If additional premium is required the 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 in the custody of the insured pursuant to an interim court order of adoption is considered an adopted child.	
Disabled Dependents	215 ILCS 5/356b	If a policy contains a provision for a limiting age for dependents, that provision will not be applicable to a handicapping condition that occurred before the attainment of the limiting age. This provision is only applicable for expense incurred policies.	
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.	
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 purposes.	
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.	

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Use of SSN on ID Cards	815 ILCS 505 2QQ 215 ILCS 139/15	<p>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:</p> <ul style="list-style-type: none"> • 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 • Printing an individual’s SSN on any materials mailed to an individual unless required by state or federal law. <p>Insurers must comply with both provisions.</p>	
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.	
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).	
Continuation of Care	45 CFR 156.230(d)(2)	A provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause. Must allow an enrollee in active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. See referenced statute for definition of on-going course of treatment.	

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Provider Termination	§156.230(d)	Written notices of termination of a discontinued provider 30 days prior to the effective date of the change or otherwise as soon as practicable to all enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause.	
OUT-OF-POCKET EXPENSE			
Out-Of- Pocket Expense	§1302(e) of the ACA 26 U.S.C. §36B(c)(3)	These plans would offer less coverage but at a lower premium. Their coverage level would be set at the HAS current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible.” http://www.kff.org/healthreform/upload/7908-02.pdf . 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. These catastrophic plans are also not eligible for premium tax credits as the Internal Revenue Code provides for a refundable credit for coverage under a Qualified Health Plan, and the code provided that the term Qualified Health Plan does not include a catastrophic plan described in §1302(e) of the ACA, 26 U.S.C. §36B(c)(3).	
HIPAA REQUIREMENTS			
HIPAA REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	
Pre-Existing Conditions	ACA	Pre-existing condition exclusions are no longer permitted.	
Definition of Individual Health Plan	215 ILCS 97/5	“Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.	

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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; or 5. Association membership ceases.	
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.	
AMBULATORY PATIENT SERVICES			
BENEFIT	BENCHMARK REQUIREMENT	CONDITIONS FOR COVERAGE OR LIMITATIONS	
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	

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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.	
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.).	

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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			
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.	

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HOSPITALIZATION			
Inpatient medical and surgical care	Yes		
Assistant Surgeon/ Surgical Assistant	Yes	Registered Surgical Assistant	
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	

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Anesthesia	Yes		
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.	

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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.	
Blood transfusions	Yes		
Hospice	Yes	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. Coverage includes: *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			

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Alcoholism and Drug Abuse	215 ILCS 5/330c(2.5) 215 ILCS 5/370c(5.5) HB 1 (effective 9.9.15)	Coverage must include diagnosis, detoxification and treatment of medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. The ACA requires coverage of ten essential benefits including mental health and substance use disorder (MH/SUD) services by individual and small group policies. Substance Use Disorder is defined by 5/370c(2.5) as: <ul style="list-style-type: none"> • Substance abuse disorders; • Substance dependence disorders; • Substance induced disorders. Acute treatment Services and Clinical Stabilization services for SUD must be provided. 215 ILCS 5/370c(5.5).	
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<p>Mental Health Mental Health Substance Use Disorder Parity</p>	<p>215 ILCS 370c and c.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 5/370c	Shall offer for individual and group health and accident policies for coverage for medically necessary services.	
Emergency MH/SUD Admission	Yes		
Partial Hospitalization	Yes	Both In-network and out-of-work benefits are required under HB 1. Out-of-network benefits may apply.	
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	
Electroconvulsive Therapy	Yes		

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<p>Other MH/SUD Exclusions (this is not an exhaustive list)</p>		<p>Exclusions include but may not be limited to:</p> <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. 	
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PRESCRIPTION DRUGS			
Retail	Yes		
Mail Order		Plans cannot require the use of mail order only.	
Generic	Yes		
Brand	Yes		
Specialty	Yes		

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Self-Injectable medications	Yes		
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			

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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.	
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		
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.	

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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		
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		
Hearing Aids	Yes		
Cochlear Implants/Bone Anchored	Yes	Covers Osseo integrated auditory implants	
LABORATORY SERVICES			
Lab Tests, X-ray services and Pathology – Inpatient/Outpatient	Yes		Inpatient -- Outpatient --
Imaging/Diagnostics (eg. 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.	

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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.	
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)	<p>*Coverage of screening by low-dose mammography (including 3D mammograms or breast tomosynthesis for all women over 35);</p> <p>*Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older</p> <p>*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> <p>*Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described.</p> <p>*Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.</p> <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	

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Diabetes Care Management	Yes		
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.	
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.	

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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			
Change of Occupation	215 ILCS 5/357.15	An insured who is injured or becomes sick after having changed occupations to one classified as either more or less hazardous, will have a suitable premium adjustment made as provided.	
Misstatement of Age	215 ILCS 5/357.16	If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.	
Other Insurance in Company	215 ILCS 5/357.17	Excess coverage protection provisions.	
Insurance with Other Companies	215 ILCS 5/357.18 215 ILCS 5/357.19	Excess coverage protection provisions for insurance with other companies for expense incurred type policies and for indemnity type policies.	

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Unpaid Premium	215 ILCS 5/357.21	Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted.	
Cancellation	215 ILCS 5/357.22	Cancellation provisions with prior notification requirements. Subject to HIPAA requirements.	
Disclosure of Conformity with State Statutes	215 ILCS 5/357.23	Any provision of the policy, which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.	
Illegal Occupation	215 ILCS 5/357.24	An insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Pro-rata Refund	215 ILCS 5/357.31	Insurers must provide pro-rata refunds of premium upon receipt of proper notification of insured's death. Refund may not be based on short-rate table.	
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."	

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Precertification penalties	215 ILCS 5/143(1)	The Division will permit a failure to pre-certify a hospital admission penalty of the lesser of up to \$1,000 or 50% of the billed charge. The penalty may be no more frequent than a per confinement basis.	
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.	