Illinois Department of Insurance

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Governor

ANN GILLESPIE
Director

TO: All Health Insurance Issuers Writing Accident and Health Insurance and Health Maintenance Organization Health Care Plans

FROM: Ann Gillespie, Director ARG

DATE: November 21, 2025

RE: Company Bulletin 2025-19 – Reimbursement for Travel, Food, & Lodging for Treatment of Mental Health and Substance Use Disorders (MHSUD)

The Department issues this Company Bulletin to provide guidance to health insurance issuers subject to the Network Adequacy and Transparency Act (NATA) of their obligation to implement a process for beneficiaries seeking benefits for medically necessary mental, emotional, nervous, or substance use disorders or conditions to claim reasonable reimbursement for travel, food, and lodging, when the beneficiary would need to wait longer than ten (10) business days for an in-network appointment or travel in excess of time or distance standards because the plan's network does not have a proximate preferred provider or facility available to provide the requested care in a timely manner.

Pursuant to Public Act 104-0028, a plan or policy effective on or after January 1, 2026, must provide reasonable travel, food, and lodging reimbursements to beneficiaries who have sought and have been granted a mental health and substance use disorder (MHSUD)-related network exception, as outlined in Section 215 ILCS 124/10(d-5)(3)(A)(i) through (iv).

For travel occurring outside of Illinois or more than 100 miles from the beneficiary's residence, the issuer may deny reimbursement unless the beneficiary has made a good faith effort to locate a provider within that distance who is available to provide the medically necessary health care service within ten (10) business days. In the absence of a specific administrative rule, the Department will accept an interpretation that "good faith effort" means "…accessing the provider directory, calling the network plan, and calling the provider…" as provided in 215 ILCS 124/10(b)(6).

If the issuer denies the claim for reimbursement, the issuer must provide the beneficiary a reasonable time to appeal the denial. Although the claims for travel, lodging, and food are not themselves subject to utilization review based on medical necessity, in the absence of a specific administrative rule for this type of claim, the Department will accept the minimum "60 days following receipt of a notification of" denial found in 29 C.F.R. 2560.503-1(h)(2)(i) as a reasonable time to appeal.

Issuers are reminded that **at the time** the MHSUD network exception has been granted, the issuer must provide written notification to the beneficiary of their potential eligibility for reimbursement related to travel, food, and lodging. The notification must comply with the template criteria specified at the end of

this bulletin. To comply with the requirement to provide the written notification at the time the network exception has been granted, the issuer must, in addition to having the notification posted on its website, send the notice directly to the beneficiary through their normal postal or electronic transmission method for similar notices.

Issuers must allow the beneficiary at least 60 days to submit the reimbursement claim(s) after the last date of service for which the beneficiary travelled under the network exception. Except for this 60-day deadline, Illinois requirements generally applicable to health insurance issuers for notices of claims, claim forms, proofs of loss, and timeliness of payment apply to reimbursement claims filed under 215 ILCS 124/10(d-5)(3).

All eligible food and lodging reimbursement shall be paid at the current prevailing rates in effect at the time and location the expenses were incurred as set forth by the United States General Services Administration.

Mileage reimbursement by vehicle shall be paid at the current per mile amount in effect at the time the services were rendered as set forth by the Internal Revenue Service self-employed standard mileage rates.

Nothing prevents the issuer from requiring the submission of receipts for eligible reimbursement items.

The following criteria comprise the template that the issuer's reimbursement notification form **must** follow under 215 ILCS 124/10(d-5)(3)(A)(ii). All information below should be presented in plain language and should be printed in no less than a 14-point font. The Department may amend this template with advance notice to issuers.

- Legal name of the risk-bearing entity - use of the risk-bearing entity's logo is acceptable; the issuer may include its trade name or group name in addition to its legal name;
- Address of plan or issuer;
- Title: "Notice of Potential Eligibility for Travel Reimbursement"
- Statement acknowledging the beneficiary has been granted a network exception to obtain mental health or substance use disorder services from a non-preferred provider at the in-network benefit level, and that the beneficiary may be eligible for reasonable reimbursement of food, travel, and lodging expenses for travel to and from a non-preferred provider whom the beneficiary visits under the network exception. If the network exception only applies to one or more specific non-preferred providers, for example when an HMO requires the use of a non-preferred provider for whom the beneficiary has received a referral, the notification should be clear that travel-related reimbursement is only available related to visits to non-preferred providers within the scope of the network exception;
- Instructions on how to file a claim for reimbursement, including:
    - Weblink for the beneficiary to access the claim form for travel-related reimbursement;
    - Phone number for the beneficiary to request the hard copy version of the claim form;
- Disclosure regarding the use of United States General Services Administration prevailing rates for food and lodging based upon the location where expenses were incurred;
- Disclosure regarding the use of federal Internal Revenue Service self-employed standard mileage rates;
- Disclosure that the beneficiary must submit the claim form within 60 days of the date of the last date of the health care service for which the beneficiary travelled;
- Disclosure that, if the beneficiary seeks care outside of Illinois or more than 100 miles from the beneficiary's residence, the issuer may deny reimbursement of travel-related expenses unless the

beneficiary demonstrates that a "good faith effort" was made to obtain the health care service from a non-preferred provider within Illinois or within 100 miles of the beneficiary's residence. The notification should expressly identify the steps involved in making a "good faith effort." This bullet point does not apply if an issuer voluntarily chooses not to require beneficiaries to demonstrate a good faith effort for non-participating providers outside Illinois or more than 100 miles from the beneficiary's residence;

- Disclosure that the beneficiary may appeal a denial of reimbursement and that instructions on how to appeal will be provided in the notice of denial;
- An issuer may choose to include additional information specific to a beneficiary or to a beneficiary's plan so long as it does not conflict with the criteria in this template.

Please direct questions regarding this Bulletin to DOI.InfoDesk@illinois.gov.