



Illinois Department of Insurance

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TO: All Companies Writing Accident and Health Insurance; Self-funded Counties, Municipalities, and School Districts; Health Care Preferred Provider Program Administrators; Third Party Administrators; and Other Contracted Third Parties

FROM: Ann Gillespie, Director *ARG*

DATE: September 11, 2026

RE: Company Bulletin 2026-12 Guidance on Implementation of HB 1085

This bulletin clarifies provisions of 215 ILCS 5/370c.4, which was added by HB 1085 and ultimately enacted as [Public Act 104-0446](#). Although the legislation nominally became law effective June 1, 2026, Section 370c.4 of the Illinois Insurance Code only imposes requirements on insurers and contracted third parties in relation to group or individual policies amended, delivered, issued, or renewed on or after January 1, 2027.

Section 370c.4 establishes requirements related to the administration of coverage for mental health and substance use disorder (MH/SUD) treatment in the areas of:

- Reimbursement rate floors for participating providers [Subsection (b)]
- Same-day services provided on an outpatient and inpatient basis by the same provider or facility [Subsection (c)]
- Services furnished by behavioral health trainees working under the supervision of a fully licensed provider [Subsection (d)]
- 60-minute psychotherapy sessions billed using Current Procedural Terminology (CPT) Code 90837 [Subsection (e)]
- Contracting and credentialing processes in applying to become a participating provider, as well as claims for MH/SUD services submitted after the contract takes effect [Subsection (f)]

To the extent Sections 370c and 370c.1 of the Illinois Insurance Code subsume prevention, screening, management, and diagnosis under the scope of “treatment” of MH/SUD conditions, the Department recognizes such services as within the scope of “treatment” under Section 370c.4, too.

For the sake of simplicity, this bulletin will consistently refer to the coverage document issued by an insurer to a policyholder as a “policy” or “plan” and the agreement signed by a provider or third party as a “contract.”

I. Policy and Plan Applicability

Section 370c.4 applies to group or individual policies written under Class 1(b) or 2(a) of 215 ILCS 5/4 that use any sort of health care preferred provider program under 215 ILCS 5/Art. XX 1/2, often referred

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to as Preferred Provider Organization (PPO) policies. Additionally, subsections (c), (d), and (e) of Section 370c.4 do not depend on the existence of a direct or indirect contractual relationship between an MH/SUD provider and an insurer. Therefore, subsections (c), (d), and (e) also apply to group or individual non-network indemnity health insurance policies written under Class 1(b) or 2(a) of 215 ILCS 5/4. **Section 370c.4 does not apply to HMO health care plans.**

Because of incorporations by reference in 55 ILCS 5/5-1069.3, 65 ILCS 5/10-4-2.3, and 105 ILCS 5/10-22.3f, self-funded group health plans offered for the employees of Illinois counties, municipalities, and school districts trigger the provisions of Section 370c.4 of the Illinois Insurance Code if the plan provides MH/SUD on a non-network indemnity, PPO, or similar basis.¹ Nothing in those statutes exempts any fully-insured policy of accident and health insurance, or the insurer of such policy, from the provisions of Section 370c.4, even if the coverage is issued for a county, municipality, or school district.

Pursuant to 215 ILCS 5/121-2, 5/121-2.05, 5/122-1 – 5/122-4, 5/352b, and 5/370c.4(j), HB 1085 does not apply in relation to:

- Excepted benefits (e.g., workers compensation, dental-only, hospital indemnity, Medigap, etc.)
- Medicaid or All-Kids
- Medicare
- Tricare
- Federal Employee Health Benefits Program
- Any self-funded group health plan that is not for the employees of Illinois counties, municipalities, and school districts
- Any group or blanket policy situated outside Illinois that meets the criteria in [215 ILCS 5/121-2.05](#)²

II. Contracted Third Party Applicability

Section 370c.4 also applies to a policy or plan in relation to a “contracted third party administering the behavioral health benefits for the insurer.” This includes a health care preferred provider program administrator as defined at 50 Ill. Adm. Code 2051.220, a [third-party] administrator as defined at 215 ILCS 5/511.101(a), or any other third party with a contractual obligation to administer MH/SUD benefits for the insurer of the policy or plan. The statute applies regardless of whether the contracted third party administers only MH/SUD benefits or administers a combination of MH/SUD and other health benefits under the policy.

Please note that the applicability of Section 370c.4 to a “contracted third party administering the behavioral health benefits for the insurer” is not limited to third parties that have a direct contract with the provider. For example, subsection (b) pertains to the amount of reimbursement in each instance of a covered claim. If the third party determining whether or how much a provider will be reimbursed for a covered claim is administering behavioral health benefits for an insurer of a policy or plan subject to Section 370c.4, then the third party’s conduct will be subject to Section 370c.4(b) to ensure that the amount of reimbursement for MH/SUD services is no less than the rate floor established by that subsection.

¹ Self-funded group health plans for counties, municipalities, and school districts that are subject to Section 370c.4 may also have an Exclusive Provider Organization (EPO) network structure.

² For example, if an insurer issues a group PPO policy to an employer with a situs in another state, that policy generally will not be subject to Section 370c.4 even if the policy covers an employee who is an Illinois resident.

III. Provider Applicability

Section 370c.4 addresses the relationship among mental health and substance use disorder treatment providers, the insurer or its contracted third party, and the MH/SUD benefits provided by the insured or enrollee's coverage.

Subsection (b) applies only with respect to participating providers, and subsection (f) applies only with respect to applying providers and participating providers.

In contrast, the language of subsections (c), (d), and (e) does not depend on the involvement of a participating provider or applying provider. If a policy or plan provides out-of-network or non-network coverage, those subsections apply to such coverage.

A. Participating Provider

The statute defines “participating provider” as a “mental health or substance use disorder treatment provider that has a contract to provide mental health or substance use disorder services with an insurer.” 215 ILCS 5/370c.4(a).

Even if a provider's contract is not entered directly with an insurer, the provider is a participating provider whose MH/SUD services are subject to the entirety of Section 370c.4³ if the provider contracts with a third party “to provide mental health or substance use disorder services with an insurer.” *Id.* This assumes that the provider is furnishing those MH/SUD services under a policy or plan that, itself, is subject to Section 370c.4.

B. Applying Provider

Similarly, the statute defines an “applying provider” as a “provider or facility that has submitted a completed application to become a participating provider or facility with an insurer.” *Id.*

Even if a provider does not submit its application directly to an insurer, or even if the application is not submitted for the purpose of entering a contract directly with an insurer, a provider is an applying provider if it has submitted a “completed application to become a participating provider or facility with an insurer.” *Id.* This provision depends on the meaning of “participating provider” within the context of Section 370c.4. Thus, it includes a provider's, including a facility's, applications to contract with a third party, such as a health care preferred provider program administrator, where such contract is the means “to provide mental health or substance use disorder services with an insurer,” assuming services are furnished under the insurer's policy or plan that is subject to Section 370c.4. The statute applies with respect to policies or plans that are amended, delivered, issued, or renewed on or after January 1, 2027.

C. Mental Health or Substance Use Disorder Treatment Provider

Section 370.4(a) does not contain a definition of “mental health or substance use disorder treatment provider,” which is a term repeatedly used in the Section. However, subsection (d) elaborates that the term includes the following:

“mental health or substance use disorder treatment provider who is a:

[1] physician licensed to practice medicine in all its branches,

³ Other than clauses within subsection (f) that only apply to a provider while it is an applying provider.

- [2] licensed clinical psychologist,
- [3] licensed clinical social worker,
- [4] licensed clinical professional counselor,
- [5] licensed marriage and family therapist,
- [6] licensed speech-language pathologist, or
- [7] other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act

who is engaged in treating mental, emotional, nervous, or substance use disorders or conditions.”

215 ILCS 5/370c.4(d). Therefore, whenever Section 370c.4 refers to a mental health or substance use disorder provider, it at least includes any of the license or certification types listed above, including the non-specific types encompassed by [7].

Section 370c.4(d) does not address facilities, and neither does subsection (e). However, subsections (b), (c), and (f) clearly refer to facilities, as do the definitions of “applying provider,” “completed application,” and “contracting process,” in subsection (a).

Subsection (d) relates to whether an MH/SUD service would be covered if furnished by a behavioral health trainee under the supervision of a fully-licensed MH/SUD provider. It does not depend on facility affiliation, though the supervising provider’s own affiliation may affect whether the behavioral health trainee’s service counts as having been furnished by a participating provider. As for subsection (e), nothing appears to depend on what facility the furnishing health care professional is affiliated with if the policy or plan otherwise covers the 60-minute psychotherapy service billed using CPT Code 90837.

Therefore, except in subsections (d) and (e), the Department understands the phrase “mental health or substance use disorder treatment provider” to include facilities. Namely, it includes facilities that employ or directly or indirectly contract with the types of health care professionals listed in subsection (d) to provide MH/SUD treatment.

IV. Reimbursement Rate Floor

A. In General

Section 370c.4(b) requires insurers and any contracted third party administering behavioral health benefits for the insurer to comply with “reimbursement rate floors for all **in-network** mental health and substance use disorder services, including inpatient services, outpatient services, office visits, and residential care.”

This means that “reimbursement for each service...must be equal to *or* greater than the dollar amounts applicable under this subsection on the date of service for the geographic location” (emphasis added) *Id.* For fully-insured policies that use participating providers, the provisions of Section 368b of the Illinois Insurance Code [[215 ILCS 5/368b](#)] continue to apply to fee schedules during the provider contracting process and to changes to the fee schedule under an existing provider contract.

Even if the fee schedule in effect on the date of service specifies a reimbursement rate for an MH/SUD service that is below the rate floor applicable for the geographic location, the insurer or third party nevertheless must pay the participating provider or facility at least the rate floor dollar amount. Failure to update a nonconforming fee schedule will not defer the insurer or contracted third party’s obligation to comply with the rate floor when actually paying benefits. Nothing relieves an insurer or contracted

third party from the obligation to meet required deadlines related to changes to a fee schedule provided in Section 368b(d) of the Illinois Insurance Code.

However, if the fee schedule provides a reimbursement rate “equal to *or* greater than” the rate floor, then that rate will apply because the contract already complies with the statute.

Section 370c.4(b) applies to group or individual policies that are amended, delivered, issued, or renewed on or after January 1, 2027. This means that the deadline by which insurers and their contracted third parties must comply with the rate floor is based on the start of the plan year or policy year of the underlying coverage, not the date a provider contract is up for renewal.⁴

- If an individual or employer with a policy subject to Section 370c.4 has their coverage amended, delivered, issued, or renewed on January 1, 2027, then the insurer or contracted third party must comply with the rate floor with respect to in-network MH/SUD services covered under that policy by January 1, 2027.
- If an individual or employer with a policy subject to Section 370c.4 does not have their plan or policy year start until a date later than January 1, 2027 and before January 1, 2028, then the insurer or contracted third party must comply with the rate floor with respect to in-network MH/SUD services covered under that policy by the mid-2027 start of that plan or policy year. This latter situation may happen in some group policies or in grandfathered policies in the individual market.

Nothing in the statute prevents an insurer from paying at least the rate floor dollar amount before the compliance deadline.

B. Methodology to Determine the Dollar Amount of the Reimbursement Rate Floor

Insurers and contracted third parties must calculate the dollar amount of the reimbursement rate floor for a covered MH/SUD service using the methodology described in Section 370c.4(b). The Department does not intend to publish a complete set of reimbursement rate floor dollar amounts.

Subsection (b) provides that the dollar amount of the rate floor for an MH/SUD service shall be calculated by multiplying a specified percentage against a “benchmark rate” for that service. The statute refers to the Research Triangle Institute (RTI) International's April 2024 study entitled “[Behavioral Health Parity - Pervasive Disparities in Access to In-Network Care Continue](#)” (hereinafter, the “RTI study”) both for calculating the percentage and to determine the source of the benchmark rate.

1. The Percentage

After doing the calculation prescribed by the statute, the applicable percentage is always 141.7%. Section 370c.4(b)(1)(A) requires two figures from the RTI study to be added together to arrive at the applicable percentage:

⁴ However, if the provider contract were amended to provide a reimbursement rate greater than the rate floor, the change to the reimbursement rate would take effect based on the terms of the contract amendment.

“(A)(i) the average reimbursement percentage for Illinois All Medical/Surgical Clinicians, as listed on the first line of Appendix C-13, page C-52 of the Research Triangle Institute International study, plus;
(ii) half of the difference between the average reimbursement percentage and the percentage at the 75th percentile for Illinois All Medical/Surgical Clinicians, as listed in the first line in Appendix C-13, page C-52...”

On the first line of Appendix C-13, page C-52 of the RTI study, the average reimbursement percentage for Illinois All Medical/Surgical Clinicians is listed as 132.0.

On the first line of Appendix C-13, page C-52 of the RTI study, the 75th percentile for Illinois All Medical/Surgical Clinicians is listed as 151.4.

The difference between the 75th percentile and the average reimbursement percentage is 19.4. Half of that difference equates to 9.7.

Therefore, the sum of subsection (b)(1)(A)(i) and (b)(1)(A)(ii) is $132.0 + 9.7 = 141.7$.

2. *The Benchmark Rate*

To arrive at the reimbursement rate floor, the statute requires the above percentage to be multiplied by a “benchmark rate” that must be calculated based on the “methodologies used in the Research Triangle Institution study using comparable benefits within the same classification.” 215 ILCS 5/370c.4(b)(1). The RTI study’s “source of the benchmark rate that was used to calculate the percentages in items (i) and (ii) of subparagraph (A),” which were 132.0 and 9.7, respectively, was Medicare fee-for-service (FFS) allowed amounts. *See* pp. 17-18 of the RTI study. **Therefore, the “benchmark rate” mentioned in Section 370c.4(b)(1)(B) and (b)(2) is the Medicare FFS allowed amount for medical/surgical clinicians that render comparable MH/SUD benefits within the same classification, using all applicable adjusters and outliers, which are in effect on the date of service for the geographical location.**

Under Section 370c.4(b)(1)(B), as applied to the RTI study, the benchmark rate depends on the type of service:

- A. Professional Services (CPT / HCPCS)
Benchmark = the updated medical/surgical clinician rate (e.g., Medicare Physician Fee Schedule) for the same code, on the date of service, for that geographic location.
- B. Hospital Inpatient (MS-DRG)
Benchmark = the rate produced by:
 - Medicare Acute Inpatient Prospective Payment System (IPPS)
 - Using all adjusters and applicable outliers
 - For that date and geographic location.
- C. Hospital Outpatient (APC)
Benchmark = the rate produced by:
 - Medicare Outpatient Prospective Payment System (OPPS)
 - With applicable adjusters/outliers.
- D. Other classifications (EAPG, APR-DRG) - Use the same benchmark methodology used in the RTI study.

When available and appropriate for the services rendered and billed by a participating provider, the Department expects insurers and their contracted third parties to use the following benchmark sources:

- Professional services (CPT/HCPCS):
 - o Medicare Physician Fee Schedule (MPFS) PFS Look-Up Tool
 - o PFS Relative Value Files
 - o MPFS datasets
- Hospital Inpatient Services Medicare Severity-Diagnosis Related Group (MS-DRG) / All Patient Refined Diagnosis Related Groups (APR-DRG)
 - o Federal CMS Hospital Inpatient Prospective Payment System (IPPS)
 - o Applicable FY IPPS Final Rule data files.
- Hospital Outpatient Services Ambulatory Payment Classifications (APCs)
 - o Medicare Outpatient Prospective Payment System (OPPS)
 - o Quarterly OPPS Addenda Updates
 - o Integrated Outpatient Code Editor (I/OCE)

3. Reimbursement Rate Floor Dollar Amount

The reimbursement rate floor dollar amount is 141.7% of the Medicare FFS allowed amount determined by the methodology described above. Because the RTI study ties the benchmark rate to Medicare, a federal health program, Section 370c.4(b)(2) prescribes that all rate floor dollar amounts in effect on January 1, 2027, are equal to 141.7% of the Medicare FFS allowed amount in effect on that date of service for the geographic location. After January 1, 2027, the statute requires a new or updated rate floor dollar amount for an MH/SUD service to take effect on the same date a new or updated Medicare FFS allowed amount takes effect for that service.

Section 370c.4(b) only provides a reimbursement rate floor for MH/SUD services that Medicare covers on an FFS basis. **If there is no Medicare FFS reimbursement rate for the MH/SUD service's CPT, HCPCS, MS-DRG, APC, EAPG, or APR-DRG code, then Section 370c.4(b) does not apply to that service;** the insurer or contracted third party paying for coverage of that service will apply the reimbursement rate from the fee schedule that the provider contract has adopted.

Please note further that Section 356z.22(d) of the Illinois Insurance Code [[215 ILCS 5/356z.22\(d\)](#)] requires:

For purposes of reimbursement, an individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall reimburse an in-network health care professional or facility, including a health care professional or facility in a tiered network, for telehealth services provided through an interactive telecommunications system on the same basis, in the same manner, and at the same reimbursement rate that would apply to the services if the services had been delivered via an in-person encounter by an in-network or tiered network health care professional or facility. This subsection applies only to those services provided by telehealth that may otherwise be billed as an in-person service. This subsection is inoperative on and after January 1, 2028, except that this subsection is operative after that date with respect to mental health and substance use disorder telehealth services.

As a result, even if Medicare would apply an adjuster or outlier to reduce the reimbursement rate for an MH/SUD service furnished via telehealth instead of in-person, Section 356z.22(d) still requires that, for Illinois-regulated policies, a participating provider that furnished an MH/SUD service via telehealth must be reimbursed at the same rate as if they provided that same service in-person.

V. Same-Day Services

The statute requires an insurer or contracted third party administering behavioral health benefits for the insurer to “...cover all medically necessary mental health or substance use disorder services received by the same insured on the same day from the same or different mental health or substance use provider or facility for both outpatient and inpatient care.” 215 ILCS 5/370c.4(c).

As a result, the statute prohibits reimbursement policies or other claims administration practices from denying or reducing coverage for a medically necessary mental health or substance use disorder service solely because another covered mental health or substance use disorder service from the same or different mental health or substance use provider or facility for both outpatient and inpatient care was provided on the same day. Reimbursement policies may bundle related covered services together as long as the bundling is not implemented in a manner that conflicts with the statute.

As described above in Section III of this bulletin, this requirement applies regardless of whether the providers or facilities are in-network or out-of-network or whether the insured has a non-network indemnity policy.

If the services are provided in-network, then Section 370c.4(b) also applies, including when related covered services are bundled together.

VI. Behavioral Health Trainees

The new law further requires an insurer or contracted third party administering behavioral health benefits for the insurer to “...cover any medically necessary mental health or substance use disorder service provided by a behavioral health trainee when the trainee is working toward clinical State licensure and is under the supervision of a fully licensed mental health or substance use disorder treatment provider...” of any of the types listed above in Section III.C of this bulletin “who is engaged in treating mental, emotional, nervous, or substance use disorders or conditions.” 215 ILCS 5/370c.4(d). The coverage requirement only applies if services provided by the trainee are billed under the supervising clinician’s rendering National Provider Identifier. *Id.*

As described above in Section III of this bulletin, this requirement applies regardless of whether the providers are in-network or out-of-network or whether the insured has a non-network indemnity policy.

VII. Psychotherapy

Section 370c.4(e) requires an insurer or a contracted third party administering the behavioral health benefits for the insurer to:

- “(1) cover medically necessary 60-minute psychotherapy billing using the Current Procedural Terminology Code 90837 for Individual Therapy;
- (2) not impose more onerous documentation requirements [for CPT Code 90837] on the provider than is required for other psychotherapy Current Procedural Terminology (CPT) codes; and

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(3) not audit the use of Current Procedural Terminology Code 90837 more frequently than audits for the use of other psychotherapy Current Procedural Terminology codes.”

As described above in Section III of this bulletin, this requirement applies regardless of whether the providers are in-network or out-of-network or whether the insured has a non-network indemnity policy.

VIII. Timely Credentialing and Payment of MH/SUD Providers

Section 370c.4(f) establishes detailed requirements related to the contracting and credentialing process for providers, including facilities, that furnish MH/SUD services under policies or plans that use provider networks.

1. Contracting and Credentialing Timeline

Paragraph (1) requires an insurer or any contracted third party administering the behavioral health benefits for the insurer to “complete the contracting process with a mental health or substance use disorder treatment provider or facility for becoming a participating provider in the insurer’s network, including the verification of the provider’s credentials, within 60 days from the date of a completed application to the insurer to become a participating provider.” 215 ILCS 5/370c.4(f)(1). This provision does not require that the application be submitted directly to an insurer. The insurer may delegate the collection or processing of applications to a contracted third party. Such delegation does not relieve the insurer of responsibility to ensure the contracted third party’s activities comply with applicable requirements.

As defined in Section 370c.4(a):

"Application" means a person's or facility's application to become a participating provider with an insurer in at least one of the insurer's provider networks.

"Completed application" means a person's or facility's application to become a participating provider that has been submitted to the insurer and includes all the required information for the application to be considered by the insurer according to the insurer's policies and procedures for verifying a provider's or facility's credentials.”

"Contracting process" means the process by which a mental health or substance use disorder treatment provider or facility makes a completed application with an insurer to become a participating provider with the insurer until the effective date of a final contract between the provider or facility and the insurer. "Contracting process" includes the process of verifying a provider's credentials.

As a result, Section 370c.4(f)(1) governs the contracting process, including the verification of a provider’s credentials, whenever a provider or facility submits a completed application to become a participating provider with respect to at least one of the provider networks used by the insurer for at least one of its policies or plans that is subject to Section 370c.4.

Paragraph (1) also states: “Nothing in this paragraph (1), however, presumes or establishes a contract between an insurer and a provider.” Even though the failure to complete the contracting and credentialing process within 60 days from the date of a completed application is a regulatory violation

that subjects an insurer or its contracted third party to civil penalties of \$1,000 per violation under Section 370c.4(g), **the statute does not deem a contract automatically to be in force solely because the insurer or contracted third party fails to reject the completed application within 60 days.**

The Department notes that, for physicians only, the Health Care Professionals Credentialing Act already requires:

Each health care entity and health care plan shall complete the process of verifying a health care professional's credentials data in a timely fashion and shall complete the process of credentialing or recredentialing of the health care professional within 60 days after submission of all credentials data and completion of verification of the credentials data.

410 ILCS 517/15(f). *See also* 77 Ill. Adm. Code 965.140(b). Nothing in the new Section 370c.4 of the Illinois Insurance Code prevents the Illinois Department of Public Health from enforcing this requirement of their statute. Additionally, the Health Care Professionals Credentialing Act requires the use of specific forms for the credentialing and recredentialing of physicians. 410 ILCS 517/15. Nothing in the new Section 370c.4 of the Illinois Insurance Code requires or prohibits the use of specific forms for any type of licensed, certified, or otherwise authorized health care professional, so it does not supersede the Health Care Professionals Credentialing Act's requirements for the uniform forms adopted thereunder, even for physicians that engage in the treatment of mental health and substance use disorders.

2. Coverage for Services While Completed Application Pending

Section 370c.4(f)(2) requires an insurer or contracted third party administering behavioral health benefits for the insurer to:

reimburse a participating mental health or substance use disorder treatment provider or facility at the contracted reimbursement rate for any medically necessary services provided to an insured from the date of submission of the provider's or facility's completed application to become a participating provider with the insurer up to the effective date of the provider's contract. **The provider's claims for such services shall be reimbursed only when submitted after the effective date of the provider's contract with the insurer.** This paragraph (2) does not apply to a provider that does not have a completed contract with an insurer. If a provider opts to submit claims for medically necessary mental health or substance use disorder services pursuant to this paragraph (2), the provider must notify the insured following submission of the claims to the insurer that the services provided to the insured **may be** treated as in-network services.

Please note that, to the extent the policy or plan includes coverage for the same MH/SUD service when furnished by non-participating providers, the policy or plan generally still must cover a medically necessary MH/SUD service at least at the out-of-network rate either if:

- A. the applying provider submits their claim before the effective date of their provider contract;
OR
- B. the applying provider's completed application to join the provider network is rejected altogether.

Because insurers and their contracted third parties are required to ensure that their contracts, including any incorporated fee schedules, provide reimbursement rates at no less than the reimbursement rate floor under Section 370c.4(b), those reimbursement rate floors also apply to an applying provider that becomes a participating provider and meets the criteria of Section 370c.4(f)(2).

3. Coverage When an Applying Provider Is Under the Supervision of a Participating Provider

Section 370c.4(f)(3) requires an insurer or contracted third party administering behavioral health benefits for the insurer to cover medically necessary MH/SUD services provided by a fully licensed applying provider before the provider's participating contract becomes effective, if the provider:

- A. has submitted a completed application,
- B. is supervised by a participating provider in the same group practice, AND
- C. the services are billed under the supervising provider's NPI.

4. Required Disclosures to Applying Providers

Section 370c.4(f)(4) requires an insurer or contracted third party administering the behavioral health benefits for the insurer to “provide an applying provider with the insurer’s credentialing policies and procedures.” To the extent an insurer has delegated responsibility to its contracted third party to develop or administer credentialing policies and procedures, those policies and procedures are imputed to the insurer for the purposes of Section 370c.4(f)(4).

Additionally, an insurer or its contracted third party must “...post the following nonproprietary information on its website and make that information available to all applicants:

- (A) a list of the information required to be included in an application;
- (B) a checklist of the materials that must be submitted in the credentialing process; and
- (C) designated contact information of a network representative, including a designated point of contact, an email address, and a telephone number, to which an applicant may address any credentialing inquiries.”

With respect to physicians, nothing in Section 370c.4(f)(4) generally waives constraints that the Health Care Professionals Credentialing Act may place on an insurer’s credentialing policies and procedures, such as what information or documentation the insurer would or would not be allowed to require in the checklist described in subparagraph (B) above.

The nonproprietary information posted to the insurer or contracted third party’s website is not necessarily the entirety of the credentialing policies and procedures. The statutory requirement to provide an applying the credentialing policies and procedures “upon request” is separate and independent of the statutory requirement to post certain nonproprietary information on its website.

IX. Conclusion

The Department will be monitoring compliance with the implementation of Public Act 104-0446 and will take appropriate enforcement action as provided by law, including, but not limited to, Section 370c.4(g) of the Illinois Insurance Code.

Consumers and MH/SUD providers and facilities may file complaints with the Department if an insurer or contracted third party is failing to comply with the coverage, reimbursement, or contracting and credentialing requirements of Section 370c.4 of the Illinois Insurance Code. Information about how to file a complaint is available on our website here: <https://idoi.illinois.gov/consumers/file-a-complaint.html>.

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