Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

Large Group PPO

Company Name:

SERFF Tracking #:

Checklist Directions

• The checklist corresponding with the TOI of the filing must be completed to indicate where in the filing the statutory requirements appear (e.g. form number, page number and section number).
IMPORTANT NOTICE: This Checklist does not include all requirements of Illinois laws, regulations or bulletins. Companies are responsible for reviewing Illinois laws, regulations and bulletins to ensure compliance with all statutory requirements for both benefits and company procedures.

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SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location in filing
a.1	Review Requirements Checklist	Review Requirements Checklists	A completed checklist must be attached in the appropriate section under the Supporting Documentation tab in the SERFF filing. Filings submitted without the correct completed checklist for the product included in the filing will be rejected.	
a.2	Certificate of Compliance	50 IAC 916.50	Each company doing business in the State of Illinois shall submit with each form filing a Certificate of Compliance under the Supporting Documentation Tab, as described in Section 916.50 and Exhibit A.	
a.3	Rate Filing	215 ILCS 5/355	Provide the SERFF Tracking # of the Rate filing.	SERFF Tracking #
a.4	External Review Filing	215 ILCS 180 50 IAC 4530.40	Companies must file all required sample notices found on the External Review Checklist.	SERFF Tracking #
a.5	Network Filing Required	215 ILCS 124 et. Al.	Provide SERFF tracking number for Network Adequacy and Transparency Act required filing.	SERFF Tracking #
a.6	Letter of Submission	50 IAC 2001.130(a)(3)	The insurer shall file a letter of submission, or provide the following information in the "Filing Description" field under the "General Information" tab in the SERFF, containing: The name of the form, if any, and identifying form #; Whether the submission is a new form; If the form is intended to supersede another, the number of the form replaced and the date it was approved by the Department, with all changes from the previously approved form highlighted.	

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a.7	Summary of Benefits & Coverage	215 ILCS 5/355a(5)(a) 215 ILCS 5/355a(5)(b) 50 IAC 2007.80(b) & (g)	No policy shall be delivered or issued for delivery in this State unless an outline of coverage either accompanies the policy, or is delivered to the applicant at the time the application is made, and an acknowledgment signed by the insured, of receipt of delivery of the outline is provided to the insurer	
a.8	Mental Health/Substance Use Disorder – Supporting Documentation Template	Mental Health Parity Checklist	Issuers must complete and attach the Mental Health/Substance Use Disorder – Supporting Documentation Template under the Supporting Documentation tab of this filing.	Affirmed
a.9	Mental Health Parity Methodology	45 CFR 146.136	Carriers must provide methodology for determination of parity of benefits with the filing under the appropriate section of the supporting documentation in this filing. These documents may be marked as proprietary information.	Affirmed
a.10	Form of Policy	215 ILCS 5/356(a)	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.	Affirmed
a.11	Form Numbers	215 ILCS 356a(1)(f) 50 IAC 916.40(b)(2)(A) 50 IAC 2001.130(a)(2)	Each form must bear an identifying form number in the lower left corner of the first page. Form numbers are limited to 30 characters.	Affirmed
a.12	POS Indemnity policy		If PPO policy serves as POS indemnity associated policy for an HMO/POS plan, this filing must have a POS sub-TOI. Additionally, please provide SERFF tracking number of the associated HMO filing with POS sub-TOI that serves as the base for the POS plan.	SERFF Tracking #
SECTION B - CONTRACTUAL POLICY REQUIREMENTS				
b.1	Civil Union	750 ILCS 75/10 750 ILCS 75/20	Any definition or use of the terms “spouse,” “family,” “immediate family,” “dependent,” “next of kin,” and other terms descriptive of spousal relationships must include the term "Civil Union." This includes the terms “marriage” or “married,” or variations thereon. All contracts of insurance issued by Illinois-licensed insurers on Illinois risks must comply with the Act.	
b.2	Discrimination	215 ILCS 5/364 50 IAC 2603	PROHIBITED	
b.3	Pre-Existing Condition Exclusion	50 IAC 2001.5 215 ILCS 97/20	PROHIBITED	
b.4	Discretionary Clauses Prohibited	50 IAC 2001.3	PROHIBITED	
b.5	Entire Contract	215 ILCS 5/357.2	ILLINOIS STATUTORY LANGUAGE REQUIRED: ENTIRE CONTRACT; CHANGES This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."	
b.6	Time Limit on Certain Defenses	215 ILCS 5/357.3 42 USC 300gg-12	ILLINOIS STATUTORY LANGUAGE REQUIRED: "INCONTESTABLE" "After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is a person with a disability), it shall become incontestable as to the statements contained in the application." "No claim for loss incurred or disability (as defined in the policy) commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."	
b.7	Grace Period Requirement	215 ILCS 5/357.4	ILLINOIS STATUTORY LANGUAGE REQUIRED: "GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies,"10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."	

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b.8	Reinstatement	215 ILCS 5/357.5	ILLINOIS STATUTORY LANGUAGE REQUIRED: "REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the company or by any agent duly authorized by the company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the company or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."	
b.9	Notice of Claim	215 ILCS 5/357.6	ILLINOIS STATUTORY LANGUAGE REQUIRED: "NOTICE OF CLAIM: Written notice of claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the company at ....(insert the location of such office as the company may designate for the purpose), or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company."	
b.10	Claims - Claim Forms	215 ILCS 5/357.7	ILLINOIS STATUTORY LANGUAGE REQUIRED: "CLAIM FORMS: The company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."	
b.11	Claims - Proof of Loss	215 ILCS 5/357.8	ILLINOIS STATUTORY LANGUAGE REQUIRED: "PROOFS OF LOSS: Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."	
b.12	Claims - Timely Payment	215 ILCS 5/368a(c) 215 ILCS 5/357.9	ILLINOIS STATUTORY LANGUAGE REQUIRED: "TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid .... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof."	

b.13	Claims - Payment of Claims to Beneficiary, Estate, etc.	215 ILCS 5/357.10	ILLINOIS STATUTORY LANGUAGE REQUIRED: "PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured." OPTIONAL: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the company may pay such indemnity, up to an amount not exceeding $....(insert an amount which shall not exceed $1000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the company to be equitably entitled thereto. Any payment made by the company in good faith pursuant to this provision shall fully discharge the company to the extent of such payment. "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the company's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. Nothing in this provision shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person."	
b.14	Physical Examinations and Autopsy	215 ILCS 5/357.11	ILLINOIS STATUTORY LANGUAGE REQUIRED: "PHYSICAL EXAMINATIONS AND AUTOPSY: The company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."	
b.15	Legal Action	215 ILCS 5/357.12	ILLINOIS STATUTORY LANGUAGE REQUIRED: "LEGAL ACTIONS: No civil action shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished."	
b.16	Change of Beneficiary	215 ILCS 5/357.13	ILLINOIS STATUTORY LANGUAGE REQUIRED: "CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy." (The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the company's option.)	
b.17	Misstatement of Age	215 ILCS 5/357.16	ILLINOIS STATUTORY LANGUAGE REQUIRED: "MISSTATEMENT OF AGE: 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."	
b.18	Other Insurance in Company	215 ILCS 5/357.17	ILLINOIS REQUIRED STATUTORY LANGUAGE: "OTHER INSURANCE IN THIS COMPANY: If an accident or health or accident and health policy or policies previously issued by the company to the insured be in force concurrently herewith, making the aggregate indemnity for ....(insert type of coverage or coverages) in excess of $....(insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate." or, in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such policies."	

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b.19	Coordination of Benefits	215 ILCS 5/367(11a) 215 ILCS 5/367(11b) 50 IAC 2009 - Exhibit A	Policies are permitted, but not required, to contain coordination of benefits (COB) provisions consistent with the requirements of 50 IAC 2009.	
b.20	Insurance with Other Companies	215 ILCS 5/357.18 215 ILCS 5/357.19	OPTIONAL - *If included* , policy must contain statutory required language. "No policy shall reduce benefits solely on account of the existence of similar benefits provided under other policies where such reduction would reduce total benefits payable below an amount equal to 100% of total allowable expenses provided under the policies. Establishes the "birthday rule" for dependents covered under the policies."	
b.21	Reimbursement Provisions	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.40	OPTIONAL - *If included* , policy must contain statutory required language. 1). "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability." 2). "If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, covered person's parents if the covered person is a minor, or covered person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability."	
b.22	Subrogation Provision	215 ILCS 5/357.18 215 ILCS 5/357.19 50 IAC 2020.50	OPTIONAL - *If included* , policy must contain statutory required language. In addition to any other requirements set forth in the Code or Department's regulations, if an insurer includes a subrogation provision in its policy, that provision shall be in the form as follows: "We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability."	
b.23	Relation of Earnings to Insurance	215 ILCS 5/357.20	ILLINOIS REQUIRED STATUTORY LANGUAGE: "If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is greater, the company will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."	

b.24	Premium – Unpaid	215 ILCS 5/357.21	ILLINOIS REQUIRED STATUTORY LANGUAGE: "UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."	
b.25	Cancellation	215 ILCS 5/357.22	ILLINOIS REQUIRED STATUTORY LANGUAGE: "The company may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the company, stating when, not less than 30 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the company, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the company will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the company cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation."	
b.26	Disclosure of Conformity with State Statutes	215 ILCS 5/357.23	ILLINOIS STATUTORY REQUIRED LANGUAGE: "CONFORMITY WITH STATE STATUTES: Any provision of this 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."	
b.27	Illegal Occupation	215 ILCS 5/357.24	ILLINOIS STATUTORY REQUIRED LANGUAGE: "ILLEGAL OCCUPATION: The company 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."	
b.28	Termination of policy	215 ILCS 97/30	A health insurer issuing group coverage must renew or continue in force coverage at the option of the individual except for: 1. Nonpayment of premium, 2. Group Contract Cancellation, 3. Termination of the plan, 4. Fraud, 5. Movement outside the service area; or 5. Association membership ceases. (This may be in the group agreement)	
b.29	Notice of Department of Insurance	215 ILCS 5/143c 50 IAC 931.40	Policy must provide the address of complaint department of the insurance company and the address of the Illinois Department of Insurance: The Illinois Department of Insurance Office of Consumer Health Insurance 320 West Washington Street Springfield, IL 62767	
SECTION C - NETWORK POLICY REQUIREMENTS				
c.1	Provider Termination - Transition of Care	45 CFR 156.230(d)(2) 215 ILCS 124/20(a) & (b)	Policy must contain a provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause or for new members whose provider is not a member of the plan's network. 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.	
c.2	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.	

c.3	Limited Benefit Disclosure	215 ILCS 5/356z.3	ILLINOIS STATUTORY LANGUAGE REQUIRED: Policies must include the following disclosure on its contracts and all evidence of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON- PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of the Illinois Insurance Code. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card."	
c.4	Emergency Services Incurred with Non-Participating Providers	50 IAC 2051.310(a)(6)(J) 50 IAC 4520.110(c) 215 ILCS 124/10(b)(7)	Policy must state that benefits for emergency care received from non-participating provider must be paid at no greater out-of-pocket to the member than had a participating provider been utilized.	
c.5	Notice of Provider Nonrenewal or Termination	215 ILCS 124/15(a)	A health care plan is required to provide 60 days' notice of nonrenewal or termination of a health care provider to both the provider and to his/her enrollees. *Applies to all plans with provider networks with effective dates of 01/01/2019 or later pursuant to passage of the Network Adequacy and Transparency Act (215 ILCS 124)	
SECTION D - MEMBERSHIP/ELIGIBILITY/COVERAGE PERIOD				
d.1	Dependent Children - Adopted (and Pending) and Foster Child	215 ILCS 5/356h 26 USC 152(f)(c) 42 USC 300gg-91(d)(12)	A policy that covers the insured's immediate family or children must provide the same coverage for an adopted child or a child not residing with the insured.	
d.2	Dependent Children - Disabled	215 ILCS 5/356b 215 ILCS 5/367b	If a policy contains a provision for a limiting age for dependents, that provision will not be applicable to a disabling condition that occurred before the attainment of the limiting age.	
d.3	Dependent Children - Newborn	215 ILCS 5/356c	A policy of accident and health insurance shall cover the hospital or medical expenses of newborn infants from and after the moment of birth. To guarantee coverage from the moment of birth, the insured must apply for coverage for the newborn within 31 days of birth.	
d.4	Dependent Children Covered to Age 26 or 30	215 ILCS 5/356z.12	A policy that includes dependent coverage must offer coverage to all dependents up to age 26, regardless of marital status, financial dependency on parents or residence. Policies must include coverage for dependents up to age 30, who is an Illinois resident, who has been released from military service other than dishonorable discharged.	
d.5	Continuation of Coverage	215 ILCS 5/367e	A group policy insures employees or members shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership or because of a reduction in hours below the minimum required by the group plan shall be entitled to continue their coverage for themselves and their eligible dependents.	
d.6	Spousal Continuation Privilege	215 ILCS 5/367.2	Policy must provide for a continuation of the existing insurance benefits for an employee's spouse and dependent children who are insured under the provisions of that group policy or certificate thereunder, notwithstanding that the marriage is dissolved by judgment or terminated by the death of the employee or, after the effective date of this amendatory Act of the 93rd General Assembly, notwithstanding the retirement of the employee provided that the employee's spouse is at least 55 years of age, in each case without any other eligibility requirements.	

d.7	Dependent Child Continuation Privilege	215 ILCS 5/367.2-5	Policy must provide for a continuation of the existing insurance benefits for an employee's dependent child who is insured under the provisions of that group policy or certificate in the event of the death of the employee and the child is not eligible for coverage as a dependent under the provisions of Section 367.2 (Spousal Continuation Privilege) or the dependent child has attained the limiting age under the policy.	
d.8	Discontinuance and Replacement	215 ILCS 5/367i 50 IAC 2013	Group health insurance policies shall provide a reasonable extension of benefits in the event of total disability on the date the policy is discontinued for any reason.	
d.9	Continuation of Coverage upon Death of Employee	215 ILCS 5/367(5)	No policy of group accident and health insurance may be issued or delivered in this State unless it provides that upon the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.	
SECTION E - OUT-OF-POCKET/ ELIGIBLE EXPENSES				
e.1	Out-Of- Pocket Expense	Section 1302 of the ACA 42 USC 300gg-6	Policy must state all out-of-pocket limitations. The ACA sets the annual limitation on cost sharing. 2023 Out-of-pocket maximums: Self-Only $9,100 -- Other than self-only coverage $18,200. 2024 Out-of-pocket maximums: Self-Only $9,45 -- Other than self-only coverage and $18,900	
e.2	Precertification Penalties	50 IAC 2051.310(a)(6)(K) 215 ILCS 124/10(b)(8)	If a plan intends to impose penalties for failure to pre-certify a hospital admission, the penalty must be defined in the policy and may not exceed $1,000. The penalty may be no more frequent than a per confinement basis.	
e.3	Copay/Deductible Accumulators	215 ILCS 134/30(d)	A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance.	
SECTION F - BENEFITS - ESSENTIAL HEALTH BENEFITS / ILLINOIS MANDATES				
f.1	Essential Health Benefits	42 U.S.C. § 300gg-11 45 C.F.R. § 147.126 50 Ill. Adm. Code 2001.6	Prohibition on annual and/or lifetime dollar amount limits on Essential Health Benefits	
f.2	Inpatient Hospital Services (e.g., Hospital Stay)	Benchmark p. 15	Essential Health Benefit	
f.3	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Benchmark p. 15	Essential Health Benefit	
f.4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Benchmark p. 21	Essential Health Benefit	
f.5	Emergency Medical Condition	215 ILCS 5/155.36 215 ILCS 134/10	Required to use definition of emergency medical condition as defined in the Managed Care Reform and Patient's Rights Act.	
f.6	Emergency Transportation/ Ambulance	Benchmark p. 17	Essential Health Benefit	
f.7	Emergency Room Services	Benchmark p. 7	Essential Health Benefit	
f.8	Emergency Medical Care - Criminal Sexual Assault	215 ILCS 5/367(8) 215 ILCS 5/356e	Policy must state that it will provide coverage for charges for testing and examination for victims of criminal sexual assault for actual expenses incurred, without offset or reduction for benefit deductibles or coinsurance amounts.	
f.9	Home Health Care	Benchmark p. 5	Essential Health Benefit	

f.10	Hospice	Benchmark p. 28	Essential Health Benefit	
f.11	Skilled Nursing Facility	Benchmark p. 21	Essential Health Benefit	
f.12	Office Visit	Benchmark p. 11	Essential Health Benefit	
f.13	Physician Surgical Benefits	Benchmark p. 10	Including assist at surgery services	
f.14	Anesthesia Services	Benchmark p. 10	Inpatient and Ambulatory Surgical Centers	
f.15	Dental Anesthesia Services - Other Indications	215 ILCS 5/356z.2	Mandated for certain criteria.	
f.16	Dental Anesthesia Services - Autism	215 ILCS 5/356z.2(a-5)	Mandated under age 26	
f.17	Anesthesia Services – Oral Surgery	Benchmark p. 10	Benefits are provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.	
f.18	Allergy Testing and Treatment (Serum)	Benchmark p. 11	Essential Health Benefit	
f.19	Amino Acid-Based Elemental Formulas	215 ILCS 5/356z.10	Mandated.	
f.20	Bariatric Surgery (Obesity)	Benchmark p. 21	Essential Health Benefit	
f.21	Breast - Fibrocystic Breast Condition	215 ILCS 5/356n	Policy must provide coverage for fibrocystic breast condition.	
f.22	Breast - Post Mastectomy Care	215 ILCS 5/356t	Mandated	
f.23	Breast Cancer Pain Medication and Therapy	215 ILCS 5/356g.5-1	Mandated	
f.24	Breast Implant Removal	215 ILCS 356p	Mandated	
f.25	Breast Reconstruction After Mastectomy	215 ILCS 5/356g(b) 50 IAC 2016	Mandated Essential Health Benefit	
f.26	Qualified Clinical Cancer Trials - Prohibition on routine patient care exclusions	215 ILCS 5/364.01 Benchmark p. 12	Policy must not exclude routine patient care services if associated with a clinical cancer trial and the services are included in the policy benefit structure.	
f.27	Chiropractic & Osteopathic Manipulation	Benchmark p. 12	Essential Health Benefit May be limited to 25 visits per benefit period.	
f.28	Accidental Injury -- Dental	Benchmark p. 17	Essential Health Benefit	
f.29	Dental Care - Oral Surgery	Benchmark p. 10	Allowed limitations found in the Benchmark	
f.30	Temporomandibular Joint Disorder (TMJ)	Benchmark p. 13 & 24 215 ILCS 5/356q	Essential Health Benefit Optional coverage expansion.	
f.31	Diabetes - Self Management, Education and Nutrition	215 ILCS 5/356w	Mandated Essential Health Benefit	
f.32	Routine Foot Care	215 ILCS 5/356w(f)	Covered only for persons diagnosed with Diabetes	

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f.33	Diabetes Supplies	215 ILCS 5/356w(d)(e) 50 IAC 2019.40	a). Coverage for durable medical equipment shall be subject to the same deductible, copayment, and coinsurance provisions provided for other durable medical equipment, depending on whether such coverage is provided under the policy or a durable medical equipment rider to the policy. Such minimum benefit shall not apply to a group policy of accident and health insurance that does not provide durable medical equipment. b). Coverage for pharmaceuticals and supplies shall be subject to the same coverage, deductible, co-payment, and co-insurance provisions provided for other pharmaceuticals, depending on whether such coverage is provided under the policy or a drug rider to the policy. Such minimum benefit shall not apply to a group policy of accident and health insurance that does not provide drug coverage.	
f.34	Diabetes Telehealth Services	215 ILCS 5/356z.22	Mandated if telehealth benefits are covered.	
f.35	Durable Medical Equipment	Benchmark p. 13	Essential Health Benefit	
f.36	Habilitative and Rehabilitative Services and Devices	Benchmark pgs. 8 & 11	Essential Health Benefit May not combine habilitative and rehabilitative visit limitations.	
f.37	Habilitative Services for Children	215 ILCS 5/356z.15	Essential Health Benefit Mandated - Prohibits denial of benefits solely on location of where medically necessary services are rendered.	
f.38	Hearing Aids	215 ILCS 5/356z.30 Benchmark pgs. 17 & 35	Essential Health Benefit - Bone anchored Mandated -- 2 every 3 years under the age of 18	
f.39	Optional Hearing Aids	215 ILCS 5/356z.30a CB 2020-14	Coverage for hearing instruments. Additional, optional coverage shall be offered for hearing instrument (for each ear) and related services, for an additional premium with no age restrictions. Maximum for the hearing instrument and related services of no more than $2,500 per hearing instrument every 24 months	
f.40	Cochlear Implants/Bone anchored hearing aids	Benchmark p.17	Essential Health Benefit -- Cochlear implants covered for all ages	
f.41	Infertility (Fertility) Treatment	215 ILCS 5/356m 50 IAC 2015 Benchmark pgs. 23-24	Essential Health Benefit Mandate Expands infertility to include a broader inclusive patient base, including coverage of surrogates.	
f.42	Fertility Preservation Services	215 ILCS 5/356z.32	Mandate	
f.43	Maternity and Newborn Care	50 IAC 2007.60e(3) 215 ILCS 5/356c Benchmark pgs. 8 & 22	Essential Health Benefit Mandated	
f.44	PANDAS/PANS	215 ILCS 5/356z.25	Mandated	
f.45	Physical Therapy - Multiple Sclerosis Patients	215 ILCS 5/356z.8	Mandated	
f.46	Private-Duty Nursing	Benchmark p. 17	Essential Health Benefit	
f.47	Prosthetics/Orthotics	215 ILCS 5/356z.18 Benchmark p. 13	Essential Health Benefit Mandated May exclude foot orthotics defined as an in-shoe device	

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f.48	Cosmetic Surgery	Benchmark p. 35	Essential Health Benefit May be excluded except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases.	
f.49	Transplants - Human Organ Transplants	215 ILCS 5/356k 215 ILCS 5/367(13)	Essential Health Benefit Mandated	
f.50	Transplants - Human Organ Transplants Transportation and Lodging	Benchmark p. 18	Benefits must be provided for transportation and lodging for covered patient receiving transplant and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, the patient's place of residency must be more than 50 miles from the Hospital where the transplant will be performed.	
f.51	Cardiopulmonary monitors	P.A. 101-0218 215 ILCS 5/356z.34	Mandated 18 years old or younger	
f.52	Human Breast Milk	P.A. 101-0511 215 ILCS 5/356z.38	Mandated	
f.53	Whole Body Skin Examination	215 ILCS 5/356z.37	Mandated No Cost Sharing	
f.54	Tick-Borne Disease	P.A. 101-0371 215 ILCS 5/356z.35	Mandated	
f.55	Pancreatic Cancer Screening	215 ILCS 5/356z.47	Coverage for medically necessary pancreatic cancer screening.	
f.56	Biomarker Testing	215 ILCS 5/356z.46	Biomarker testing must be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test is supported by medical and scientific evidence.	
f.57	Telehealth Mandate	215 ILCS 5/356z.22	Mandates telehealth coverage.	
f.58	Colonoscopy	215 ILCS 5/356z.48	No cost-sharing for medically necessary colonoscopies that are follow up exams based on initial screen.	
f.59	Port Wine Stains	215 ILCS 5/356z.51	Mandates coverage for medically necessary elimination or maximum feasible treatment of nevus flammeus (port wine stains) for children aged 18 years or younger - does not cover cosmetic removal.	
f.60	Comprehensive Cancer Testing	215 ILCS 356z.50	Mandates coverage for medically necessary comprehensive cancer testing.	
f.61	A1C Testing	215 ILCS 5/356z.49	Coverage for A1C testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes.	
f.62	Vitamin D testing	215 ILCS 5/356z.44	Coverage for vitamin D testing recommended by a health care provider in accordance with vitamin D deficiency risk factors identified by the CDC.	
f.63	Improving Health Care for Pregnant and Post-Partum Individuals Act	215 ILCS 5/356z.40	Mandates clinically appropriate case management programs for high-risk pregnancies and all pregnant and postpartum individuals have access to MH/SUD benefits.	
SECTION G - BENEFITS - PREVENTIVE				
g.1	Preventive Services ACA	42 U.S.C. 300gg-13 50 IAC 2001.8 50 IAC 4521.110(x)	Benefits shall be provided at no cost sharing to the member when these services are delivered by a network provider. Policy must contain language indicating that all preventive services covered are covered with no cost-sharing to the member pursuant to A and B recommendations found in the United States Preventive Services Task Force (USPSTF) guidelines.	
g.2	Preventive Services - Immunizations	42 U.S.C. 300gg-13(a)(2) 50 IAC 2001.8 50 IAC 4521.110(x)	Plans are required to cover immunizations recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment or coinsurance.	

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g.3	Preventive Services - Women	42 U.S.C. 300gg-13(a)(4) 50 IAC 2001.8 50 IAC 4521.110(x)	Plans are required to cover women's preventive services guidelines supported by the Health Resources & Services Administration without charging a deductible, copayment or coinsurance.	
g.4	Preventive Services - Children/ Adolescents	42 U.S.C. 300gg-13(a)(3) 50 IAC 2001.8 50 IAC 4521.110(x)	Plans are required to cover children's preventive services guidelines supported by the Health Resources & Services Administration without charging a deductible, copayment or coinsurance. Benefits must include routine hearing screenings/examinations.	
g.5	Sterilization	215 ILCS 5/356z.4(a)(3)(B)	Essential Health Benefit Mandated No Cost Sharing In-Network Male Sterilization: HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
g.6	Breast Exam - Clinical	215 ILCS 356g.5	Coverage is required for clinical breast examinations. NO COST SHARING IN-NETWORK	
g.7	Breast Feeding (Lactation) Support, Supplies and Counseling - Breast Pumps	50 IAC 2001.8 50 IAC 4521.110(x)	HRSA Guidelines	
g.8	Colorectal Cancer Examination and Screening	215 ILCS 5/356x Benchmark pgs. 12 & 16	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.9	Contraceptive/Birth Control Services	215 ILCS 5/356z.4 CMS FAQ ACA Implementation Part 54, Q2	Essential Health Benefit Mandated No Cost Sharing In-Network Male condoms are required to be covered at no cost-sharing as a preventative service when a female enrollee obtains a prescription. Carte blanche exclusions for male condoms is prohibited.	
g.10	Patient care services provided by a pharmacist	215 ILCS 5/356z.45	Coverage for health care or patient care services provided by a pharmacist if 1) the pharmacist meets the requirements set forth in section 43 of the Pharmacy Practice Act; 2) health plan provides coverage for the same service provided by a licensed physician, advanced practice registered nurse, or a physician assistant; 3) the pharmacist is included in the health benefit plan's network of participating providers; 4) a reimbursement has been successfully negotiated in good faith between the pharmacist and the health plan.	
g.11	Coverage for Abortion	215 ILCS 5/356z.4a	Requires coverage for abortion services. Coverage for abortion care may not impose deductible, coinsurance, waiting period, or other cost-sharing limitation that is greater than that required for other pregnancy-related benefits covered by the policy. Coverage shall not impose any restrictions or delays on the coverage	
g.12	HIV screening - pregnant women	215 ILCS 5/356z.1	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.13	Human Papillomavirus Vaccine (HPV)	215 ILCS 5/356z.9	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.14	Mammography - Screening	215 ILCS 5/356g(a) 215 ILCS 5/356g.5	Essential Health Benefit Mandated No Cost Sharing In-Network HDHP with HAS exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	

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g.15	Osteoporosis - Bone Mass Measurement	215 ILCS 5/356z.6	Essential Health Benefit Mandated NO COST SHARING IN-NETWORK	
g.16	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	215 ILCS 5/356u	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.17	Shingles Vaccine (Herpes Zoster)	215 ILCS 5/356z.13	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.18	Tobacco Smoking Cessation Program	215 ILCS 5/356z.21	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.19	Wellness Programs	215 ILCS 5/356z.17 50 IAC 2001.9(b)(2)(B) & (c)(3) & (f)(g)(h)(i)(j)(k)	OPTIONAL - Activity and outcome-based wellness programs are not allowed in individual plans; however, participatory programs are allowed.	
SECTION H - BENEFITS - MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES				
h.1	Autism Spectrum Disorder	215 ILCS 5/356z.14	Mandated for individuals under age 21. Prohibits denial of benefits solely on location of where medically necessary services are rendered.	
h.2	Mental (Behavioral) Health Treatment (Inpatient/Outpatient)	215 ILCS 5/370c et AL 215 ILCS 5/370c.1 et AL	Essential Health Benefit Mandated	
h.3	Substance Use Disorders (Inpatient/Outpatient)	215 ILCS 5/370c et AL 215 ILCS 5/370c.1 et AL	Essential Health Benefit Mandated	
h.4	Recovery housing for persons with substance use disorders	215 ILCS 5/356z.31	OPTIONAL - A policy may provide coverage for residential extended care services and supports for persons recovery housing for persons with substance use disorders who are at risk of a relapse following discharge from a health care clinic, federally qualified health center, hospital withdrawal management program or any other licensed withdrawal management program, or hospital emergency department so long as specific conditions are met.	
h.5	Tele-Psychiatry	Benchmark p. 11	Essential Health Benefit Required to be covered as a medical care visit	
SECTION I - BENEFITS - PRESCRIPTION DRUGS - ALL POLICIES				
i.1	Inhalants - Prescription	215 ILCS 5/356z.5	Mandated	
i.2	Immunosuppressant Drugs - Organ Transplant Medication Notification Act	215 ILCS 175/15	Plans must cover medically necessary immunosuppressant drugs with a written prescription after an approved human organ transplant. When a prescribing physician has indicated on a prescription "MAY NOT SUBSTITUTE", a health insurance policy or healthcare service plan that covers immunosuppressant drugs, may not require, or cause a pharmacist to interchange another immunosuppressant drug or formulation, issued on behalf of a person to inhibit or prevent the activity of the immune system of the patient to prevent the rejection of the transplanted organs & tissues without notification and the documented consent of the prescribing physician and the patient.	
i.3	Synchronization	215 ILCS 356z.26	Mandated	
i.4	Cancer Drug Parity	215 ILCS 5/356z.20	Mandated	
i.5	Topical Eye Medication Prescriptions	215 ILCS 156/5	Mandated	

i.6	Immune Gamma Globulin Therapy	215 ILCS 5/356z.24	Mandated	
i.7	Opioid Medically Assisted Treatment (MAT)	Benchmark p. 21	Essential Health Benefit	
i.8	Opioid Antagonist	215 ILCS 5/356z.23	Essential Health Benefit Mandated	
i.9	Intranasal opioid reversal agent associated with opioid prescriptions	Benchmark p.32	Essential Health Benefit Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.	
i.10	Topical Anti-Inflammatory acute and chronic pain medication	Benchmark p. 32	Essential Health Benefit	
i.11	Prescription Drug 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.	
i.12	Epinephrine Injectors	215 ILCS 5/356z.33	Coverage for medically necessary epinephrine injectors for persons 18 years of age or under.	
i.13	Insulin Co-Pay	215 ILCS 5/356z.41	Required to limit cost sharing $100 per 30-day supply	
i.14	Prescription drug benefits & plan choice	215 ILCS 134/45.3	Requires issuers to satisfy minimum benefit design requirements for plans offering prescription drugs.	
SECTION J - ATTESTATIONS				
j.1	Optometric Services	215 ILCS 5/364.1	Every policy which provides coverage for services coming within the practice of optometry shall, upon issuance or delivery, be accompanied by a written notice to the policyholder that such policyholder may elect for optometric services received to be reimbursed to either a physician licensed to practice medicine in all its branches or to an optometrist licensed in this State.	Affirmed
j.2	Stage 4 Advanced Metastatic Cancer	215 ILCS 5/356z.29	This policy directly or indirectly covers the treatment of stage 4 advanced metastatic cancer shall not limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or prove a history of failure of the drug as long as the use of the drug is consistent with best practices for treatment of stage 4 advanced metastatic cancer and is supported by peer-reviewed medical literature.	Affirmed
j.3	Mental Health and Addiction Parity	45 CFR 146.136 215 ILCS 5/370c.1	The policy documents attached to this filing are in compliance with Federal and State Mental Health Parity laws.	Affirmed
j.4	Emergency Coverage Under the Influence of Alcohol or Narcotics	215 ILCS 5/367k	Plan shall not, solely on the basis of the insured being intoxicated or under the influence of a narcotic, exclude coverage for any emergency or other medical, hospital, or surgical expenses incurred by an insured as a result of and related to an injury acquired while the insured is intoxicated or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.	Affirmed
j.5	Short-term opioid prescription limitations	Benchmark p. 31	This policy limits short-term opioid prescriptions to no more than 7 days.	Affirmed

j.6	Prescription Drug Exception	215 ILCS 134/45.1 215 ILCS 5/155.36	A process is in place for standard exception requests, expedited exception requests, and external exception request reviews. Plans must advise enrollees of the process for making exceptions for non-covered prescription drugs when: 1). the drug is not covered based on the health benefit plans formulary; 2). the health benefit plan is discontinuing coverage of the drug; 3). the prescription drug alternatives required to be used in accordance with a step therapy requirement, a). has been ineffective in the treatment or b). has caused an adverse reaction or harm to the enrollee; or 4). the number of doses available under a dose restriction for the prescription drug, a). has been ineffective in the treatment of the enrollee's disease or medical condition or b). the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.	Affirmed
j.7	Prescription Drug Formulary	215 ILCS 5/155.37	No policy of health insurance shall be offered for sale directly to consumers through the health insurance marketplace unless the most recently published prescription drug formulary is made available to the consumer when comparing policies and premiums.	Affirmed
j.8	Transition of Services	215 ILCS 124/20	A network plan shall provide for continuity of care for its beneficiaries. The network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period in accordance with the law.	Affirmed
j.9	Electronic Notices and Devices	215 ILCS 5/143.34	Must provide clear notice if documents are going to be delivered electronically, receive consent from the insured for electronic delivery, and advise that consent can be withdrawn at any time. Do you intend to deliver documents electronically? Yes No (If yes, please affirm. If no, please state N/A)	Affirmed or N/A
j.10	Autism - Prohibition on Coverage Termination	215 ILCS 5/356z.14(h-10)	This policy does not restrict coverage under an individual contract on the basis that the individual declined an alternative medication or covered service under certain circumstances.	Affirmed
j.12	Prohibition on Rescissions	50 IAC 2001.7 45 CFR 147.128	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such policy with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with 30 days-notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).	Affirmed
j.13	Discontinuance of Particular Type of Coverage - HIPAA	50 IAC 2025.60 215 ILCS 97/30(C)(1) 50 IAC 2001.4(g)(h)	Insurers must comply with the uniform termination requirements for discontinuing a particular type of coverage in the state. 1). The health insurance issuer may only discontinue a particular type of health insurance coverage upon the renewal date of the coverage with ninety (90) days' notice to insureds. 2). The health insurance issuer must offer to be purchased all products being marketed in that market. The health insurance issuer may not limit which products are to be offered for purchase.	Affirmed
j.14	Discontinuance of All Coverage - HIPAA	215 ILCS 97/30(C)(2) 50 IAC 2001.4(f)(g)(h) & (j) 50 IAC 2025.70	Insurers must comply with the uniform termination requirements for discontinuing all coverage in the state. Notification to the Department, 180 days prior to the date of discontinuation, is required for discontinuation of all health insurance coverage in the individual market. [Note: notification to insureds is also required]	Affirmed
j.15	Modification of Coverage – HIPAA	50 ILCS 2025.50 50 IAC 2001.4(j) 215 ILCS 97/30(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.	Affirmed
j.16	Assignment of Benefits	215 ILCS 5/370a	Insurers may not prohibit an insured from making an assignment of all or any part of his/her rights and privileges under the policy.	Affirmed

j.17	Use of Information Derived from Genetic Testing	215 ILCS 5/356v 215 ILCS 97/25(A)(1)(f) 410 ILCS 513/20	An insurer may not seek information derived from genetic testing for use in connection with a policy of accident and health insurance. An insurer that receives information derived from genetic testing, regardless of the source of that information, may not use the information for a nontherapeutic purpose as it relates to a policy of accident and health insurance. An insurer shall not use or disclose protected health information that is genetic information for underwriting purposes.	Affirmed
j.18	Use of SSN on ID Cards	815 ILCS 505/2QQ 815 ILCS 505/2RR	A person or entity may not print an individual's social security number on an insurance card. 815 ILCS 505/2RR prevents a person, including insurers, from printing an individual's SSN on any materials mailed to an individual unless required by state or federal law.	Affirmed
j.19	Summary of Benefits and Coverage (SBCs)	50 IAC 2001.10	SBCs must be filed for approval under the form schedule tab. Please attest that all SBCs in this filing meet the requirements of the referenced Illinois Administrative Code (50 IAC 2001.10)	Affirmed