

TO BE COMPLETED BY COMPANY

Company Name:

SERFF Tracking #:

Checklist Directions

- The checklist must be completed to indicate where in the filing the General Filing requirements appear, must acknowledge each General Form Requirement and must indicate where, in the filed materials, each required provision appears (e.g. form number, page number and section number).
- For requirements marked as “Affirmed,” companies are to acknowledge, by checking the appropriate box:
 - 1) their compliance with prohibited language; or
 - 2) their understanding of the informational nature of the requirement.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

IMPORTANT NOTICE: This Checklist does not include all of the requirements of Illinois laws, regulations or bulletins. Companies are responsible for reviewing Illinois laws, regulations and bulletins to ensure that materials are fully compliant before filing them. **Insurers are required to report to the Director any material change to an approved network plan within 15 days of the occurrence, but they may request a 15-day extension to provide all required information if preliminary information is reported as described in 50 Ill. Adm. Code 4540.50.**

<u>Page</u>	<u>Part</u>	<u>ALL POLICIES</u>
1	Section A	GENERAL FILING REQUIREMENTS
2	Section B	STATE GUIDELINES
4	Section C	ATTESTATIONS
4	Section D	EXEMPTIONS

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.A.1	Review Requirements Checklist	Review Requirements Checklists	Each filing must include a completed Review Requirements Checklist that must contain a completed “Location of Standard in Filing” column for each required element of the filing. Please indicate the proper page # and form # for each entry. Each filing must also include a completed Network Adequacy (Tiered) Collection Template, Network Adequacy County Facilities Template, Proposed Enrollment Template, and Network Adequacy Exception Form (unless there are no exceptions or deficiencies)	
1.A.2	Filing Type	Form filings	Network Adequacy filings will be filed as a separate form filing type with the Network Adequacy TOI of NA00 and sub-TOI of NA01.000 (PPO) or NA01.001 (HMO). Networks can only be implemented upon completion of Departmental review.	
1.A.3	Associated Policy Filings	215 ILCS 124/10(b) 50 ADM 4540.40(a)	Under the Supporting Documents tab, please include a list of network plan names, associated SERFF Tracking Numbers, and applicable form numbers that will use the network	

1.A.4	Networks	215 ILCS 124/10(b) 50 ADM 4540.40(b)	<u>HMO</u> - attach under the Supporting Documents tab in SERFF, the certification letter from the Illinois Department of Public Health indicating that the HMO's network meets requirements for licensure, including the county or counties, including partial counties, in which the HMO is allowed to operate. Also include a list of MCOs used within the network with all information required in 50 Ill. Adm. Code 4540.40(b). <u>ALL Filers</u> - attach under the Supporting Documents tab in SERFF, a list of all PPPAs through which the filer has contracted to include providers in the network for the plans associated with this filing, including all information required in 50 Ill. Adm. Code 4540.40(b)(3). ALL filers also must provide the specific name of the network.
1.A.5	Plan Network Adequacy	45 CFR 156.230 45 CFR 156.235	REQUIRED OF ALL QHPs - The provider network of each QHP must meet these standards: 1) Include essential community providers that serve predominately low income, medically underserved individuals 2) Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay 3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA.
1.A.6	Combination 2023/2024 Filing (not applicable to all insurers)	50 ADM 4540.40(s)	If a network plan is issued or renewed during 2023 that does not use the same network as any Department-approved QHP from the same insurer for the same year, an insurer may submit a filing no later than July 1, 2023, that combines the annual filings for both 2023 and 2024. Any insurer submitting a combination filing must mark "Affirmed" here and either attach under the Supporting Documents tab in SERFF the cover letter described in 50 Ill. Adm. Code 4540.40(s)(3) or attest that all filenames indicate whether they apply to 2023, 2024, or both years.
SECTION B - STATE GUIDELINES			
1.B.1	Provider Directories	215 ILCS 124/25 215 ILCS 124/10(b)(2) 215 ILCS 124/10(b)(4) 50 ADM 4540.40(c)	Web-based directory of health care professionals and facilities must be up to date, and include accurate provider/facility type, location, contact information, and all other information required under 215 ILCS 124/25. Providers available by telehealth or telemedicine should be clearly identified and include information required under 215 ILCS 124/25(b)(1)(K).
1.B.2	Maximum Travel Distance and Time (except MH/SUD)	215 ILCS 124/10(b)(5)(C) 215 ILCS 124/10(d) 50 ADM 4540.40(d)	Demonstrates compliance with time and distance standards for plan beneficiaries in each county of the service area. Except for standards related to providers of treatment for mental health and substance use disorders, the maximum limits of travel in minutes and miles that a beneficiary residing in a given county type may be expected to undertake to a preferred provider of a given provider specialty type are provided in Appendix A for individual providers and Appendix B for facility providers.
1.B.3	Ratio of providers to enrollees: Individual Providers	215 ILCS 124/10(c)(1) 215 ILCS 124/10(b)(5)(B) 50 ADM 4540.40(e)	1 per 1,000 – PCP/Pediatrician 1 per 2,500 – OB/GYN 1 per 5,000 – General Surgery, and Behavioral Health 1 per 10,000 – Cardiology, Chiropractor, Dermatology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, Pulmonary, Rheumatology, and Urology 1 per 15,000 – Infectious Disease, Allergy/Immunology, ENT/Otolaryngology, Oncology/Radiation, and Physiatry/Rehabilitative 1 per 20,000 – Plastic Surgery, and Neurology
1.B.4	Ratio of providers to enrollees: Facilities per County	215 ILCS 124/10(d) 50 ADM 4540.40(e)-(f)	Complete the Network Adequacy County Facilities template and attach under supporting documents. Please complete the hospital and behavioral health facility tabs by listing the name, address and phone number of each facility by county. Acute Inpatient Hospital with Emergency Services Available 24/7 -- 1 per County Inpatient or Residential Behavioral Health Facility -- 1 per County

1.B.5	Access to MH/SUD	215 ILCS 124/10(d-5) 50 ADM 4540.40(d)(2)	Timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. In the event a preferred provider is not available, necessary exceptions will apply pursuant to 50 Ill. Adm. Code 4540.40(d)(2).	
1.B.6	Access to Outpatient MH/SUD Services (Metro Counties)	215 ILCS 124/10(d-5)(1)(A)	<p>Metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, timely and proximate access to treatment for MH/SUD requires:</p> <ul style="list-style-type: none"> • Beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient MH/SUD benefits; • Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the outpatient MH/SUD facility or provider; • Beneficiaries shall not be required to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the outpatient MH/SUD facility or provider. 	
1.B.7	Access to Outpatient MH/SUD Services (Non-Metro Counties)	215 ILCS 124/10(d-5)(1)(B)	<p>For beneficiaries residing in counties <u>outside</u> of Cook, DuPage, Kane, Lake, McHenry, and Will, timely and proximate access to treatment for MH/SUD requires:</p> <ul style="list-style-type: none"> • Beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient MH/SUD benefits; • Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the outpatient MH/SUD facility or provider; • Beneficiaries shall not be required to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the outpatient MH/SUD facility or provider. 	
1.B.8	Access to Inpatient/Residential MH/SUD (All counties)	215 ILCS 124/10(d-5)(B)(2)	Beneficiaries residing in all Illinois counties shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for MH/SUD benefits.	
1.B.9	Required Exceptions to Non-Network MH/SUD Services	215 ILCS 124/10(d-5)(3) 50 ADM 4540.40(d)(2)	If no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for MH/SUD in accordance with the network adequacy standards, the issuer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards.	
1.B.10	No Network Exception Requests for MH/SUD requirements	215 ILCS 124/10(g)	No Network Exception will be granted in regard to the requirements set forth in 215 ILCS 124/10(d-5).	

1.B.11	Health Care Service Delivery	215 ILCS 124/10(b)(5)(50 ADM 4540.40(p))	A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries, including the type of health care services to be provided by the network plan.	
1.B.12	Telehealth and Innovative Care	215 ILCS 124/10(b)(5)(D) 215 ILCS 5/356z.22 215 ILCS 124/10(f) 50 ADM 4540.40(p)(4)	A description of the availability of telehealth care, including how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable..	
1.B.13	Provider changes	215 ILCS 124/10(a)(1) 50 ADM 4540.40(g)(1)	The written policies and procedures for adding providers to meet patient needs based on increases in number of beneficiaries, changes in patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.	
1.B.14	Referral processes	215 ILCS 124/10(a)(2) 50 ADM 4540.40(g)(2)	For HMOs, the written policies and procedures for making referrals within and outside the network.	
1.B.15	24-7 Care	215 ILCS 124/10(a)(3) 50 ADM 4540.40(g)(3)	The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and woman's principal health care providers.	
1.B.16	Patient Advocacy	125 ILCS 124/10(a) 50 ADM 4540.40(o)	Language from the provider contract specifically noting that network providers are not prohibited from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under State or Federal law.	
1.B.17	Geographic Map	215 ILCS 124/10(b)(1) 50 ADM 4540.40(h)	Insurers are required to file geographic maps of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers and highlighted areas for the applicable time and distance standards. Maps should be in the aggregate, consisting of all preferred providers under the plan, including all contracted network groups, except that for network plans with tiered networks that are not solely offered as group health plans, the map must only include preferred providers from the lowest cost-sharing tier. A separate map with marked locations should be provided for each provider type listed under Appendix A or B or under 215 ILCS 124/10(d-5).	
1.B.18	Provider Listing	215 ILCS 124/10(b)(2) 50 ADM 4540.40(i)	A list of all preferred providers, identified by specialty type, for each network to be submitted via the Illinois Network Adequacy (Tiered) Collection Template and attached under the Supporting Documents tab in SERFF. The information should be consistent with the most recently updated version of the provider directory, for which the date of that update should be specified.	
1.B.19	Plan Participants	215 ILCS 124/10(b)(3) 50 ADM 4540.40(j)	The number of participants anticipated to be covered by each network plan, as well as the aggregate participants anticipated for all of the filer's plans that use the network. Filers may satisfy this requirement by attaching the Proposed Enrollment Template under the Supporting Documentation tab.	

<p>1.B.20</p>	<p>Accessibility and Transparency (Online)</p>	<p>215 ILCS 124/10(b)(4) 215 ILCS 124/25(a)(1) 215 ILCS 124/25(a)(2) 215 ILCS 124/25(b) 215 ILCS 124/25(c) 50 ADM 4540.40(c)</p>	<p>The description shall include an internet website and toll-free number for beneficiaries and prospective beneficiaries to access current and accurate lists of network providers. The website is prohibited from requiring beneficiaries to create accounts or enter a contract or policy number, in order to access the provider directory. The online provider directory shall be updated at least monthly and clearly identify which plan or plans for which it is applicable. Electronic directories must also make the following information available in a SEARCHABLE FORMAT:</p> <p>1) Health Care Professionals - A) name, B) gender, C) participating office locations, D) specialty, if applicable, E) medical group affiliations, if applicable, F) facility affiliations, if applicable, G) participating facility affiliations, if applicable, H) languages spoken other than English, if applicable, I) whether accepting new patients; J) board certifications, if applicable, K) use of telehealth or telemedicine</p> <p>2) Hospitals - A) hospital name, B) hospital type, C) participating hospital location, D) hospital accreditation status,</p> <p>3) Facilities other than hospitals - A) facility name, B) facility type, C) types of services performed, D) participating facility location or locations.</p> <p>In addition to the information required to be searchable, the electronic directory shall include:</p> <p>1) Health Care Professionals - A) contact information, B) language spoken other than English by clinical staff, if applicable</p> <p>2) Hospitals - A) telephone number</p> <p>3) Facilities other than hospitals - A) telephone number</p>	
<p>1.B.21</p>	<p>Accessibility and Transparency (Print)</p>	<p>215 ILCS 124/10(b)(4) 215 ILCS 124/25(a)(1) 215 ILCS 124/25(a)(2) 215 ILCS 124/25(a)(4) 215 ILCS 124/25(b) 215 ILCS 124/25(d) 215 ILCS 124/25(e) 215 ILCS 124/25(f) 50 ADM 4540.40(c)</p>	<p>A company must submit a PDF of its most recent print copy of the provider directory along with any errata in the Supporting Documents tab in SERFF. Print copies of the provider directory must be available to any beneficiary or prospective beneficiary upon request. Print copies must be updated quarterly. Print copies must clearly identify for which plans they associated. Required information to be included for each provider:</p> <p>1) Health Care Professionals - A) Name, B) contact information, C) participating office location or locations, D) specialty, if applicable, E) languages spoken other than English, if applicable, F) whether accepting new patients, G) use of telehealth or telemedicine</p> <p>2) Hospitals - A) Hospital name, B) hospital type, C) participating hospital locations and telephone numbers</p> <p>3) Facilities other than hospitals - A) Facility name, B) Facility type, C) Types of services performed, D) Participating facility location or locations and telephone numbers.</p> <p>Print directories shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the insurer's electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information.</p>	

1.B.22	Sample Notice of Termination	50 ADM 4540.40(k) 50 ADM 4540.70	Samples of any notices of nonrenewal or termination that will be sent to providers and beneficiaries served by those providers (see Section 15 of the Act).
1.B.23	Notice of Termination of a provider	215 ILCS 124/15	A network must give at least 60 days-notice of nonrenewal or termination of a provider to the provider and to the beneficiaries served by the provider. Immediate written notice may be provided without 60 days' notice when a provider's license has been disciplined by a State licensing board or when the network plan reasonably believes direct imminent physical harm to patients under the provider's care may occur.
1.B.24	Provider Directory Language	215 ILCS 124/25(a)(5)	Required language in both print and online directories: a) in plain language, a description of the criteria the plan has used to build its provider network; b) if applicable, in plain language, a description of the criteria the insurer or network plan has used to create tiered networks; c) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed; d) if applicable, a notation that authorization or referral may be required to access some providers
1.B.25	Material Changes to Network	215 ILCS 124/10(h) 50 ADM 4540.50	Insurers must submit a new network adequacy filing, as described in Section 4540.50(a), within 15 days of any material change in an approved network plan, but they may request a 15-day extension to provide all required information if preliminary information is reported as described in 50 Ill. Adm. Code 4540.50(b).

SECTION C - ATTESTATIONS

ATTESTATION INSTRUCTIONS: The below network adequacy and transparency requirements are required to be embedded in the policy language. Please attest that the requirement is met within the policy by indicating the SERFF Tracking number, form number and corresponding page number on which the language appears for each requisite below.

1.C.1	In-Network Provider availability	215 ILCS 124/10(b)(6) 215 ILCS 124/10(a)(2) 50 ADM 4540.40(l)	The policy(ies) associated with this network filing contain language allowing for in-network benefits to be paid to Out of Network Providers when a provider with the required specialty is not available in the network and the member has made a good faith effort to utilize a preferred provider. In the case of an HMO policy, the plan contains language specifying the procedure for a Primary Care Physician to follow in order to refer outside the network when a specialist is not available within the HMO.
1.C.2	Emergency Care	215 ILCS 124/10(b)(7) 50 ADM 4540.40(m)	The policy contains a provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider (in-network or out-of-network provider) and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider.
1.C.3	Precertification	215 ILCS 124/10(b)(8) 50 ADM 4540.40(n)	If a plan intends to impose penalties for failure to pre-certify an inpatient hospital treatment 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.

SECTION D - EXCEPTIONS

1.D.1	Exceptions and Deficiencies	215 ILCS 124/10(g) 50 ADM 4540.40(q)	Insurers who are not able to comply with the provider ratios or time and distance standards established by the Department may request an exception to these requirements for the Department's consideration. Note: No exceptions will be granted for time and distance or appointment waiting time requirements set forth in 215 ILCS 124/10(d-5) pursuant 215 ILCS 124/10(g), but insurers are still required to report any deficiencies in meeting those standards. Insurers must use the Network Adequacy Exception Form.
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Appendix A

Individual Provider Specialty Type	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OG/BYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry/Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Primary Care Physician (Adult)	10	5	15	10	30	20	40	30	70	60
Primary Care Physician (Child)	10	5	15	10	30	20	40	30	70	60
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100

Appendix B

Facility Specialty Type	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (Must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Freestanding; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100