Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

ACA Small 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.

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location in filing or applicable SERFF Tracking #
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 et. al. 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. 50 IAC 4540 et. al.	Provide SERFF tracking number for Network Adequacy and Transparency Act required filing.	SERFF Tracking #
a.6	Letter of Submission	50 IAC 916.40(b)	2). 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.	
a.7	Summary of Benefits & Coverage	50 IAC 2001.10	A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to file for the Director's approval prior to use a written summary of benefits and coverage (SBC) for each benefit package and provide the SBC without charge to entities and individuals	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

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a.8	Mental Health/Substance Use Disorder – Supporting Documentation Checklist	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 5/356a	No policy of accident and health insurance may be delivered or issued for delivery to any person in this state unless it adheres to the provisions of this section.	Affirmed ☐
a.11	Form Numbers	215 ILCS 5/356a(1)(f) 50 IAC 916.40(b)(2)(A)	Each form must bear an identifying form number in the lower left corner of the policy form to be approved. Form numbers are limited to 30 characters.	Affirmed ☐
			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	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 for ALL Non-Advance Premium Tax Credit Recipient Policies	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."	
b.8	Grace Period for Advance Premium Tax Credit Recipients	45 CFR 155.430(b)(2)(ii) 45 CFR 156.270(d) & (g)	A QHP issuer must provide a grace period of 3 consecutive months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit.	

Emily Downs, Assistant Deputy Director - Health Compliance
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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	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."	

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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	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."	
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."	

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b.23	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.24	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.25	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.26	Termination of Policy	215 ILCS 97/30	A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following: 1. Nonpayment of premium 2 Fraud 3 Violation of participation or contribution rules 4 Termination of the plan 5 Movement outside the service area; or 6 Association membership ceases. (This may be in the group agreement)	
b.27	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	
b.28	Binding Arbitration	215 ILCS 5/356z.3a	In the event that a medical bill is not resolved within 30 days, permits the health insurance issuer, nonparticipating provider, or the facility to initiate binding arbitration for a single bill or group of bills.	
			SECTION C - NETWORK POLICY REQUIREMENTS	
c.1	Provider Termination - Transition of Care	45 CFR 156.230(d)(2) 215 ILCS 124/20(a)(b) (UPDATED) P.A. 103-0650	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 (UPDATED) P.A. 103-0718	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	Accessibility or Availability of In-Network Providers	215 ILCS 124/10	The policy must include a provision that ensures that whenever a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate provider in the network, the consumer, with prior approval through the insurer, can see an out of network provider at no greater cost-sharing than if the provider had been contracted with the plan.	

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c.4	Limited Benefit Disclosure	215 ILCS 5/356z.3	ILLINOIS STATUTORY LANGUAGE REQUIRED: Policies must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments 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. Participating providers have agreed to ONLY bill members the cost-sharing 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.5	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.6	Notice of Provider Nonrenewal or Termination	215 ILCS 124/15(a) UPDATED P.A. 103-0650	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	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 45 CFR 147.120(b)(1)	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	Dependent Parent Coverage	215 ILCS 5/356z.71 (NEW) P.A. 103-0700	A group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026 that provides dependent coverage shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent meets the definition of a qualifying relative under 26 U.S.C. 152(d) and lives or resides within the accident and health insurance policy's service area.	
d.6	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.7	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.	

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d.8	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.9	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.10	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. 2026 Out-of-pocket maximums: Self-Only $10,150 -- Other than self-only coverage $20,300	
e.2	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.	
e.3	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.4	Prescription drug flat copay benefits/plan choice	215 ILCS 134/45.3 50 IAC 4500.10	Flat copay requirement -- please provide for each corresponding service area, the plan name(s), metal level(s), and schedule that meet this requirement. Any plans with prescription riders must also provide this information. The minimum requirement for PY 2026 is two group plans per service area, per metal level with a flat copay prescription benefit structure. QHP Issuers on the Exchange is limited to two non-standardized plan options per product network type, metal level (excluding catastrophic), and inclusion of dental and/or vision coverage, in any service area. The Issuer must offer at least one standardized plan option at every product network type, metal level (excluding catastrophic plans), and throughout every service area that it also offers a non-standardized option, including the income-based CSR variations for silver plans.	
			SECTION F - BENEFITS - ESSENTIAL HEALTH BENEFITS / ILLINOIS MANDATES	
f.1	Essential Health Benefits	Section 1302 of the ACA 42 USC 18022 45 CFR 156.155(a)(3) 45 CFR 147.126 50 IAC 2001.11	Mandated	
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 Benchmark p. 7	Essential Health Benefit 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. 4, 17	Essential Health Benefit	
f.7	Emergency Room Services	Benchmark p. 7, 13	Essential Health Benefit	

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f.8	Coverage for Mobile Integrated Health Care Services	215 ILCS 5/356z.71 (NEW) P.A. 103-1024	A group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026, shall provide coverage to an eligible recipient for medically necessary mobile integrated health care services.	
f.9	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.10	Home Health Care	215 ILCS 5/356z.53 Benchmark p. 5	Mandated Essential Health Benefit	
f.11	Hospice	Benchmark p. 28	Essential Health Benefit	
f.12	Skilled Nursing Facility	Benchmark p. 21	Essential Health Benefit	
f.13	Office Visit	Benchmark p. 8 , 11	Essential Health Benefit	
f.14	Physician Surgical Benefits	Benchmark p. 10	Essential Health Benefit Including assist at surgery services	
f.15	Anesthesia Services	Benchmark p. 10	Essential Health Benefit Inpatient and Ambulatory Surgical Centers	
f.16	Dental Anesthesia Services - Other Indications	215 ILCS 5/356z.2 Benchmark p.10	Essential Health Benefit Mandated for certain criteria	
f.17	Dental Anesthesia Services - Autism	215 ILCS 5/356z.2(a-5)	Mandated under age 26	
f.18	Anesthesia Services – Oral Surgery	Benchmark p. 10	Essential Health Benefit 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.19	Allergy Testing and Treatment (Serum)	Benchmark p. 11	Essential Health Benefit	
f.20	Amino Acid-Based Elemental Formulas	215 ILCS 5/356z.10	Mandated	
f.21	Bariatric Surgery (Obesity)	Benchmark p. 21	Essential Health Benefit	
f.22	Breast - Fibrocystic Breast Condition	215 ILCS 5/356n	Mandated Policy must provide coverage for fibrocystic breast condition.	
f.23	Breast - Post Mastectomy Care	215 ILCS 5/356t Benchmark p. 24	Mandated Essential Health Benefit	
f.24	Breast Cancer Pain Medication and Therapy	215 ILCS 5/356g.5-1 Benchmark p. 12, 32	Mandated Essential Health Benefit	
f.25	Breast Implant Removal	215 ILCS 356p Benchmark p. 25	Mandated Essential Health Benefit	
f.26	Breast Reconstruction After Mastectomy	215 ILCS 5/356g(a)(4.3) (UPDATED) Benchmark p. 24 50 IAC 2016 P.A. 103-0808	Mandated Essential Health Benefit	
f.27	Breast Reduction Surgery	215 ILCS 356z.54	Mandated	
f.28	Qualified Clinical Cancer Trials - Prohibition on routine patient care exclusions	215 ILCS 5/364.01 Benchmark p. 34	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.29	Chiropractic & Osteopathic Manipulation	Benchmark p. 12	Essential Health Benefit May be limited to 25 visits per benefit period.	
f.30	Accidental Injury -- Dental	Benchmark p. 17	Essential Health Benefit	
f.31	Dental Care - Oral Surgery	Benchmark p. 10	Essential Health Benefit Allowed limitations found in the Benchmark	

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320 West Washington Street
Springfield, IL 62767

f.32	Temporomandibular Joint Disorder (TMJ)	Benchmark p. 24 215 ILCS 130/4003 215 ILCS 165/10 215 ILCS 5/356q	Essential Health Benefit TMJ optional coverage expansion.	
f.33	Coverage for Care and Treatment of Major Injury to jaw (Accident/Disease)	215 ILCS 5/356.71 (NEW) P.A. 103-0972	Medically necessary care and treatment to address a major injury to the jaw either through an accident or disease" includes: (1) Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, or maintain vital functions; (2) Dental implants, crowns, or bridges; (3) Prosthetic treatment such as obturators, speech appliances, and feeding appliances; (4) Orthodontic treatment and management; (5) Prosthodontic treatment and management; and (6) Otolaryngology treatment and management. Coverage under this Section may impose the same deductibles, coinsurance, or other cost-sharing limitations that are imposed on other related benefits under the policy.	
f.34	Diabetes - Self Management, Education and Nutrition	215 ILCS 5/356w(b)(c) Benchmark p. 11	Mandated Essential Health Benefit	
f.35	Routine Foot Care	215 ILCS 5/356w(f) Benchmark p. 11, 35	Mandated for persons diagnosed with Diabetes Essential Health Benefit	
f.36	Diabetes Supplies	215 ILCS 5/356w(d)(e) 50 IAC 2019.40 Benchmark p. 31	Mandated Essential Health Benefit under Durable Medical Equipment	
f.37	Continuous Glucose Monitors	215 ILCS 5/356z.59	Mandated NO COST SHARE HDHP with HSA Exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
f.38	Diabetes Telehealth Services	215 ILCS 5/356z.22	Mandated if telehealth benefits are covered.	
f.39	Durable Medical Equipment	Benchmark p. 13	Essential Health Benefit	
f.40	Compression Sleeves	215 ILCS 5/356z.64	Mandated for compression sleeves that is medically necessary for the enrollee to prevent or mitigate lymphedema.	
f.41	Dry Needling by Physical Therapist	215 ILCS 5/356z.28	OPTIONAL	
f.42	Neuromuscular, Neurological, or Cognitive Impairment for Children	215 ILCS 5/356z.69	Mandated Expands insurance coverage to include therapy, diagnostic testing, and equipment for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder including low tone neuromuscular impairment.	
f.43	Habilitative and Rehabilitative Services and Devices	45 CFR 156.115(a)(5) Benchmark pp. 8, 11, 22, 35	Essential Health Benefit May not combine habilitative and rehabilitative visit limitations.	
f.44	Habilitative Services for Children	215 ILCS 5/356z.15 Benchmark p. 22	Mandated - Prohibits denial of benefits solely on location of where medically necessary services are rendered. Essential Health Benefit	
f.45	Hearing Aids	215 ILCS 5/356z.30 Benchmark p. 35	Mandated -- One per ear every 3 years Essential Health Benefit	
f.46	Cochlear Implants/Bone anchored hearing aids	Benchmark p.17	Essential Health Benefit -- Cochlear implants covered for all ages	
f.47	Infertility (Fertility) Treatment	215 ILCS 5/356m(a-5) (UPDATED) 50 IAC 2015 Benchmark pgs. 23-24 P.A. 103-0751	Mandated Essential Health Benefit Expands infertility to include a broader inclusive patient base, including coverage of surrogates.	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

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f.48	Fertility Preservation Services	215 ILCS 5/356z.32	Mandated	
f.49	Maternity and Newborn Care	215 ILCS 5/356c 215 ILCS 5/356s Benchmark p. 8, 22	Mandated Essential Health Benefit	
f.50	PANDAS/PANS	215 ILCS 5/356z.25	Mandated	
f.51	Physical Therapy - Multiple Sclerosis Patients	215 ILCS 5/356z.8 Benchmark p.11	Mandated Essential Health Benefit	
f.52	Private-Duty Nursing	Benchmark p. 17	Essential Health Benefit	
f.53	Prosthetics/Orthotics	215 ILCS 5/356z.18 Benchmark p. 13	Mandated Essential Health Benefit May exclude foot orthotics defined as an in-shoe device Provides that with respect to an enrollee at any age, in addition to coverage of a prosthetic or custom orthotic device, benefits shall be provided for a prosthetic or custom orthotic device determined by the enrollee's provider to be the most appropriate model that is medically necessary for the enrollee to perform physical activities.	
f.54	Wigs and Hair Prostheses	215 ILCS 5/356z.61 (NEW) P.A. 103-0753	Mandated Must provide coverage, no less than once every 12 months, for one wig or other scalp prosthesis worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other conditions.	
f.55	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.56	Reconstructive Services (Physical Appearance)	215 ILCS 5/356z.65	Mandated - may not deny coverage for medically necessary reconstructive services that are intended to restore physical appearance.	
f.57	Cleft Lip/Cleft Palate	215 ILCS 5/356c 215 ILCS 5/356z.55	Mandated	
f.58	Transplants - Human Organ Transplants	215 ILCS 5/356k 215 ILCS 5/367(13) Benchmark p. 18, 31	Mandated Essential Health Benefit	
f.59	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.60	Cardiopulmonary Monitors	215 ILCS 5/356z.34	Mandated 18 years old or younger	
f.61	Human Breast Milk	215 ILCS 5/356z.38	Mandated	
f.62	Whole Body Skin Examination	215 ILCS 5/356z.37	Mandated NO COST SHARE	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

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f.63	Diagnostic Mammogram	215 ILCS 5/356g(a)(6)	Mandated NO COST SHARE HDHP with HSA Exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
f.64	Tick-Borne Disease	215 ILCS 5/356z.35	Mandated	
f.65	Pancreatic Cancer	215 ILCS 5/356z.47	Mandated Coverage for medically necessary pancreatic cancer screening.	
f.66	Biomarker Testing	215 ILCS 5/356z.46	Mandated 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.67	Telehealth	215 ILCS 5/356z.22	Mandates telehealth coverage.	
f.68	Colonoscopy	215 ILCS 5/356z.48 (UPDATED) P.A. 103-0800	Mandated NO COST SHARE for medically necessary colonoscopies that are follow up exams based on initial screen. (b) A group or individual policy of accident and health insurance or managed care plan amended, issued, or renewed on or after January 1, 2026 shall provide coverage for a colonoscopy determined to be medically necessary.	
f.69	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.70	Genetic Testing and Evidence-Based Screenings	215 ILCS 5/356u.10 (NEW) P.A. 103-0914	Mandated Coverage for clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer, as recommended by a health care professional in accordance with current evidence-based clinical practice guidelines, including, but not limited to, the current version of the National Comprehensive Cancer Network clinical practice guidelines. The coverage shall limit the total amount that a covered person is required to pay for a clinical genetic test under this subsection to an amount not to exceed $50.	
f.71	Comprehensive Cancer Testing	215 ILCS 5/356z.50	Mandates coverage for medically necessary comprehensive cancer testing.	
f.72	Home Saliva Cancer Screening	215 ILCS 5/356z.68	Mandated Cover a medically necessary home saliva cancer screening every 24 months if the patient: (1) is asymptomatic and at high risk for the disease being tested for; or (2) demonstrates symptoms of the disease being tested for at a physical exam.	
f.73	Proton Beam Therapy	215 ILCS 5/356z.66	Mandated Shall not apply a higher standard of clinical evidence for the coverage of proton beam therapy than the insurer applies for the coverage of any other form of radiation therapy treatment.	
f.74	Liver Disease Screening	215 ILCS 5/356z.61	Mandated for preventative liver disease screenings for individuals 35 years of age or older and under the age of 65 at high risk for liver disease. NO COST SHARE	
f.75	A1C Testing	215 ILCS 5/356z.49	Mandated Coverage for A1C testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes.	
f.76	Vitamin D Testing	215 ILCS 5/356z.44	Mandated Coverage for vitamin D testing recommended by a health care provider in accordance with vitamin D deficiency risk factors identified by the CDC.	
f.77	Improving Health Care for Pregnant and Post-Partum Individuals Act	215 ILCS 5/356z.4b 215 ILCS 5/356z.40 215 ILCS 165/10	Mandated 356z.4b= Allows hospitals to bill separately for long acting contraceptives (implants and intrauterine devices) 356z.40= Mandates clinically appropriate case management programs for high-risk pregnancies and all pregnant and postpartum individuals have access to MH/Sud benefits.	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

Illinois Department of Insurance

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Springfield, IL 62767

f.78	Pediatric Palliative Care	215 ILCS 5/356z.57	Mandated Plan must provide coverage for community-based pediatric palliative care and hospice care to any qualifying child with a serious illness by a trained interdisciplinary team. Allows a child to receive community-based pediatric palliative care and hospice care while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.	
f.79	Coverage for Hormonal and Non-Hormonal Therapy to Treat Menopause	215 ILCS 5/356z.56 (UPDATED) P.A. 103-0703	Mandated Plans amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for medically necessary hormonal and non-hormonal therapy to treat menopausal symptoms if the therapy is recommended by a qualified health care provider who is licensed, accredited, or certified under Illinois law and the therapy has been proven safe and effective in peer-reviewed scientific studies.	
f.80	Coverage for Annual Menopause Health Visit	215 ILCS 5/356z.71 (NEW) P.A. 103-0751	Mandated Shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit. A policy subject to this Section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided.	
			SECTION G - BENEFITS - PREVENTIVE	
g.1	Preventive Services ACA	42 U.S.C. 300gg-13 50 IAC 2001.8 215 ILCS 5/356z.62	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(a)(1)(B)	Plans are required to cover immunizations recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment or coinsurance.	
g.3	Preventive Services - Women	42 U.S.C. 300gg-13(a)(4) 50 IAC 2001.8(a)(1)(D)	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(a)(1)(c)	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) 215 ILCS 5/356z.4 (a)(4) Benchmark p. 10, 19	Mandated Essential Health Benefit NO COST SHARE 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 5/356g.5	Coverage is required for clinical breast examinations NO COST SHARE In-Network	
g.7	Breast Feeding (Lactation) Support, Supplies and Counseling-Breast Pumps	50 IAC 2001.8	HRSA Guidelines	
g.8	Colorectal Cancer Examination and Screening	215 ILCS 5/356x Benchmark p. 12, 16	Mandated Essential Health Benefit NO COST SHARE In-Network	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

g.9	Contraceptive/Birth Control Services	CMS FAQ ACA Implementation Part 54, Q2 215 ILCS 5/356z.4 215 ILCS 5/356z.4b	Mandated Essential Health Benefit NO COST SHARE In-Network Requires insurers to cover pharmacists ordering contraceptives for individuals without a script from a physician. 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	Coverage for Abortion	215 ILCS 5/356z.4a (UPDATED) CB 2022-15 P.A. 103-0720	Mandated Requires coverage for abortion services. Coverage for abortion care may not impose deductible, coinsurance, waiting period, or other cost-sharing limitation Coverage shall not impose any restrictions or delays on the coverage. HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
g.11	Abortifacients, Hormonal Therapy, and Human Immunodeficiency Virus Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis	215 ILCS 5/356z.60	Mandated NO COST SHARE In-Network HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
g.12	Patient Care Services Provided by a Pharmacist	215 ILCS 5/356z.45	Mandated 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.13	Coverage of Vaccination Administration Fees	215 ILCS 5/356z.71 (NEW) P.A. 103-0918	Mandated Shall provide coverage for vaccinations for COVID-19, influenza, and respiratory syncytial virus, including the administration of the vaccine by a pharmacist or health care provider authorized to administer such a vaccine, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement, if the following conditions are met: (1) The vaccine is authorized or licensed by the United States Food and Drug Administration; and (2) The vaccine is ordered and administered according to the Advisory Committee on Immunization Practices standard immunization schedule.	
g.14	Prescription Estrogen	215 ILCS 5/356z.67	Mandated Coverage for one or more therapeutic equivalent versions of vaginal estrogen in its formulary. Therapeutic equivalent version has the meaning given to that term in paragraph (2) of subsection (a) of Section 356z.4. NO COST SHARE	
g.15	Coverage of Pharmacy Testing, Screening, Vaccinations, and Treatment	215 ILCS 5/356z.63	Mandated shall provide coverage for health care or patient care services provided by a pharmacist if: (1) The pharmacist meets the requirements and scope of practice described in paragraph (15), (16), or (17) of subsection (d) of Section 3 of the Pharmacy Practice Act; (2) The health plan provides coverage for the same service provided by a licensed physician, an advanced practice registered nurse, or a physician assistant; (3) The pharmacist is included in the health benefit plan's network of participating providers; and (4) Reimbursement has been successfully negotiated in good faith between the pharmacist and the health plan.	
g.16	HIV Screening - Pregnant Women	215 ILCS 5/356z.1 Benchmark p. 19	Mandated Essential Health Benefit NO COST SHARE In-Network	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

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g.17	Human Papillomavirus Vaccine (HPV)	215 ILCS 5/356z.9 Benchmark p. 12, 20	Mandated Essential Health Benefit NO COST SHARE In-Network	
g.18	Mammography - Screening (Incl. Molecular Breast Imaging)	215 ILCS 5/356g(a) 215 ILCS 5/356g(a)(4.5) (UPDATED) Benchmark p. 18, 20 P.A. 103-0808	Mandated Essential Health Benefit NO COST SHARE In-Network HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
g.19	Osteoporosis - Bone Mass Measurement	215 ILCS 5/356z.6 Benchmark p. 12, 16	Mandated Essential Health Benefit NO COST SHARE In-Network	
g.20	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	215 ILCS 5/356u Benchmark p. 12, 16	Mandated Essential Health Benefit NO COST SHARE In-Network	
g.21	Coverage for Genetic Testing for Breast and Ovarian Cancer Susceptibility.	215 ILCS 5/356u.5	Shall provide coverage for the cost of the genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer if recommended by a health care provider in accordance with the United States Preventive Services Task Force's recommendations for testing	
g.22	Shingles Vaccine (Herpes Zoster)	215 ILCS 5/356z.13 Benchmark p. 12, 19	Mandated Essential Health Benefit NO COST SHARE In-Network	
g.23	Tobacco Smoking Cessation Program	215 ILCS 5/356z.21 Benchmark p. 19	Mandated Essential Health Benefit NO COST SHARE In-Network	
g.24	Mental Health Prevention and Wellness Visits	215 ILCS 5/356z.70	Mandated One Annual mental health prevention and wellness visit for children and for adults up to 60 minutes. NO COST SHARE	
g.25	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 Benchmark p. 21, 22	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	215 ILCS 5/370c et. al. (UPDATED) P.A. 103-0650 215 ILCS 5/370c.1 et. al. Benchmark p. 21	Mandated Essential Health Benefit No Prior Authorization Requirement for Admission	
h.3	Substance Use Disorders (Inpatient/Outpatient)	215 ILCS 5/370c et. al. (UPDATED) P.A. 103-0650 215 ILCS 5/370c.1 et. al. Benchmark p. 21	Mandated Essential Health Benefit No Prior Authorization Requirement for Admission	
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.	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

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(c) (UPDATED) P.A. 103-0951	Mandated HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met. A group or individual policy of accident and health insurance or managed care plan subject to this subsection shall limit the total amount that a covered person is required to pay for a covered prescription inhaler to an amount not to exceed $25 per 30-day supply.	
i.2	Immunosuppressant Drugs - Organ Transplant Medication Notification Act	215 ILCS 175/15 Benchmark p. 31	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 5/356z.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	Mandated Plans that provides coverage for naloxone hydrochloride shall not impose a copayment on the coverage provided. HDHP with HSA exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
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 Benchmark p. 32	Mandated 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	Mandated Coverage for medically necessary epinephrine injectors for persons 18 years of age or under. Caps the cost of a twin-pack of medically necessary epinephrine at $60.	
i.13	Insulin Co-Pay	215 ILCS 5/356z.41	Mandated Required to limit cost sharing $35 per 30 day supply	

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

i.14	Prenatal Vitamins	215 ILCS 5/356z.58	Mandated	
i.15	Coverage During Generic Drug Shortage	215 ILCS 5/356z.71 (NEW) P.A. 103-0758	Mandated If a generic drug or a therapeutic equivalent is unavailable due to a supply issue and dosage cannot be adjusted, a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed after January 1, 2026 shall provide coverage for a brand name eligible prescription drug until supply of the generic drug or a therapeutic equivalent is available.	
i.16	Coverage for At-Home Pregnancy Tests	215 ILCS 5/356z.71 (NEW) P.A. 103-0870	Mandated Shall provide coverage for at-home, urine-based pregnancy tests that are prescribed to the covered person, regardless of whether the tests are otherwise available over-the-counter. The coverage required under this Section is limited to 2 at-home, urine-based pregnancy tests every 30 days.	
			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 156.110(a)(5) 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	45 CFR 156.122(c) 215 ILCS 134/45.1 215 ILCS 5/155.36 P.A. 103-0650	A process is in place for standard exception requests, expedited exception requests, and external exception request reviews as stipulated in 215 ILCS 134/45.1 and 45 CFR 156.22(c). 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; 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	Step Therapy	215 ILCS 134/45.1 215 ILCS 5/370c (6.5)(B) (UPDATED) P.A. 103-0650	A health carrier shall not use the authorization of alternative covered medications under this section in a manner that effectively creates a step therapy requirement.	Affirmed ☐

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

j.7	Prescription Drug Formulary	215 ILCS 5/155.37(b)(c) (UPDATED) P.A. 103-0650	(1) Include information on cost-sharing tiers and utilization controls, such as prior authorization, for each covered drug; (2) Indicate any drugs on the formulary that are preferred over other drugs on the formulary; (3) Include information to educate insureds about the differences between drugs administered or provided under a policy's medical benefit and drugs covered under a drug benefit and how to obtain coverage information about drugs that are not covered under the drug benefit; (4) Include information to educate insureds that policies that provide drug benefits are required to have a method for enrollees to obtain drugs not listed in the formulary if they are deemed medically necessary by a clinician under Section 45.1 of the Managed Care Reform and Patient Rights Act; (5) Include information on which medications are covered, including both generic and brand name; and (6) Include information on what tier of the plan's drug formulary each medication is in. (c) No formulary may establish a step therapy requirement as prohibited by Section 87 of the Managed Care Reform and Patient Rights Act.	Affirmed ☐
j.8	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.9	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.10	Group Guarantee Issue	215 ILCS 97/40(A)	Insurers must accept every small employer that applies for such coverage. Insurers must also accept every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll in the coverage.	Affirmed ☐
j.11	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.12	Discontinuance of Particular Type of Coverage - HIPAA	50 IAC 2025 215 ILCS 97/30(C)(1) 50 IAC 2001.4(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.13	Discontinuance of All Coverage - HIPAA	50 IAC 2025 215 ILCS 97/30(C)(2)	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.14	Modification of Coverage – HIPAA	50 ILCS 2025 215 ILCS 97/30(D) 50 IAC 2001.4(j)	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.15	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.16	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.17	Use of SSN on ID Cards	815 ILCS 505/2QQ 815 ILCS 505/2RR 215 ILCS 139/15	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.18	Schedule 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 ☐

Emily Downs, Assistant Deputy Director - Health Compliance
Emily.Downs@illinois.gov