Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767

Network Adequacy Checklist

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 policy form, 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 forms are fully compliant before filing the forms. Insurers are required to report to the Director any material change to an approved network plan within 15 days of the occurrence. (215 ILCS 124/10(h)).

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 Collection Template and a Proposed Enrollment Template	
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 Departmental approval.	
1.A.3	Associated Policy Filings	215 ILCS 124/10(b)(5)(a)	Under the Supporting Documents tab, please include a list of policy filings of the policy documents indicating the number of lives anticipated under each plan	
1.A.4	Networks		HMO - 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. PPO - attach under the supporting documents tab in SERFF, a list of all PPAs leased or owned by the company that make-up the entire network for the plans associated with this filing.	
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.	

SECTION B - STATE GUIDELINES

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1.B.1	Provider and Hospital Directories	215 ILCS 124/25 215 ILCS 124/10(b)(2) 215 ILCS 124/10(b)(4)	Web-based physician and hospital directory must be up to date, and include accurate provider/facility type, location and contact information. Providers available by telehealth or telemedicine should be clearly identified and include information required under subparagraph (K) of paragraph (1) of subsection (b) in 215 ILCS 124/25.	
1.B.2	Maximum Travel Distance or Time	215 ILCS 124/10(b)(5)(C) 215 ILCS 124/10(d)	A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries, including the travel and distance standards for plan beneficiaries in county service areas. The maximum recommended distance from any point of service area to a point of service area is: ·30 minutes or 30 miles for primary care, OB-GYN and general hospital care for urban ·60 minutes or 60 miles for primary care, OB-GYN and general hospital care for rural ·45 minutes or 60 miles for specialist in urban ·75 minutes or 100 miles for specialist in rural	
1.B.3	Ratio of providers to enrollees	215 ILCS 124/10(c)(1) 215 ILCS 124/10(b)(5)(B)	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	Facilities per County	215 ILCS 124/10(d)	Complete the County Facility template and attach under supporting documents. Please complete the hospital and mental health facility tabs by listing the name, address and phone number of each facility by county. Hospital -- 1 per County Mental Health Facility -- 1 per County	
1.B.5	NEW Access to MH/SUD (Eff. 1/1/2022)	215 ILCS 124/10(d-5)	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.	
1.B.6	NEW Access to Outpatient MH/SUD Services (Metro Counties) (Eff. 1/1/2022)	215 ILCS 124/10(d-5)(1)(A)	Metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will timely and proximate access to treatment for MH/SUD: • 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.	

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1.B.7	NEW Access to Outpatient MH/SUD Services (Non-Metro Counties) (Eff. 1/1/2022)	215 ILCS 124/10(d-5)(1)(B)	For beneficiaries residing in counties outside of Cook, DuPage, Kane, Lake, McHenry, and Will timely and proximate access to treatment for MH/SUD: • 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	NEW Access to Inpatient/Residential MH/SUD (All counites) (Eff. 1/1/2022)	215 ILCS 124/10(d-5)(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	NEW Required Exceptions to Non-Network MH/SUD Services (Eff. 1/1/2022)	215 ILCS 124/10(d-5)(3)	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	NEW No Network Exception Requests for MH/SUD requirements (Eff. 1/1/2022)	215 ILCS 124/10(g)	No Network Exception requests may be made or considered in regards 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)(A)	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)	Companies are encouraged to explore and include innovative methods of providing high quality care at lower costs. A description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable. If telehealth services are not available under the plans associated with the network, then please specifically indicate that in the network document.	
1.B.13	Provider changes	215 ILCS 124/10(a)(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)	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)	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)	Language 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)	Insurers are required to file a geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for network providers. Maps should be in the aggregate, including all leased networks under the plan. A separate map with marked locations should be provided for each provider type listed under 215 ILCS 124/10(c)(1).	

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1.B.18	Provider Listing	215 ILCS 124/10(b)(2)	Names, addresses, phone numbers and specialties of providers attached under the Supporting Documents tab in SERFF. The information should be taken from 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)	The number of participants anticipated to be covered by the network. This number should be in the aggregate including all plans for which the network is applicable and should be provided by attaching the proposed enrollment template under the Supporting Documentation tab.	
1.B.20	Accessibility and Transparency (Online)	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)	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: 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; and, J) board certifications, if applicable 2) Hospitals - A) hospital name, B) hospital type, C) participating hospital location, D) hospital accreditation status, 3) Facilities other than hospitals - A) facility name, B) facility type, C) types of services performed, D) participating facility location or locations.	
1.B.21	Accessibility and Transparency (Print)	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)	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: 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 2) Hospitals - A) Hospital name, B) hospital type, C) participating hospital locations and telephone numbers 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. 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.	
1.B.22	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.23	Provider listing	215 ILCS 124/25(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	

SECTION C - ATTESTATIONS

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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	Plan description	215 ILCS 124/10(b)	The policy(ies) associated with this network filing are submitted for approval or have already been approved by the IL Dept. of Insurance. (Please attest that those filings are included in the requirement for all SERFF Tracking numbers in Section 1.A.4 above.)	
1.C.2	In-Network Provider availability	215 ILCS 124/10(b)(6) 215 ILCS 124/10(a)(2)	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.3	Emergency Care	215 ILCS 124/10(b)(7)	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 or in-network provider.	
1.C.4	Precertification	215 ILCS 124/10(b)(8) (excludes HMO)	If a plan intends to impose penalties for failure to pre-certify a 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	Exception	215 ILCS 124/10(g)	Insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements for the Department's consideration. Note: No exceptions allowed for requirements set forth in 215 ILCS 124/10(d-5) pursuant 215 ILCS 124/10(g).	

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