Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

ACA Small Group HMO/POS

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.

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 125/4-13 50 IAC 4521.60 50 IAC 2026 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) 50 IAC 4521.112	1). Each form must bear an identifying form number in the lower left corner of the first page. 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.	

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a.7	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.8	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.9	Form of Policy	50 IAC 4521.110	No policy may be delivered or issued for delivery to any person in this state unless it adheres to the provisions of this section.	
a.10	Form Numbers	50 IAC 916.40(b)(2)(A)	Each form must bear an identifying form number in the lower left corner of the first page. Form numbers are limited to 30 characters.	
			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 215 ILCS 125/5-3(a) 50 IAC 4521.110(v)	PROHIBITED	
b.3	Discretionary Clauses Prohibited	50 IAC 2001.3 50 IAC 4521.110(x)	PROHIBITED	
b.4	Entire Contract	50 IAC 4521.110(d)	The individual contract and evidence of coverage shall contain a statement that the individual contract, all applications, and any amendments shall constitute the entire agreement between the parties.	
b.5	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.	
b.6	Grace Period	50 IAC 4521.110(l)	A group contract not involving the use of a premium tax credit shall provide for a grace period for the payment of any premium, except the first, during which coverage shall remain in effect if payment is made during the grace period. The grace period for an individual contract shall not be less than 31 days.	
b.7	Claims - Timely Payment	215 ILCS 5/368a(c)	all claims and indemnities concerning health care services other than for any periodic payment shall be paid within 30 days after receipt of due written proof of such loss.	
b.8	Coordination of Benefits	50 IAC 4521.110(s) 50 IAC 2009 - Exhibit A	Policies are permitted, but not required, to contain coordination of benefits (COB) provisions. Any COB provision must be consistent with the requirements of 50 IAC 2009.	
b.9	Termination of policy	215 ILCS 97/30	A health insurer issuing individual coverage must renew or continue in force coverage at the option of the individual except for: 1. Nonpayment of premium 2. Group Contract Cancellation 3. Termination of the plan 4. Fraud 5. Movement outside the service area; or 5. Association membership ceases. (This may be in the group agreement)	
b.10	Administrative Complaints and Appeals	215 ILCS 134/50 215 ILCS 125/4-6 50 IAC 4521.110(p)	1). Healthcare plans must accept and review appeals of determinations and complaints related to administrative issues (not healthcare services, procedures & treatments) initiated by enrollees or healthcare providers 2). Complainants not satisfied with the plan's resolution of any complaint may appeal that final plan decision to the Department.	

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b.11	Notice of Department of Insurance	215 ILCS 5/143c 215 ILCS 125/4-7	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.12	Binding Arbitration	215 ILCS 125/5-3(a) 215 ILCS 5/356z.3a (NEW) P.A. 103-0440	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 134/25 50 IAC 4520.60 215 ILCS 124/20(a) & (b)	Policy must contain a provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause or for new members whose provider is not a member of the plan's network. Must allow an enrollee in active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.	
c.2	Women's Principal HealthCare Provider	215 ILCS 125/5-3.1(a) 215 ILCS 5/356r 45 CFR 147.138 45 CFR 149.310	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. Referral requirements prohibited for accessing any participating OB/GYN physician.	
c.3	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.4	Out of Area Benefits and Services	50 IAC 4521.110(h)	The individual contract and evidence of coverage shall contain a specific description of benefits and services available out of the HMO's designated service area.	
c.5	Standing Referral to a Specialist	215 ILCS 134/40(b)	A health care plan shall establish a procedure by which an enrollee who requires the treatment of a specialist physician or other health care provider may obtain a standing referral to that individual. Such a referral may be effective for up to one year and may be renewed and re-renewed.	
c.6	Utilization of Health Care Facilities	215 ILCS 134/43	A health care plan must provide its enrollees with a description of their rights and responsibilities for obtaining referrals and for making appropriate use of health care facilities when their PCP is not available.	
			SECTION D - MEMBERSHIP/ELIGIBILITY/COVERAGE PERIOD	
d.1	Dependent Children - Adopted (and Pending) Foster Child	215 ILCS 125/4-9 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 125/4-9.1 50 IAC 4521.110(t)	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 125/4-8	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.12 215 ILCS 125/5-3(a) 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	Reinstatement	50 IAC 4521.110(k)	The individual contract and evidence of coverage, shall contain the conditions of the enrollee's right to reinstatement	
d.6	Eligibility Requirements	215 ILCS 125/4-8 50 IAC 4521.110(e)	The individual contract and evidence of coverage must contain eligibility requirements that explain the conditions that must be met to enroll in the plan, the limiting age for enrollees and eligible dependents, including the effects of Medicare eligibility, and a clear statement regarding newborn coverage.	

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d.7	Continuation of Coverage	215 ILCS 125/4-9.2	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.8	Spousal Continuation Privilege	215 ILCS 5/367.2 215 ILCS 125/5-3(a)	Policy must provide for a continuation of the existing insurance benefits for an employee's spouse and dependent children who are insured under the provisions of that group policy or certificate thereunder, notwithstanding that the marriage is dissolved by judgment or terminated by the death of the employee or, after the effective date of this amendatory Act of the 93rd General Assembly, notwithstanding the retirement of the employee provided that the employee's spouse is at least 55 years of age, in each case without any other eligibility requirements.	
d.9	Dependent Child Continuation Privilege	215 ILCS 5/367.2-5 215 ILCS 125/5-3(a)	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.10	Discontinuance and Replacement	215 ILCS 5/367i 215 ILCS 125/5-3(a) 50 IAC 2013	Group health insurance policies issued, amended, delivered or renewed on and after the effective date of this amendatory Act of 1989, shall provide a reasonable extension of benefits in the event of total disability on the date the policy is discontinued for any reason.	
			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. 2025 Out-of-pocket maximums: Self-Only $9,200 -- Other than self-only coverage $18,400	
e.2	Precertification Penalties	50 IAC 2051.310(a)(6)(K) 215 ILCS 124/10(b)(8)	If a plan intends to impose penalties for failure to pre-certify a hospital admission, the penalty must be defined in the policy and may not exceed $1,000. The penalty may be no more frequent than a per confinement basis.	
e.3	Emergency Services Prior to Stabilization	215 ILCS 134/65 50 IAC 4520.110(b)	The plan shall cover emergency services in a manner that those services will be provided without imposing a requirement under the plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the plan for the providing of services.	
e.4	Post Stabilization Services	215 ILCS 134/70 50 IAC 4520.120	If prior authorization for covered post-stabilization services is required by the healthcare plan, the plan shall provide access 24 hours a day, 7 days a week to persons designated by the plan to make such determinations. The health care plan shall provide reimbursement for covered post-stabilization medical services if: 1). authorization to render them is received from the healthcare plan or its delegated health care provider, or 2). after two documented good faith efforts, the treating health care provider has attempted to contact the enrollee's health care plan and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request.	
e.5	Deductibles and Copayments	215 ILCS 125/4-20 50 IAC 4521.110(i)	An HMO may require deductibles and copayments of enrollees as a condition for the receipt of specific health care services, including basic health care services. Deductibles and copayments shall be the only allowable charge, other than premiums, assessed enrollees. Copayments and deductibles appearing in the policy shall be for specific dollar amounts or for specific percentages of the cost of the health care services.	
e.6	Refunds/ Additional Premiums	215 ILCS 125/5-3(f)	If an HMO and a group policy holder (employer or other enrollment unit) agree to refund arrangements or charge additional premiums, the following terms and conditions must be met: 1). the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); 2). the amount of the refund or additional premium shall not exceed 20% of the HMO's profitable or unprofitable experience with respect to the group or other enrollment unit for the period.	
e.7	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. HDHP with HSA exempt from counting third-party payments until the minimal deductible under 26 U.S.C. § 223 has been met.	

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e.8	Prescription drug flat copay benefits/plan choice	215 ILCS 134/45.3	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 2025 is two group plans per service area, per metal level, with a flat copay prescription benefit structure. NEW for PY 2025: a QHP Issuer on the Federally-facilitated 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 147.126 50 IAC 2001.11 50 IAC 4521.130(l)	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 134/10 Benchmark p. 7	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	215 ILCS 125/4-15 Benchmark p. 17	Essential Health Benefit	
f.7	Emergency Room Services	Benchmark p. 7	Essential Health Benefit	
f.8	Emergency Medical Care - Criminal Sexual Assault	215 ILCS 125/4-4	Policy must state that it will provide coverage for charges for testing and examination for victims of criminal sexual assault for actual expenses incurred, without offset or reduction for benefit deductibles or coinsurance amounts.	
f.9	Home Health Care	215 ILCS 5/356z.53 215 ILCS 125/5-3(a) Benchmark p. 5	Mandated	
f.10	Hospice	Benchmark p. 28	Essential Health Benefit	
f.11	Skilled Nursing Facility	Benchmark p. 21	Essential Health Benefit	
f.12	Office Visit	Benchmark p. 8 & 11	Essential Health Benefit	
f.13	Referrals and Second Opinions/Additional Surgical Opinion	215 ILCS 125/4-10 50 IAC 4521.130(a) Benchmark p. 11	Plan must contain a description of any limitation for referrals and access to second opinions to ensure access and availability of health care services for the insured is not restricted. Coverage includes benefits for an additional surgical opinion following a recommendation for elective surgery.	
f.14	Physician Surgical Benefits	Benchmark p. 10	Including assist at surgery services	
f.15	Anesthesia Services	Benchmark p. 10	Inpatient and Ambulatory Surgical Centers	
f.16	Dental Anesthesia Services - Other Indications	215 ILCS 5/356z.2 215 ILCS 125/5-3(a) Benchmark p. 10	Mandated for certain criteria	
f.17	Dental Anesthesia Services - Autism	215 ILCS 5/356z.2(a-5) 215 ILCS 125/5-3(a)	Mandated under age 26	
f.18	Anesthesia Services – Oral Surgery	Benchmark p. 10	Benefits are provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.	

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f.19	Allergy Testing and Treatment (Serum)	Benchmark p. 11 50 IAC 4521.130(g)	Essential Health Benefit	
f.20	Amino Acid-Based Elemental Formulas	215 ILCS 5/356z.10 215 ILCS 125/5-3(a)	Mandated	
f.21	Bariatric Surgery (Obesity)	Benchmark p. 21	Essential Health Benefit	
f.22	Breast - Fibrocystic Breast Condition	215 ILCS 125/4-16	Policy must provide coverage for fibrocystic breast condition.	
f.23	Breast - Post Mastectomy Care	215 ILCS 125/4-6.5 215 ILCS 5/356t Benchmark p. 24	Mandated	
f.24	Breast Cancer Pain Medication and Therapy	215 ILCS 5/356g.5-1 215 ILCS 125/5-3(a) Benchmark p. 12 & 32	Mandated	
f.25	Breast Implant Removal	215 ILCS 125/4-6.2 Benchmark p. 25	Mandated	
f.26	Breast Reconstruction After Mastectomy	215 ILCS 125/4-6.1(b) 50 IAC 4521.132 Benchmark p. 24	Essential Health Benefit Mandated	
f.27	Breast Reduction Surgery	215 ILCS 356z.54 215 ILCS 125/5-3(a)	Mandated	
f.28	Cancer - Qualified Clinical Cancer Trials	215 ILCS 5/364.01 215 ILCS 125/5-3(a) 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	
f.32	Temporomandibular Joint Disorder (TMJ)	Benchmark p. 24 215 ILCS 125/5-3(a) 215 ILCS 130/4003 215 ILCS 165/10 215 ILCS 5/356q	Essential Health Benefit TMJ optional coverage expansion.	
f.33	Diabetes - Self Management, Education and Nutrition	215 ILCS 125/5-3(a) 215 ILCS 5/356w Benchmark p. 11	Essential Health Benefit Mandated	
f.34	Routine Foot Care	215 ILCS 5/356w(f) 215 ILCS 125/5-3(a) Benchmark p. 11 & 35	Essential Health Benefit Covered only for persons diagnosed with Diabetes	
f.35	Diabetic Supplies	215 ILCS 5/356w(d)(e) 50 IAC 2019.40 215 ILCS 125/5-3(a) Benchmark p. 31	Essential Health Benefit under Durable Medical Equipment Mandated	
f.36	Continuous Glucose Monitors	215 ILCS 5/356z.59 215 ILCS 125/5-3(a)	Mandated	

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f.37	Diabetes Telehealth Services	215 ILCS 5/356z.22 215 ILCS 125/5-3(a)	Mandated if telehealth benefits are covered.	
f.38	Durable Medical Equipment	Benchmark p. 13	Essential Health Benefit	
f.39	Compression Sleeves	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0091	Mandated for compression sleeves that is medically necessary for the enrollee to prevent or mitigate lymphedema.	
f.40	Dry Needling by Physical Therapist	215 ILCS 125/5-3(a) 215 ILCS 5/356z.28 (NEW) P.A. 103-0426	OPTIONAL	
f.41	Neuromuscular, Neurological, or Cognitive Impairment for Children	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0458	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.42	Habilitative and Rehabilitative Services and Devices	45 CFR 156.115(a)(5) Benchmark pp. 8 & 11, 22 & 35 50 IAC 4521.130(j)	Essential Health Benefit May not combine habilitative and rehabilitative visit limitations. Outpatient rehabilitation therapy, including but not limited to, speech therapy, physical therapy, and occupational therapy directed at improving physician functioning of a member must be provided up to 60 treatments per year for conditions which are expected to result in significant improvement within two months as determined by the PCP and HMO Medical Director.	
f.43	Habilitative Services for Children	215 ILCS 5/356z.15 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated - Prohibits denial of benefits solely on location of where medically necessary services are rendered.	
f.44	Hearing Aids	215 ILCS 5/356z.30 (UPDATED) 215 ILCS 125/5-3(a) P.A. 103-0530	Essential Health Benefit Mandated -- One per ear every 3 years	
f.45	Cochlear Implants/Bone anchored hearing aids	Benchmark p.17	Essential Health Benefit -- Cochlear implants covered for all ages	
f.46	Infertility (Fertility) Treatment	Benchmark p. 23 215 ILCS 5/356m 215 ILCS 125/5-3(a) 50 IAC 2015	Essential Health Benefit, for groups with more than 25 employees Expands infertility to include a broader inclusive patient base, including coverage of surrogates. Note: this mandate only applies to groups of more than 25 members.	
f.47	Fertility Preservation Services	215 ILCS 5/356z.32 215 ILCS 125/5-3(a)	Mandated	
f.48	Maternity and Newborn Care	215 ILCS 125/4-8 215 ILCS 5/356s 215 ILCS 125/4-6.4 Benchmark p. 8 & 22	Essential Health Benefit Mandated	
f.49	PANDAS/PANS	215 ILCS 5/356z.25 215 ILCS 125/5-3(a)	Mandated	
f.50	Physical Therapy - Multiple Sclerosis Patients	215 ILCS 5/356z.8 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated	
f.51	Private-Duty Nursing	Benchmark p. 17	Essential Health Benefit	
f.52	Prosthetics/Orthotics	215 ILCS 5/356z.18 (UPDATED) 215 ILCS 125/5-3(a) Benchmark p. 13 P.A. 103-0512	Essential Health Benefit Mandated 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.53	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.	

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f.54	Reconstructive Services (Physical Appearance)	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0123	Mandated - may not deny coverage for medically necessary reconstructive services that are intended to restore physical appearance.	
f.55	Cleft Lip/Cleft Palate	215 ILCS 125/5-3(a) 215 ILCS 5/356z.55 (NEW) P.A. 103-0426	Mandated	
f.56	Transplants - Human Organ Transplants	215 ILCS 5/356k 215 ILCS 125/4-5 Benchmark p. 18 & 31	Essential Health Benefit Mandated	
f.57	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.58	Cardiopulmonary Monitors	215 ILCS 125/5-3(a) 215 ILCS 5/356z.34 (NEW) P.A. 103-0426	Mandated	
f.59	Human Breast Milk	215 ILCS 125/5-3(a) 215 ILCS 5/356z.38 (NEW) P.A. 103-0426	Mandated	
f.60	Basic Health Care Services	50 IAC 4521.130	Except when superseded by other law or ACA EHB requirements, HMO's must provide coverage for Basic Health Care Services as provided by 50 IAC 4521.130.	
f.61	Whole Body Skin Examination	215 ILCS 5/356z.37 215 ILCS 125/5-3(a)	Mandated No Cost Sharing	
f.62	Diagnostic Mammogram	215 ILCS 125/4-6.1 215 ILCS 5/356g(a)(6)	Mandated No Cost Sharing HDHP with HSA Exempt from no cost-sharing requirement until the minimal deductible under 26 U.S.C. § 223 has been met.	
f.63	Tick-Borne Disease	215 ILCS 125/5-3(a) 215 ILCS 5/356z.35	Mandated	
f.64	Pancreatic cancer	215 ILCS 5/356z.47 215 ILCS 125/5-3(a)	Coverage for medically necessary pancreatic cancer screening.	
f.65	Biomarker testing	215 ILCS 5/356z.46 215 ILCS 125/5-3(a)	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.66	Telehealth mandate	215 ILCS 5/356z.22 215 ILCS 125/5-3(a)	Mandates telehealth coverage.	
f.67	Colonoscopy	215 ILCS 5/356z.48 215 ILCS 125/5-3(a)	No cost-sharing for medically necessary colonoscopies that are follow up exams based on initial screen.	
f.68	Port wine stains	215 ILCS 5/356z.51 215 ILCS 125/5-3(a)	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.69	Comprehensive cancer testing	215 ILCS 5/356z.50 215 ILCS 125/5-3(a)	Mandates coverage for medically necessary comprehensive cancer testing.	
f.70	Home Saliva Cancer Screening	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0445	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.71	Proton Beam Therapy	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0325	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.	

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f.72	Liver Disease Screening	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0084	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.73	A1C testing	215 ILCS 5/356z.49 215 ILCS 125/5-3(a)	Coverage for A1C testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes.	
f.74	Vitamin D testing	215 ILCS 5/356z.44 215 ILCS 125/5-3(a)	Coverage for vitamin D testing recommended by a health care provider in accordance with vitamin D deficiency risk factors identified by the CDC.	
f.75	Improving health care for pregnant and post partum individuals act	215 ILCS 5/356z.40 215 ILCS 125/5-3(a)	Mandates clinically appropriate case management programs for high-risk pregnancies and all pregnant and postpartum individuals have access to mh/sud benefits.	
f.76	Pediatric Palliative Care	215 ILCS 5/356z.57 215 ILCS 125/5-3(a)	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.77	Hormone therapy to treat menopause	215 ILCS 5/356z.56 215 ILCS 125/5-3(a)	Mandated	
			SECTION G - BENEFITS - PREVENTIVE	
g.1	Preventive Services ACA	42 U.S.C. 300gg-13 50 IAC 2001.8 50 IAC 4521.110(x)	Benefits shall be provided at no cost sharing to the member when these services are delivered by a network provider. Policy must contain language indicating that all preventive services covered are covered with no cost-sharing to the member pursuant to A and B recommendations found in the United States Preventive Services Task Force (USPSTF) guidelines.	
g.2	Preventive Services - Immunizations	42 U.S.C. 300gg-13(a)(2) 50 IAC 2001.8(1)(B) 50 IAC 4521.110(x)	Plans are required to cover immunizations recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment or coinsurance.	
g.3	Preventive Services - Women	42 U.S.C. 300gg-13(a)(4) 50 IAC 2001.8(1)(D) 50 IAC 4521.110(x)	Plans are required to cover women's preventive services guidelines supported by the Health Resources & Services Administration without charging a deductible, copayment or coinsurance.	
g.4	Preventive Services - Children/ Adolescents	42 U.S.C. 300gg-13(a)(3) 50 IAC 2001.8(1)(C) 50 IAC 4521.110(x)	Plans are required to cover children's preventive services guidelines supported by the Health Resources & Services Administration without charging a deductible, copayment or coinsurance. Benefits must include routine hearing screenings/examinations.	
g.5	Sterilization	215 ILCS 5/356z.4(a)(3)(B) 215 ILCS 5/356z.4 (a)(4) 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated No Cost Sharing In-Network Male Sterilization: HDHP with HAS 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 125/4-6.5 215 ILCS 5/356g.5	Coverage is required for clinical breast examinations. NO COST SHARING IN-NETWORK	
g.7	Breast Feeding (Lactation) Support, Supplies and Counseling - Breast Pumps	50 IAC 2001.8 50 IAC 4521.110(x)	HRSA Guidelines	
g.8	Colorectal Cancer Examination and Screening	215 ILCS 5/356x 215 ILCS 125/5-3(a) Benchmark p. 12 & 16	Essential Health Benefit Mandated No Cost Sharing In-Network	

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g.9	Contraceptive/Birth Control Services	215 ILCS 5/356z.4 215 ILCS 125/5-3(a) CMS FAQ ACA Implementation Part 54, Q2 CB 2022-15	Essential Health Benefit Mandated No Cost Sharing 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	Patient Care Services Provided by a Pharmacist	215 ILCS 125/5-3(a) 215 ILCS 5/356z.45	Coverage for health care or patient care services provided by a pharmacist if 1) the pharmacist meets the requirements set forth in section 43 of the Pharmacy Practice Act; 2) health plan provides coverage for the same service provided by a licensed physician, advanced practice registered nurse, or a physician assistant; 3) the pharmacist is included in the health benefit plan's network of participating providers; 4) a reimbursement has been successfully negotiated in good faith between the pharmacist and the health plan.	
g.11	Prescription Estrogen	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0420	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 Sharing	
g.12	Coverage of pharmacy testing, screening, vaccinations, and treatment	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0001	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.13	Coverage for Abortion	215 ILCS 5/356z.4a 215 ILCS 125/5-3(a) CB 2022-15	Requires coverage for abortion services. Coverage for abortion care may not impose deductible, coinsurance, waiting period, or other cost-sharing limitation that is greater than that required for other pregnancy-related benefits covered by the policy. Coverage shall not impose any restrictions or delays on the coverage	
g.14	Abortifacients, Hormonal Therapy, and Human Immunodeficiency Virus Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis	215 ILCS 5/356z.60 215 ILCS 125/5-3(a)	Mandated No Cost Sharing 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.15	HIV screening - pregnant women	215 ILCS 5/356z.1 215 ILCS 125/4-6.5	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.16	Human Papillomavirus Vaccine (HPV)	215 ILCS 5/356z.9 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.17	Mammography - Screening	215 ILCS 5/356g(a) 215 ILCS 125/4-6.1 Benchmark p. 24	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.18	Osteoporosis - Bone Mass Measurement	215 ILCS 5/356z.6 215 ILCS 125/5-3(a) Benchmark p. 16	Essential Health Benefit Mandated NO COST SHARING IN-NETWORK	
g.19	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	215 ILCS 5/356u 215 ILCS 125/4-6.5 Benchmark p. 16	Essential Health Benefit Mandated No Cost Sharing In-Network	

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g.20	Shingles Vaccine (Herpes Zoster)	215 ILCS 5/356z.13 215 ILCS 125/5-3(a) Benchmark p. 12 & 19	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.21	Tobacco Smoking Cessation Program	215 ILCS 5/356z.21 215 ILCS 125/5-3(a) Benchmark p. 19	Essential Health Benefit Mandated No Cost Sharing In-Network	
g.22	Mental Health Prevention and Wellness Visits.	215 ILCS 125/5-3(a) 215 ILCS 5/356z.61 (NEW) P.A. 103-0535	Mandated one annual mental health prevention and wellness visit for children and for adults up to 60 minutes. No Cost Sharing	
g.23	Wellness Programs	215 ILCS 5/356z.17 215 ILCS 125/5-3(a) 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.14 215 ILCS 125/5-3(a)	Mandated for individuals under age 21. Prohibits denial of benefits solely on location of where medically necessary services are rendered.	
h.2	Mental (Behavioral) Health Treatment (Inpatient/Outpatient)	215 ILCS 5/370c et. Al. 215 ILCS 5/370c.1 et. Al. 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated	
h.3	Substance Use Disorders (Inpatient/Outpatient)	215 ILCS 5/370c et. Al. 215 ILCS 5/370c.1 et. Al. 215 ILCS 125/5-3(a)	Essential Health Benefit Mandated	
h.4	Recovery Housing for persons with substance use disorders	215 ILCS 5/356z.31 215 ILCS 125/5-3(a)	OPTIONAL - A policy may provide coverage for residential extended care services and supports for persons recovery housing for persons with substance use disorders who are at risk of a relapse following discharge from a health care clinic, federally qualified health center, hospital withdrawal management program or any other licensed withdrawal management program, or hospital emergency department so long as specific conditions are met.	
h.5	Tele-Psychiatry	Benchmark p. 11	Essential Health Benefit Required to be covered as a medical care visit	
SECTION I - BENEFITS - PRESCRIPTION DRUGS - ALL POLICIES				
i.1	Inhalants - Prescription	215 ILCS 5/356z.5 215 ILCS 125/5-3(a)	Mandated	
i.2	Immunosuppressant Drugs - Organ Transplant Medication Notification Act	215 ILCS 175/15	Plans must cover medically necessary immunosuppressant drugs with a written prescription after an approved human organ transplant. When a prescribing physician has indicated on a prescription "MAY NOT SUBSTITUTE", a health insurance policy or healthcare service plan that covers immunosuppressant drugs, may not require, or cause a pharmacist to interchange another immunosuppressant drug or formulation, issued on behalf of a person to inhibit or prevent the activity of the immune system of the patient to prevent the rejection of the transplanted organs & tissues without notification and the documented consent of the prescribing physician and the patient.	
i.3	Prescription Drugs - Cancer Treatment	215 ILCS 125/4-6.3 Benchmark p. 32	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.4	Cancer Drug Parity	215 ILCS 125/5-3(a) 215 ILCS 5/356z.20 (NEW) P.A. 103-0426	Mandated	
i.5	Immune Gamma Globulin	215 ILCS 125/5-3(a) 215 ILCS 5/356z.24 (NEW) P.A. 103-0426	Mandated	

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i.6	Opioid Antagonists	215 ILCS 125/5-3(a) 215 ILCS 5/356z.23 (NEW) P.A. 103-0426	Mandated	
i.7	Synchronization	215 ILCS 5/356z.26 215 ILCS 125/5-3(a)	Mandated	
i.8	Opioid Medically Assisted Treatment (MAT)	Benchmark p. 21	Essential Health Benefit	
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	Epinephrine Injectors	215 ILCS 125/5-3(a) 215 ILCS 5/356z.33 (UPDATED) P.A. 103-0454	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.12	Insulin Co-Pay	215 ILCS 125/5-3(a) 215 ILCS 5/356z.41 (UPDATED) P.A. 103-0429	Required to limit cost sharing $35 per 30 day supply	
i.13	Prenatal Vitamins	215 ILCS 125/5-3(a) 215 ILCS 5/356z.58 (NEW) P.A. 103-0426	Mandated	
SECTION J - ATTESTATIONS				
j.1	Stage 4 Advanced Metastatic Cancer	215 ILCS 5/356z.29 215 ILCS 125/5-3(a)	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.2	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.3	Short-term opioid prescription limitations	Benchmark p. 31	This policy limits short-term opioid prescriptions to no more than 7 days.	Affirmed ☐
j.4	Prescription Drug Exception	45 CFR 156.122(c) 215 ILCS 134/45.1	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; 3). the prescription drug alternatives required to be used in accordance with a step therapy requirement, a). has been ineffective in the treatment or b). has caused an adverse reaction or harm to the enrollee; or 4). the number of doses available under a dose restriction for the prescription drug, a). has been ineffective in the treatment of the enrollee's disease or medical condition or b). the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.	Affirmed ☐

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j.5	Prescription Drug Formulary	215 ILCS 134/15 (a-5)(1) 215 ILCS 134/25(a)(3) 215 ILCS 125/4-6.5 215 ILCS 5/155.37	No policy of health insurance shall be offered for sale directly to consumers through the health insurance marketplace unless the most recently published prescription drug formulary is made available to the consumer when comparing policies and premiums. Plans offering prescription drugs shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change	Affirmed ☐
j.6	Transition of Services (Incl. Formulary)	215 ILCS 134/25	Mandated. Continuity/transition of care requirements	Affirmed ☐
j.7	Autism - Prohibition on Coverage Termination	215 ILCS 5/356z.14(h-10) 215 ILCS 125/5-3(a)	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.8	Prohibition on Rescissions	50 IAC 2001.7 50 IAC 4521.110(x) 45 CFR 147.128	A group 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.9	Discontinuance of Particular Type of Coverage - HIPAA	50 IAC 2025 215 ILCS 97/30(C)(1) 50 IAC 2001.4(g)(h) & (j)	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.10	Discontinuance of All Coverage - HIPAA	215 ILCS 97/30(C)(2) 50 IAC 2025 215 ILCS 97/60	Insurers must comply with the uniform termination requirements for discontinuing all coverage in the state. Notification to the Department is required for discontinuation of all health insurance coverage in the individual market 90 days before the issuer notifies covered individuals, which must be given 180 days before the effective date of termination.	Affirmed ☐
j.11	Modification of Coverage – HIPAA	50 ILCS 2025 215 ILCS 97/30(D)	An insurer may only modify a contract at renewal as long as the modification is consistent with Illinois law and consistent on a uniform basis among all individuals with that policy form.	Affirmed ☐
j.12	Use of Information Derived from Genetic Testing	215 ILCS 5/356v 410 ILCS 513/20 215 ILCS 125/5-3(a)	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.13	Use of SSN on ID Cards	815 ILCS 505/2QQ 815 ILCS 505/2RR 215 ILCS 139/15 (NEW)	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.14	Schedule of Benefits and Coverage (SBCs)	50 IAC 2001.10 50 IAC 4521.110(x) 50 IAC 4521.110(b)	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 ☐
j.15	Prohibition on Medicaid Language	215 ILCS 125/4-2(b)	An HMO contract may not contain any provision which limits or excludes payments of health care services to or on behalf of the enrollee because the enrollee or any covered dependent is eligible for or is receiving Medicaid benefits in this or any other state.	Affirmed ☐
SECTION K - POS PLAN REQUIREMENTS				
If the filing to which this checklist is attached holds a policy that will be used as a base plan for a Point-of-Service (POS) product, this section must be completed.				
k.1	In Plan/Out of Plan Services	215 ILCS 125/4.5-1(a)(3) 50 IAC 4521.113	Point of Service plan may not offer services out-of-plan without providing those services on an in-plan basis	

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k.2	Comparison of Benefits	50 IAC 4521.113(a)(7)	Point of Service plan filing must include a comparison of benefits offered by the HMO carrier and the indemnity carrier.	
k.3	ID Cards	50 IAC 4521.113(a)(2) 215 ILCS 139/15 (NEW)	Point of Service plan filing must include enrollment application and member identification card disclosing the names of both the HMO and indemnity carrier.	
k.4	Limited Benefit Disclosure	215 ILCS 125/4.5-1(a)(7)	HMO must include the following disclosure on its Point of Service plan contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card."	
k.5	Out of Network Benefits		Point of Service plan out of network benefits must meet applicable requirements stated within this checklist. If the out-of- network piece is being offered through an agreement with an insurer, please provide the SERFF Tracking #.	SERFF Tracking #

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