[215 Ill. Comp. Stat. §§ 125/4-10 through 125/4-20.]

§§ 125/4-10 through 125/4-20: Health Maintenance Organization Act -- Delivery of Services – Required Provisions and Marketing

§ 4-10. Medical necessity; dispute resolution; independent second opinion.

Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure.

§ 4-11. Limited insurance representative.

Any person who enrolls recipients of Public Aid or Medicare in a health maintenance organization, either personally or by mail, shall, on or after July 1, 1989, be licensed as a limited insurance representative under Section 495.1 of the Illinois Insurance Code. No such person shall be required to pass a written examination in order to qualify to be licensed as a limited insurance representative under this Section.

§ 4-12. Changes in Rate Methodology and Benefits, Material Modifications.

A health maintenance organization shall file with the Director, prior to use, a notice of any change in rate methodology, or benefits and of any material modification of any matter or document furnished pursuant to Section 2-1, together with such supporting documents as are necessary to fully explain the change or modification.

(a) Contract modifications described in subsections (c)(5), (c)(6) and (c)(7) of Section 2-1 shall include all form agreements between the organization and enrollees, providers, administrators of services and insurers of health maintenance organizations.

(b) Material transactions or series of transactions other than those described in subsection (a) of this Section, the total annual value of which exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current twelve month period as determined from filed financial statements.

(c) Any agreement between the organization and an insurer shall be subject to the provisions of the laws of this State regarding reinsurance as provided in Article XI of the Illinois Insurance Code. All reinsurance agreements must be filed. Approval of the Director is required for all agreements except the following:

individual stop loss, aggregate excess, hospitalization benefits or out-of-area of the participating providers unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements require approval.

§ 4-13. Prior approval of policy forms.

No health maintenance organization shall issue or deliver in this State a group contract or evidence of coverage, attach an endorsement or rider thereto, incorporate by reference bylaws or other matter therein, or use an application blank in this State until the form and content of the group contract or evidence of coverage, endorsement, rider, bylaw, or other matter incorporated by reference or application blank has been filed with and approved by the Director, except that any such endorsement or rider that is to be attached to a group contract or evidence of coverage after the date the group contract or evidence of coverage is issued must be filed with, reviewed, and approved by the Director before the date it is attached to a group contract or evidence of coverage issued or delivered in this State. The Director shall withhold approval of any such group contract, evidence of coverage, endorsement, rider, bylaw, or other matter incorporated by reference or application blank if it contains provisions that may encourage misrepresentation or that are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to the law or public policy of this State or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the group contract or evidence of coverage. The Director shall not withhold approval of a form under this Section solely because of the absence of coverage for mental health services if the Department of Children and Family Services presents evidence that coverage of mental health services for clients of that Department will be provided by another entity. In all cases the Director shall approve or disapprove any such form within 60 days after submission unless the Director extends by not more than an additional 30 days the period within which he shall approve or disapprove any such form by giving written notice to the organization of the extension before expiration of the initial 60-day period.

The Director shall withdraw his approval of a group contract or evidence of coverage, endorsement, rider, bylaw, or other matter incorporated by reference or application blank if he subsequently determines that the group contract or evidence of coverage, endorsement, rider, bylaw, other matter, or application blank is misrepresentative, unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to the law or public policy of this State, or contains exceptions or conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the group contract or evidence of coverage. The Director shall not withdraw approval of a form under this Section solely because of the absence of coverage for mental health services if the Department of Children and Family Services presents evidence that coverage of mental health services for clients of that Department is being or will be provided by another entity.

If a previously approved group contract or evidence of coverage, endorsement, rider, bylaw, or other matter incorporated by reference or application blank is withdrawn for use, the Director shall serve upon the company an order of withdrawal of use, either personally or by mail. If the service is by mail, the service shall be completed if the notice is deposited in the post office, postage prepaid, addressed to the health maintenance organization's last known address specified in the records of the Department of Insurance. The order of withdrawal of use shall take effect 30 days from the date of mailing but shall be stayed if within the 30-day period a written request for hearing is filed with the Director. The hearing shall be held at the time and place designated in the order given by the Director. The hearing may be held either in the City of Springfield,

the City of Chicago, or in the county where the principal business address of the health maintenance organization is located.

The action of the Director in disapproving or withdrawing the form shall be subject to judicial review under the Administrative Review Law.

§ 4-14. Evidence of Coverage.

(a) Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The health services to which each enrollee is entitled;

(2) Eligibility requirements indicating the conditions which must be met to enroll in a Health Care Plan;

(3) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any reasonable deductibles, copayments, or other charges;

(4) The terms or conditions upon which coverage may be cancelled or otherwise terminated;

(5) Where and in what manner information is available as to where and how services may be obtained; and

(6) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

§ 4-15. Emergency transportation by ambulance.

(a) No contract or evidence of coverage for basic health care services delivered, issued for delivery, renewed or amended by a Health Maintenance Organization shall exclude coverage for emergency transportation by ambulance. For the purposes of this Section, the term "emergency" means a need for immediate medical attention resulting from a life threatening condition or situation or a need for immediate medical attention as otherwise reasonably determined by a physician, public safety official or other emergency medical personnel.

(b) Upon reasonable demand by a provider of emergency transportation by ambulance, a Health Maintenance Organization shall promptly pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by ambulance provided to an enrollee in a health care plan arranged for by the Health Maintenance Organization. By accepting any such payment from the Health Maintenance Organization, the provider of emergency transportation by ambulance agrees not to seek any payment from the enrollee for services provided to the enrollee.

§ 4-16. Fibrocystic condition; denial of coverage.

No contract or evidence of coverage issued by a Health Maintenance Organization shall be denied by the Organization, nor shall any contract or evidence of coverage contain any exception or exclusion of benefits, solely because the enrollee has been diagnosed as having a fibrocystic breast condition, unless the condition is

diagnosed by a breast biopsy that demonstrates an increased disposition to the development of breast cancer or unless the enrollee's medical history confirms a chronic, relapsing, symptomatic breast condition.

§ 4-17. Basic outpatient preventive and primary health care services for children.

In order to attempt to address the needs of children in Illinois (i) without health care coverage, either through a parent's employment, through medical assistance under the Illinois Public Aid Code, or any other health plan or (ii) who lose medical assistance if and when their parents move from welfare to work and do not find employment that offers health care coverage, a health maintenance organization may undertake to provide or arrange for and to pay for or reimburse the cost of basic outpatient preventive and primary health care services. The Department shall promulgate rules to establish minimum coverage and disclosure requirements. These requirements at a minimum shall include routine physical examinations and immunizations, sick visits, diagnostic x-rays and laboratory services, and emergency outpatient services. Coverage may also include preventive dental services, vision screening and one pair of eyeglasses, prescription drugs, and mental health services. The coverage may include any reasonable co-payments, deductibles, and benefit maximums subject to limitations established by the Director by rule. Coverage shall be limited to children who are 18 years of age or under, who have resided in the State of Illinois for at least 30 days, and who do not qualify for medical assistance under the Illinois Public Aid Code. Any such coverage shall be made available to an adult on behalf of such children and shall not be funded through State appropriations. In counties with populations in excess of 3,000,000, the Director shall not approve any arrangement under this Section unless and until an arrangement for at least one health maintenance organization under contract with the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) for furnishing health services pursuant to Section 5-11 of the Illinois Public Aid Code and for which the requirements of 42 CFR 434.26(a) have been waived is approved.

§ 4-18. Retirement facility residents.

With respect to an enrollee who is a resident of a retirement facility consisting of a long-term care facility, as defined in the Nursing Home Care Act, and residential apartments, a contract or evidence of coverage issued, amended, delivered, or renewed after the effective date of this amendatory Act of 1997 shall provide that the enrollee's primary care physician must refer the enrollee to the retirement facility's long-term care facility for Medicare covered skilled nursing services if the primary care physician finds that:

(1) it is in the best interests of the patient;

(2) the facility, if not a participating provider in the specific health maintenance organization, agrees during the preauthorization period to a negotiated rate for skilled nursing services covered in that organization's health care plan; and

(3) the facility meets all the requirements of a participating provider for skilled nursing services as defined and covered under the health maintenance organization's health care plan.

Both the facility and the health maintenance organization must fully disclose all pertinent information to consumers to assure that their decisions are based upon full knowledge of the implications of their decision making.

§ 4-19. Purchase of ophthalmic goods or services.

A health maintenance organization may not require a provider, as a condition of participation in the health maintenance organization's health care plan, to purchase ophthalmic goods or services, including but not limited to eyeglass frames, in a quantity or dollar amount in excess of the quantity or dollar amount an enrollee purchases under the terms of the health care plan.

§ 4-20. Deductibles and copayments.

(a) A Health Maintenance Organization 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 charges, other than premiums, assessed enrollees. Nothing within this subsection (a) shall preclude the provider from charging reasonable administrative fees, such as service fees for checks returned for non-sufficient funds and missed appointments.

(b) Deductibles and copayments shall be for specific dollar amounts or for specific percentages of the cost of the health care services.

(c) No combination of deductibles and copayments paid for the receipt of basic health care services may exceed the annual maximum out-of-pocket expenses of a high deductible health plan as defined in 26 U.S.C. 223.

(d) Deductibles and copayments applicable to supplemental health care services, catastrophic-only plans as defined under the federal Affordable Care Act, or pre-existing conditions are not subject to the annual limitations described in this Section.

(e) This Section applies to enrollees and does not limit the health care plan payment for services provided by non-participating providers.

(f) This Section applies to enrollees and does not limit the health care plan payment for services provided by non-participating providers.