

[215 Ill. Comp. Stat. § 134/15.]

§ 134/15. Provision of information: Managed Care Reform and Patient Rights Act

(a) A health care plan shall provide annually to enrollees and prospective enrollees, upon request, a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

- (1) the service area;
- (2) the covered benefits and services with all exclusions, exceptions, and limitations;
- (3) the pre-certification and other utilization review procedures and requirements;
- (4) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy;
- (5) the emergency coverage and benefits, including any restrictions on emergency care services;
- (6) the out-of-area coverage and benefits, if any;
- (7) the enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;
- (8) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by that provider;
- (9) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; and
- (10) a statement of all basic health care services and all specific benefits and services mandated to be provided to enrollees by any State law or administrative rule.

(a-5) Without limiting the generality of subsection (a) of this Section, no qualified health plans shall be offered for sale directly to consumers through the health insurance marketplace operating in the State in accordance with Sections 1311 and 1321 of the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued thereunder (collectively, "the Federal Act"), unless, in addition to the information required under subsection (a) of this Section, the following

information is available to the consumer at the time he or she is comparing health care plans and their premiums:

(1) With respect to prescription drug benefits, the most recently published formulary where a consumer can view in one location covered prescription drugs; information on tiering and the cost-sharing structure for each tier; and information about how a consumer can obtain specific copayment amounts or coinsurance percentages for a specific qualified health plan before enrolling in that plan. This information shall clearly identify the qualified health plan to which it applies.

(2) The most recently published provider directory where a consumer can view the provider network that applies to each qualified health plan and information about each provider, including location, contact information, specialty, medical group, if any, any institutional affiliation, and whether the provider is accepting new patients. The information shall clearly identify the qualified health plan to which it applies. In the event of an inconsistency between any separate written disclosure statement and the enrollee contract or certificate, the terms of the enrollee contract or certificate shall control.

(b) Upon written request, a health care plan shall provide to enrollees a description of the financial relationships between the health care plan and any health care provider and, if requested, the percentage of copayments, deductibles, and total premiums spent on healthcare related expenses and the percentage of copayments, deductibles, and total premiums spent on other expenses, including administrative expenses, except that no health care plan shall be required to disclose specific provider reimbursement.

(c) A participating health care provider shall provide all of the following, where applicable, to enrollees upon request:

(1) Information related to the health care provider's educational background, experience, training, specialty, and board certification, if applicable.

(2) The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(3) Information regarding the health care provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(d) A health care plan shall provide the information required to be disclosed under this Act upon enrollment and annually thereafter in a legible and understandable format. The Department shall promulgate rules to establish the format based, to the extent practical, on the standards developed for supplemental insurance coverage under Title XVIII of the federal Social Security Act as a guide, so that a person can compare the attributes of the various health care plans.

(e) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

(f) Each issuer of qualified health plans for sale directly to consumers through the health insurance marketplace operating in the State shall make the information described in subsection (a) of this Section, for each qualified health plan that it offers, available and accessible to the general public on the company's Internet website and through other means for individuals without access to the Internet.

(g) The Department shall ensure that State-operated Internet websites, in addition to the Internet website for the health insurance marketplace established in this State in accordance with the Federal Act and its implementing regulations, prominently provide links to Internet-based materials and tools to help consumers be informed purchasers of health care plans.

(h) Nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act. This Section shall apply to all qualified health plans offered for sale directly to consumers through the health insurance marketplace operating in this State for any coverage year beginning on or after January 1, 2015.