**Section 4521.110 Requirements for Group Contracts, Evidences of Coverage and Individual Contracts**

a) Any group contract, evidence of coverage, individual contract, enrollee handbook, enrollment application, identification card or other form that affects the terms and conditions applicable to the subscriber or enrollee in the provision of health care services must be filed with and approved by the Director prior to use in accordance with the filing requirements of Section 4521.112 of this Part and Section 4-13 of the Act. The HMO shall issue to each subscriber or enrollee a group contract, evidence of coverage, or individual contract. Any conflicting information between the valid current document referenced in this subsection issued to the subscriber or enrollee and the current group contract shall be interpreted according to whichever is most beneficial to the subscriber or enrollee. Any group contract, evidence of coverage, or individual contract shall provide for the rendering of health care services as defined in that document for either a specific period of not less than 12 months from the date of issuance or for another period mutually agreed to by the HMO and the group or individual contractholder, and shall provide for renewal on a basis mutually agreed to by both parties, unless the HMO has given 31 days' written notice of nonrenewal prior to the renewal date of the contract.

b) A detailed statement of any exceptions, exclusions, or limitations shall be set forth in the group contract, evidence of coverage, and individual contract for any type of health care service to be excepted. Exception, exclusions, or limitations shall appear with the same prominence in the group contract, evidence of coverage, and individual contract as any benefit.

c) The group contract, evidence of coverage, and individual contract shall set forth a detailed statement of the terms and conditions of maternity benefits and any related exceptions, exclusions, limitations, copayments, and deductibles. Exceptions, exclusions, limitations, copayments, and deductibles applicable to prenatal and postnatal care shall be covered no differently than any other covered health care services provided pursuant to the contract, with the exception of a limitation for coverage of routine prenatal care or delivery when the enrollee is outside the service area against medical advice (except when the enrollee is outside of the service area due to circumstances beyond the enrollee's control) may be included in the group contract and evidence of coverage.

d) Entire Contract. The group contract, evidence of coverage, and individual contract shall contain a statement that the group contract evidence of coverage and individual contract, all applications, and any amendments shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the HMO shall be part of a contract or evidence of coverage unless set forth in full in the document or attached to it.

e) Eligibility Requirements. The group contract, evidence of coverage, and individual contract shall contain eligibility requirements indicating the conditions that must be met to enroll in a health care plan, the limiting age for enrollees and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children as set forth in Sections 4-8 and 4-9 of the Act.

f) Benefits and Services Within the Service Area. The group contract, evidence of coverage, and individual contract shall contain a specific description of benefits and services available within the HMO's designated service area.

g) Emergency Care Services. The group contract, evidence of coverage, and individual contract shall contain a specific description of benefits and services available for emergencies 24 hours per day, 7 days per week, including disclosure of any restrictions on emergency care services. No group contract, evidence of coverage, or individual contract shall limit the coverage of emergency services within the service area to those providers having a contract with the HMO.

h) Out-of-area Benefits and Services. The group contract, evidence of coverage, and individual contract shall contain a specific description of benefits and services available out of the HMO's designated service area.

i) Deductibles and Copayments

1) An HMO may require deductibles and copayments from 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. Nothing within this subsection (i) shall preclude the provider from charging reasonable administrative fees, such as service fees for checks returned for non-sufficient funds and missed appointments.

2) 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.

3) No combination of deductibles and copayments for 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.

4) Deductibles and copayments applicable to supplemental health care services or catastrophic-only plans as defined under the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), are not subject to the annual limitations described in this Section.

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

j) Cancellation. The group contract, evidence of coverage, and individual contract shall contain the conditions upon which they can be cancelled by the HMO or the enrollee as set forth in Section 4521.111.

k) Reinstatement. The group contract, evidence of coverage, and individual contract shall contain the conditions of the enrollee's right to reinstatement.

l) Grace Period

1) A group contract or individual 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 a group contract shall not be less than 10 days. The grace period for an individual contract shall not be less than 31 days. During the grace period, the HMO shall remain liable for providing the services and benefits contracted for. The subscriber shall remain liable for the payment of the premium for the time coverage was in effect during the grace period and the enrollee shall remain liable for the payment of any applicable share of the premium for the time coverage was in effect, as well as for any copayments owed.

2) Termination of coverage for individuals receiving advance payments of premium tax credits shall comply with the requirements of 45 CFR 155 and 45 CFR 156.270 (2020).

m) No group contract, evidence of coverage, or individual contract may be delivered in this State unless the subscriber or enrollee is provided written notice required by Section 143c of the Illinois Insurance Code [215 ILCS 5/143c].

n) Right to Examine Contract. An individual contract, with the exception of an HMO Medicare contract entered into between the Health Care Financing Administration and the HMO under Title XVIII of the Social Security Act (42 U.S.C. 1395 through 1395lll), as amended from time to time, shall contain a provision stating that an enrollee who has entered into an agreement with an HMO shall be permitted to return the individual contract within ten days after receiving it and to receive a refund of the premium paid if the enrollee is not satisfied with the contract for any reason. If the individual contract is returned to the HMO or to its representative through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for the enrollee or dependent by the HMO during the 10-day examination period, the enrollee shall not be permitted to return the contract and receive a refund of the premium paid.

o) An HMO Medicare contract entered into between the Health Care Financing Administration and the HMO under Title XVIII of the Social Security Act, as amended from time to time, shall be delivered to the enrollee at least 15 days prior to the effective date of the contract. The enrollee shall be permitted to return the HMO Medicare contract prior to the effective date and to receive a refund of the premium paid if the enrollee is not satisfied with the contract for any reason, provided the enrollee complies with the disenrollment procedures of Title XVIII of the Social Security Act, as amended from time to time.

p) Every HMO will provide to every enrollee of the HMO information that generally describes the philosophy, functions, and organization of the HMO and related institutions, and specific information that describes the appropriate use of the HMO's services, including a general description of benefits and limitations. The HMO shall include in its enrollee information a description of the HMO's grievance procedure, directions for filing a grievance, and a Notice of Availability of the Department.

q) Every HMO shall provide enrollees with an identification card that must prominently display the following information:

1) the words "Health Maintenance Organization" or "HMO";

2) disclaimer language concerning an enrollee's unauthorized use of providers not selected by the HMO;

3) a current telephone number for the enrollees to use when health care services are required outside of normal office hours; and

4) the name of all enrollees entitled to coverage, along with all other mandated information, if the HMO does not issue a card to each enrollee who is entitled to coverage. In these situations, at least two cards must be issued to the primary enrollee upon enrollment and the HMO must issue additional cards to all enrollees at the request of the enrollee for no additional charge. Notification of the right to order additional cards for no additional charge must be included with information required to be disseminated to enrollees under subsection (p).

r) Enrollment Application. No individual contract shall be issued except upon the signed enrollment application of the enrollee for whom coverage is being sought. Any information or statement of the applicant shall appear on the application in the form of interrogatories by the HMO and answers by the applicant. The enrollee shall not be bound by any statement made within an application for health care coverage unless a copy of the application is attached to the individual contract. Group enrollment applications must be maintained on file by the HMO; otherwise, disputes arising from statements made within the applications will be resolved in the enrollee's favor. Except for those instances involving fraud or material misrepresentation, an HMO's failure to investigate incomplete or conflicting answers on an enrollment application shall estop the HMO from subsequently denying coverage on the basis of those responses.

s) Coordination of Benefits

1) HMOs are permitted, but not required, to adopt coordination of benefits provisions for group contracts, evidence of coverage, or individual contracts to avoid over insurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

2) If an HMO adopts coordination of benefits, the provision must be consistent with the coordination of benefits requirements set forth in 50 Ill. Adm. Code 2009.

3) To the extent necessary for an HMO to meet its obligations as a secondary carrier under 50 Ill. Adm. Code 2009, and when an enrollee has established a credit within the reserve bank, the HMO shall make payments for services that are:

A) received from non-participating providers;

B) provided outside its services areas; or

C) not covered under the terms of health care plan.

t) Dependents-termination of coverage-disability and dependency, proof-application. Every group contract, evidence of coverage, or individual contract providing that coverage of a dependent person of an enrollee terminates upon attainment of the limiting age for dependent persons shall comply with the requirements of Section 4-9.1 of the Act.

u) Conversion of Coverage

1) The group contract and evidence of coverage shall contain a conversion provision that provides that each enrollee has the right to convert coverage to an individual or group HMO contract in the following circumstances:

A) upon cancellation of eligibility for coverage under a group contract;

B) upon cancellation of the group contract; or

C) upon non-renewal of the group contract.

2) The conversion contract shall cover the enrollee and the enrollee's eligible dependents who were covered by the group contract on the date of cancellation or non-renewal of coverage. To obtain the conversion contract, an enrollee shall submit a written application, along with the application premium payment, within 31 days after the date the enrollee's coverage is cancelled.

3) The HMO may require copayments and deductibles under a conversion contract that differ from the group contract.

4) A conversion contract shall not be required to be made available if:

A) The cancellation of the enrollee's coverage occurred for any of the reasons listed in Section 4521.111(a);

B) The enrollee is covered by or is eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395lll);

C) The enrollee is covered by similar hospital, medical, or surgical benefits under State or federal law;

D) The enrollee is covered by similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

E) The enrollee is covered for similar benefits through individual coverage;

F) The enrollee has not been continuously covered during the three-month period immediately preceding cancellation of that person's coverage;

G) The enrollee has moved outside of the service area of the health maintenance organization;

H) The cancellation of the enrollee's coverage occurred in relation to the HMO being placed in rehabilitation or liquidation proceedings pursuant to Section 5-6 of the Act; or

I) The group contract has been discontinued in its entirety and there is a succeeding carrier providing coverage to the group in its entirety.

5) Benefits or coverage shall be considered "similar" if coverage is provided for at least 12 months under comprehensive type medical coverage.

6) At a minimum, the conversion contract shall provide basic health care services.

7) The conversion contract shall begin coverage of the enrollee and any dependents formerly covered under the group contract on the date of termination from the group or the former individual contract.

8) Coverage shall be provided without requiring evidence of insurability and shall not impose any pre-existing condition limitations or exclusions.

v) Discrimination between individuals of the same class in the terms and conditions of the health care plan, or in the amount charged for coverage under a health care plan except when the rate differential is based on sound actuarial principles, or in any other manner whatsoever, is prohibited.

w) Grievance Procedure

The group contract, evidence of coverage, and individual contract shall set forth a full description of the HMO grievance procedure required by Section 4521.40.

x) The provisions of 50 Ill. Adm. Code 2001, Subparts A and C, shall apply to this Part.

(Source: Amended at 48 Ill. Reg. 7266, effective April 30, 2024)