**Section 2001.8 Coverage of Preventive Health Services**

a) Services

1) In General

Beginning at the time described in subsection (b), and subject to 45 CFR 147.131, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage stated both in the policy and certificate (for group coverage) for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance or deductible) with respect to those items or services:

A)Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in subsection (c));

B)Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

C)With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

D) With respect to women, to the extent not described in subsection (a)(1)(A), preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration.

i) In developing the binding health plan coverage guidelines specified in this subsection (a)(1)(D), the Health Resources and Services Administration shall be informed by evidence and may establish exemptions from those guidelines allowed with respect to group health plans established or maintained by religious employers and health insurance coverage provided in connection with group health plans established or maintained by religious employers with respect to any requirement to cover contraceptive services under such guidelines.

ii)For purposes of this subsection (a)(1)(D), a "religious employer" is an organization that meets all of the following criteria: The inculcation of religious values is the purpose of the organization; the organization primarily employs persons who share the religious tenets of the organization; the organization serves primarily persons who share the religious tenets of the organization; the organization is a nonprofit organization as described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended (26 USC 6033).

2) Office Visits

A)If an item or service described in subsection (a)(1) is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

B)If an item or service described in subsection (a)(1) is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

C)If an item or service described in subsection (a)(1) is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

D)This subsection (a)(2) is illustrated by the examples appearing in 45 CFR 147.130.

3) Out-of-Network Providers

Nothing in this Section requires a plan or issuer that has a network of providers to provide benefits for items or services described in subsection (a)(1) that are delivered by an out-of-network provider. Moreover, nothing in this Section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a)(1) that are delivered by an out-of-network provider.

4) Reasonable Medical Management

Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a)(1) to the extent not specified in the recommendation or guideline.

5) Services Not Described

Nothing in this Section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in subsection (a)(1), even if the treatment results from an item or service described in subsection (a)(1). (45 CFR 147.130)

b) Timing

1) In General

A plan or issuer must provide coverage pursuant to subsection (a)(1) for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

2) Changes in Recommendations or Guidelines

A plan or issuer is not required under this Section to provide coverage for any items and services specified in any recommendation or guideline described in subsection (a)(1) after the recommendation or guideline is no longer described in subsection (a)(1). Other requirements of federal or Illinois law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective. (45 CFR 147.130)

c) Recommendations not Current

For purposes of subsection (a)(1)(A), and for purposes of any other provision of law, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current. (45 CFR 147.130)

d) Applicability Date

This Section applies for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See 45 CFR 147.140 for determining the application of this Section to grandfathered health plans (providing that the provisions of this Section regarding coverage of preventive health services do not apply to grandfathered health plans). (45 CFR 147.130)

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