AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by adding Sections 356z.88, 370u, and 511.119 as follows:

(215 ILCS 5/356z.88 new)

Sec. 356z.88. Hearing care plans and discounted hearing care plans.

(a) Definitions. In this Section:

"Administrator" means any administrator as defined in Section 370g or 511.101 of this Code.

"Cost sharing" has the meaning given to that term in Section 356z.3a of this Code.

"Covered items" means items for which reimbursement or capitation from an enrollee's hearing care plan is provided to a hearing instrument professional or for which a reimbursement or discount is provided to an enrollee under a hearing care plan or discounted hearing care plan.

"Covered items" includes, but is not limited to, prescription hearing aids, earmolds, domes or inserts, assistive listening devices, and hearing aid supplies and accessories. "Covered items" does not include over-the-counter hearing aids as defined in 21 CFR 800.30(b).

"Covered services" means services for which reimbursement or capitation from an enrollee's hearing care plan is provided to a hearing instrument professional or for which a reimbursement or discount is provided to an enrollee under a hearing care plan or discounted hearing care plan.

"Discount hearing care benefit" means a hearing care benefit that is offered in a discounted hearing care plan.

"Discounted hearing care plan" means a discounted health care services plan, as defined in 50 Ill. Adm. Code 2051.220, that provides discounts for covered items or services.

"Enrollee" means any individual enrolled in a hearing care plan or a beneficiary of a discounted hearing care plan.

"Excepted benefits" has the meaning given to that term in 42 U.S.C. 300gg-91(c) and federal regulations thereunder.

"Funded hearing care benefit" means hearing care benefits that are offered in the enrollee's hearing care plan contract.

"Health insurance coverage" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Hearing care benefits" means the covered items or covered services listed or otherwise covered in the contract or plan documents for an enrollee's hearing care plan or discounted hearing care plan.

"Hearing care organization" means a health insurance issuer or administrator formed under the laws of this State or another state that issues or administers a hearing care plan or discounted hearing care plan.

"Hearing care plan" means any policy, certificate, contract, or other plan of health insurance coverage, whether excepted benefits or any other coverage, that provides coverage for covered items and covered services.

"Hearing instrument professional" means a person who is licensed in this State as an audiologist, a hearing instrument dispenser, or a physician.

"Manufacturer" means the legal person, including any business entity or other form of organization, that manufactures and distributes hearing aids, earmolds, domes or inserts, assistive listening devices, and hearing aid supplies and accessories.

"Noncovered items and services" means items and services that are not funded or discounted by the enrollee's hearing care plan or discounted hearing care plan and where the enrollee is fully responsible for the cost of the item or service.

"Prescription hearing aid" means any instrument or device, including an instrument or device dispensed pursuant to a prescription or order, that is designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including earmolds.

"Prescription hearing aid" does not include batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services.

"Routine hearing care services" means services that lack medical necessity, such as pass or fail hearing screenings, that are used to determine the need for additional diagnostic hearing testing.

"Subcontractor" means any company, group, or third-party entity, including agents, servants, partially owned or wholly owned subsidiaries, and controlled organizations, that the hearing care organization contracts with to supply items or service for a hearing instrument professional or enrollee to fulfill the benefit plan of a hearing care plan or discounted hearing care plan.

(b) No hearing care organization that is an issuer or administrator of a hearing care plan or discounted hearing care plan issued, delivered, amended, or renewed on or after the effective date of this amendatory Act of the 104th General Assembly shall issue or renew a contract that requires a hearing instrument professional, as a condition of participation in the hearing care plan or discounted hearing care plan, to provide items or services to an enrollee at a fee set by the hearing care plan or discounted hearing care plan unless the items and services are covered items or covered services under the hearing care plan or discounted hearing

care plan.

(c) A hearing instrument professional who chooses not to accept as payment an amount set by a hearing care plan or discounted hearing care plan for items and services that are not covered by the hearing care plan or discounted hearing care plan shall:

(1) post, in a conspicuous place, a notice stating the following: "IMPORTANT: This hearing instrument professional does not accept the fee schedule set by your hearing care plan for hearing care items and services that are not covered benefits under your plan, when the item or service is provided prior to the hearing aid fitting, after one year following the initial fitting of the hearing aids, or after all of the allowed service visits are exhausted. In these cases, the hearing instrument professional may charge his or her usual and customary fees for those items and services. This hearing instrument professional will provide you with an estimated cost for each noncovered item or service in accordance with the No Surprises Act."; or

(2) provide the information required under paragraph (1) in a document provided by the hearing instrument professional to the patient.

(d) Hearing care benefits must be communicated in writing by the hearing care organization to an enrollee, prospective enrollee, and the hearing instrument professional. Covered

items and services subject to de minimis reimbursement are not required to be listed in this communication. Noncovered items and noncovered services must be identified in the hearing care plan's marketing materials, contract, and plan documents.

(e) No hearing care organization or its officers, directors, agents, and employees may represent a discount hearing care benefit as a funded hearing care benefit. A hearing care organization must clearly list and document, in the schedule of benefits and in marketing materials and plan documents, the specific cost sharing amounts to hearing care benefits provided by both in-network and out-of-network providers of a hearing care plan or, in the case of a discounted hearing care plan, the specific discounted amounts for the discount hearing care benefits provided by preferred providers.

(f) A hearing care plan or discounted hearing care plan may provide hearing care benefits that include routine hearing care services and medically necessary diagnostic hearing services in accordance with guidance promulgated by the Centers for Medicare and Medicaid Services. If hearing care benefits or discount hearing care benefits include routine hearing testing for the purpose of fitting or modifying a hearing aid, the hearing instrument professional shall be reimbursed, by the hearing care organization, by the enrollee, or by both, as applicable under the terms of the plan, for the costs of performing the testing regardless of whether the

enrollee proceeds with the purchase of a prescription hearing aid.

(g) If a hearing care organization is owned or operated, in whole or in part, by a hearing aid manufacturer and that manufacturer offers prescription hearing aids within the hearing care benefits of a hearing care plan or discounted hearing care plan, that hearing care organization must disclose, on its websites for enrollees or potential enrollees, in its marketing communications, and in its benefits or plan documents, its ownership or operational interest and specify which prescription hearing aids are available within the hearing care plan or discounted hearing care plan it issues or administers.

(h) The provisions of this Section apply to any subcontractors used by a hearing care organization to supply items or services to a hearing instrument professional.

(215 ILCS 5/370u new)

Sec. 370u. Hearing care plans and discounted hearing care plans. All administrators of hearing care plans or discounted hearing care plans must comply with Section 356z.88 of this Code.

(215 ILCS 5/511.119 new)

Sec. 511.119. Hearing care plans. All administrators of hearing care plans must comply with Section 356z.88 of this

Code.

Section 10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Illinois Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76, 356z.77, 356z.78, 356z.79, 356z.80, 356z.81, 356z.82, 356z.83, 356z.84, 356z.85, 356z.88, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370a, 370c,

370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois

Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) 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); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable

experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff. 6-9-25; 104-28, eff. 1-1-26; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff. 1-1-26; 104-98, eff. 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-334, eff. 8-15-25; 104-379, eff. 1-1-26; 104-417, eff. 8-15-25; revised 11-21-25.)

Section 15. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c, 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71, 356z.73, 356z.74, 356z.75, 356z.79, 356z.80, 356z.81, 356z.83, 356z.84, 356z.85, 356z.88, 364.3, 368a, 370a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service that is not a limited health service. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

(1) a corporation under the laws of this State; or

(2) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a domestic company under Article VIII 1/2 of the Illinois Insurance Code.

(Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff. 6-9-25; 104-42, eff. 8-1-25; 104-73, eff. 1-1-26; 104-98, eff. 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-334, eff. 8-15-25; 104-379, eff. 1-1-26; 104-417, eff. 8-15-25; revised 11-21-25.)

Section 99. Effective date. This Act takes effect January 1, 2027.