



Rep. Bob Morgan

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10400HB3800ham001

LRB104 09780 BAB 25019 a

1 AMENDMENT TO HOUSE BILL 3800

2 AMENDMENT NO. _____. Amend House Bill 3800 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Sections 121-2.08, 174, 194, 368d, 370c.1, and 1563
6 and by renumbering and changing Section 356z.71 (as amended by
7 Public Act 103-700) as follows:

8 (215 ILCS 5/121-2.08) (from Ch. 73, par. 733-2.08)

9 Sec. 121-2.08. Transactions in this State involving
10 contracts of insurance independently procured directly from an
11 unauthorized insurer by industrial insureds.

12 (a) As used in this Section:

13 "Exempt commercial purchaser" means exempt commercial
14 purchaser as the term is defined in subsection (1) of Section
15 445 of this Code.

16 "Home state" means home state as the term is defined in

1 subsection (1) of Section 445 of this Code.

2 "Industrial insured" means an insured:

3 (i) that procures the insurance of any risk or risks
4 of the kinds specified in Classes 2 and 3 of Section 4 of
5 this Code by use of the services of a full-time employee
6 who is a qualified risk manager or the services of a
7 regularly and continuously retained consultant who is a
8 qualified risk manager;

9 (ii) that procures the insurance ~~directly from an~~
10 ~~unauthorized insurer~~ without the services of an
11 intermediary insurance producer; and

12 (iii) that is an exempt commercial purchaser whose
13 home state is Illinois.

14 "Insurance producer" means insurance producer as the term
15 is defined in Section 500-10 of this Code.

16 "Qualified risk manager" means qualified risk manager as
17 the term is defined in subsection (1) of Section 445 of this
18 Code.

19 "Safety-Net Hospital" means an Illinois hospital that
20 qualifies as a Safety-Net Hospital under Section 5-5e.1 of the
21 Illinois Public Aid Code.

22 "Unauthorized insurer" means unauthorized insurer as the
23 term is defined in subsection (1) of Section 445 of this Code.

24 (b) For contracts of insurance procured directly from an
25 unauthorized insurer effective January 1, 2015 or later,
26 within 90 days after the effective date of each contract of

1 insurance issued under this Section, the insured shall file a
2 report with the Director by submitting the report to the
3 Surplus Line Association of Illinois in writing or in a
4 computer readable format and provide information as designated
5 by the Surplus Line Association of Illinois. The information
6 in the report shall be substantially similar to that required
7 for surplus line submissions as described in subsection (5) of
8 Section 445 of this Code. Where applicable, the report shall
9 satisfy, with respect to the subject insurance, the reporting
10 requirement of Section 12 of the Fire Investigation Act.

11 (c) For contracts of insurance procured directly from an
12 unauthorized insurer effective January 1, 2015 through
13 December 31, 2017, within 30 days after filing the report, the
14 insured shall pay to the Director for the use and benefit of
15 the State a sum equal to the gross premium of the contract of
16 insurance multiplied by the surplus line tax rate, as
17 described in paragraph (3) of subsection (a) of Section 445 of
18 this Code, and shall pay the fire marshal tax that would
19 otherwise be due annually in March for insurance subject to
20 tax under Section 12 of the Fire Investigation Act. For
21 contracts of insurance procured directly from an unauthorized
22 insurer effective January 1, 2018 or later, within 30 days
23 after filing the report, the insured shall pay to the Director
24 for the use and benefit of the State a sum equal to 0.5% of the
25 gross premium of the contract of insurance, and shall pay the
26 fire marshal tax that would otherwise be due annually in March

1 for insurance subject to tax under Section 12 of the Fire
2 Investigation Act. For contracts of insurance procured
3 directly from an unauthorized insurer effective January 1,
4 2015 or later, within 30 days after filing the report, the
5 insured shall pay to the Surplus Line Association of Illinois
6 a countersigning fee that shall be assessed at the same rate
7 charged to members pursuant to subsection (4) of Section 445.1
8 of this Code.

9 (d) For contracts of insurance procured directly from an
10 unauthorized insurer effective January 1, 2015 or later, the
11 insured shall withhold the amount of the taxes and
12 countersignature fee from the amount of premium charged by and
13 otherwise payable to the insurer for the insurance. If the
14 insured fails to withhold the tax and countersignature fee
15 from the premium, then the insured shall be liable for the
16 amounts thereof and shall pay the amounts as prescribed in
17 subsection (c) of this Section.

18 (e) Contracts of insurance with an industrial insured that
19 qualifies as a Safety-Net Hospital are not subject to
20 subsections (b) through (d) of this Section.

21 (Source: P.A. 100-535, eff. 9-22-17; 100-1118, eff. 11-27-18.)

22 (215 ILCS 5/174) (from Ch. 73, par. 786)

23 Sec. 174. Kinds of agreements requiring approval.

24 (1) The following kinds of reinsurance agreements shall
25 not be entered into by any domestic company unless such

1 agreements are approved in writing by the Director:

2 (a) Agreements of reinsurance of any such company
3 transacting the kind or kinds of business enumerated in
4 Class 1 of Section 4, or as a Fraternal Benefit Society
5 under Article XVII, a Mutual Benefit Association under
6 Article XVIII, a Burial Society under Article XIX or an
7 Assessment Accident and Assessment Accident and Health
8 Company under Article XXI, cedes previously issued and
9 outstanding risks to any company, or cedes any risks to a
10 company not authorized to transact business in this State,
11 or assumes any outstanding risks on which the aggregate
12 reserves and claim liabilities exceed 20% ~~20 percent~~ of
13 the aggregate reserves and claim liabilities of the
14 assuming company, as reported in the preceding annual
15 statement, for the business of either life or accident and
16 health insurance.

17 (b) Any agreement or agreements of reinsurance whereby
18 any company transacting the kind or kinds of business
19 enumerated in either Class 2 or Class 3 of Section 4 cedes
20 to any company or companies at one time, or during a period
21 of six consecutive months more than 20% ~~twenty per centum~~
22 of the total amount of its net ~~previously retained~~
23 unearned premium reserve liability. The Director has the
24 right to request additional filing review and approval of
25 all contracts that contribute to the statutory threshold
26 trigger. As used in this Section, "net unearned premium

1 reserve liability" means a liability associated with
2 existing or in-force business that is not ceded to any
3 reinsurer before the effective date of the proposed
4 reinsurance contract.

5 (c) (Blank).

6 (2) Requests for approval shall be filed at least 30
7 working days prior to the stated effective date of the
8 agreement. An agreement which is not disapproved by the
9 Director within 30 working ~~thirty~~ days after its complete
10 submission shall be deemed approved.

11 (Source: P.A. 98-969, eff. 1-1-15.)

12 (215 ILCS 5/194) (from Ch. 73, par. 806)

13 Sec. 194. Rights and liabilities of creditors fixed upon
14 liquidation.

15 (a) The rights and liabilities of the company and of its
16 creditors, policyholders, stockholders or members and all
17 other persons interested in its assets, except persons
18 entitled to file contingent claims, shall be fixed as of the
19 date of the entry of the Order directing liquidation or
20 rehabilitation unless otherwise provided by Order of the
21 Court. The rights of claimants entitled to file contingent
22 claims or to have their claims estimated shall be determined
23 as provided in Section 209.

24 (b) The Director may, within 2 years after the entry of an
25 order for rehabilitation or liquidation or within such further

1 time as applicable law permits, institute an action, claim,
2 suit, or proceeding upon any cause of action against which the
3 period of limitation fixed by applicable law has not expired
4 at the time of filing of the complaint upon which the order is
5 entered.

6 (c) The time between the filing of a complaint for
7 conservation, rehabilitation, or liquidation against the
8 company and the denial of the complaint shall not be
9 considered to be a part of the time within which any action may
10 be commenced against the company. Any action against the
11 company that might have been commenced when the complaint was
12 filed may be commenced for at least 180 days after the
13 complaint is denied.

14 (d) Notwithstanding subsection (a) of this Section,
15 policies of life, disability income, long-term care, health
16 insurance or annuities covered by a guaranty association, or
17 portions of such policies covered by one or more guaranty
18 associations under applicable law shall continue in force,
19 subject to the terms of the policy (including any terms
20 restructured pursuant to a court-approved rehabilitation plan)
21 to the extent necessary to permit the guaranty associations to
22 discharge their statutory obligations. Policies of life,
23 disability income, long-term care, health insurance or
24 annuities, or portions of such policies not covered by one or
25 more guaranty associations shall terminate as provided under
26 subsection (a) of this Section and paragraph (6) of Section

1 193 of this Article, except to the extent the Director
2 proposes and the court approves the use of property of the
3 liquidation estate for the purpose of either (1) continuing
4 the contracts or coverage by transferring them to an assuming
5 reinsurer, or (2) distributing dividends under Section 210 of
6 this Article. Claims incurred during the extension of coverage
7 provided for in this Article shall be classified at priority
8 level (d) under paragraph (1) of Section 205 of this Article.

9 (Source: P.A. 88-297; 89-206, eff. 7-21-95.)

10 (215 ILCS 5/356z.73)

11 Sec. 356z.73 ~~356z.71~~. Insurance coverage for dependent
12 parents.

13 (a) A group or individual policy of accident and health
14 insurance issued, amended, delivered, or renewed on or after
15 January 1, 2026 that provides dependent coverage shall make
16 that dependent coverage available to the parent or stepparent
17 of the insured if the parent or stepparent meets the
18 definition of a qualifying relative under 26 U.S.C. 152(d) and
19 lives or resides within the accident and health insurance
20 policy's service area.

21 (b) This Section does not apply to specialized health care
22 service plans, Medicare supplement insurance, hospital-only
23 policies, accident-only policies, or specified disease
24 insurance policies that reimburse for hospital, medical, or
25 surgical expenses.

1 (Source: P.A. 103-700, eff. 1-1-25; revised 12-3-24.)

2 (215 ILCS 5/368d)

3 Sec. 368d. Recoupments.

4 (a) A health care professional or health care provider
5 shall be provided a remittance advice, which must include an
6 explanation of a recoupment or offset taken by an insurer,
7 health maintenance organization, independent practice
8 association, or physician hospital organization, if any. The
9 recoupment explanation shall, at a minimum, include the name
10 of the patient; the date of service; the service code or if no
11 service code is available a service description; the
12 recoupment amount; and the reason for the recoupment or
13 offset. In addition, an insurer, health maintenance
14 organization, independent practice association, or physician
15 hospital organization shall provide with the remittance
16 advice, or with any demand for recoupment or offset, a
17 telephone number or mailing address to initiate an appeal of
18 the recoupment or offset together with the deadline for
19 initiating an appeal. Such information shall be prominently
20 displayed on the remittance advice or written document
21 containing the demand for recoupment or offset. Any appeal of
22 a recoupment or offset by a health care professional or health
23 care provider must be made within 60 days after receipt of the
24 remittance advice.

25 (b) It is not a recoupment when a health care professional

1 or health care provider is paid an amount prospectively or
2 concurrently under a contract with an insurer, health
3 maintenance organization, independent practice association, or
4 physician hospital organization that requires a retrospective
5 reconciliation based upon specific conditions outlined in the
6 contract.

7 (c) No recoupment or offset may be requested or withheld
8 from future payments 12 months or more after the original
9 payment is made, except in cases in which:

10 (1) a court, government administrative agency, other
11 tribunal, or independent third-party arbitrator makes or
12 has made a formal finding of fraud or material
13 misrepresentation;

14 (2) an insurer is acting as a plan administrator for
15 the Comprehensive Health Insurance Plan under the
16 Comprehensive Health Insurance Plan Act;

17 (3) the provider has already been paid in full by any
18 other payer, third party, or workers' compensation
19 insurer; or

20 (4) an insurer contracted with the Department of
21 Healthcare and Family Services is required by the
22 Department of Healthcare and Family Services to recoup or
23 offset payments due to a federal Medicaid requirement.

24 No contract between an insurer and a health care professional
25 or health care provider may provide for recoupments in
26 violation of this Section. Nothing in this Section shall be

1 construed to preclude insurers, health maintenance
2 organizations, independent practice associations, or physician
3 hospital organizations from resolving coordination of benefits
4 between or among each other, including, but not limited to,
5 resolution of workers' compensation and third-party liability
6 cases, without recouping payment from the provider beyond the
7 12-month ~~18-month~~ time limit provided in this subsection (c).

8 (Source: P.A. 102-632, eff. 1-1-22.)

9 (215 ILCS 5/370c.1)

10 Sec. 370c.1. Mental, emotional, nervous, or substance use
11 disorder or condition parity.

12 (a) On and after July 23, 2021 (the effective date of
13 Public Act 102-135), every insurer that amends, delivers,
14 issues, or renews a group or individual policy of accident and
15 health insurance or a qualified health plan offered through
16 the Health Insurance Marketplace in this State providing
17 coverage for hospital or medical treatment and for the
18 treatment of mental, emotional, nervous, or substance use
19 disorders or conditions shall ensure prior to policy issuance
20 that:

21 (1) the financial requirements applicable to such
22 mental, emotional, nervous, or substance use disorder or
23 condition benefits are no more restrictive than the
24 predominant financial requirements applied to
25 substantially all hospital and medical benefits covered by

1 the policy and that there are no separate cost-sharing
2 requirements that are applicable only with respect to
3 mental, emotional, nervous, or substance use disorder or
4 condition benefits; and

5 (2) the treatment limitations applicable to such
6 mental, emotional, nervous, or substance use disorder or
7 condition benefits are no more restrictive than the
8 predominant treatment limitations applied to substantially
9 all hospital and medical benefits covered by the policy
10 and that there are no separate treatment limitations that
11 are applicable only with respect to mental, emotional,
12 nervous, or substance use disorder or condition benefits.

13 (b) The following provisions shall apply concerning
14 aggregate lifetime limits:

15 (1) In the case of a group or individual policy of
16 accident and health insurance or a qualified health plan
17 offered through the Health Insurance Marketplace amended,
18 delivered, issued, or renewed in this State on or after
19 September 9, 2015 (the effective date of Public Act
20 99-480) that provides coverage for hospital or medical
21 treatment and for the treatment of mental, emotional,
22 nervous, or substance use disorders or conditions the
23 following provisions shall apply:

24 (A) if the policy does not include an aggregate
25 lifetime limit on substantially all hospital and
26 medical benefits, then the policy may not impose any

1 aggregate lifetime limit on mental, emotional,
2 nervous, or substance use disorder or condition
3 benefits; or

4 (B) if the policy includes an aggregate lifetime
5 limit on substantially all hospital and medical
6 benefits (in this subsection referred to as the
7 "applicable lifetime limit"), then the policy shall
8 either:

9 (i) apply the applicable lifetime limit both
10 to the hospital and medical benefits to which it
11 otherwise would apply and to mental, emotional,
12 nervous, or substance use disorder or condition
13 benefits and not distinguish in the application of
14 the limit between the hospital and medical
15 benefits and mental, emotional, nervous, or
16 substance use disorder or condition benefits; or

17 (ii) not include any aggregate lifetime limit
18 on mental, emotional, nervous, or substance use
19 disorder or condition benefits that is less than
20 the applicable lifetime limit.

21 (2) In the case of a policy that is not described in
22 paragraph (1) of subsection (b) of this Section and that
23 includes no or different aggregate lifetime limits on
24 different categories of hospital and medical benefits, the
25 Director shall establish rules under which subparagraph
26 (B) of paragraph (1) of subsection (b) of this Section is

1 applied to such policy with respect to mental, emotional,
2 nervous, or substance use disorder or condition benefits
3 by substituting for the applicable lifetime limit an
4 average aggregate lifetime limit that is computed taking
5 into account the weighted average of the aggregate
6 lifetime limits applicable to such categories.

7 (c) The following provisions shall apply concerning annual
8 limits:

9 (1) In the case of a group or individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the Health Insurance Marketplace amended,
12 delivered, issued, or renewed in this State on or after
13 September 9, 2015 (the effective date of Public Act
14 99-480) that provides coverage for hospital or medical
15 treatment and for the treatment of mental, emotional,
16 nervous, or substance use disorders or conditions the
17 following provisions shall apply:

18 (A) if the policy does not include an annual limit
19 on substantially all hospital and medical benefits,
20 then the policy may not impose any annual limits on
21 mental, emotional, nervous, or substance use disorder
22 or condition benefits; or

23 (B) if the policy includes an annual limit on
24 substantially all hospital and medical benefits (in
25 this subsection referred to as the "applicable annual
26 limit"), then the policy shall either:

1 (i) apply the applicable annual limit both to
2 the hospital and medical benefits to which it
3 otherwise would apply and to mental, emotional,
4 nervous, or substance use disorder or condition
5 benefits and not distinguish in the application of
6 the limit between the hospital and medical
7 benefits and mental, emotional, nervous, or
8 substance use disorder or condition benefits; or

9 (ii) not include any annual limit on mental,
10 emotional, nervous, or substance use disorder or
11 condition benefits that is less than the
12 applicable annual limit.

13 (2) In the case of a policy that is not described in
14 paragraph (1) of subsection (c) of this Section and that
15 includes no or different annual limits on different
16 categories of hospital and medical benefits, the Director
17 shall establish rules under which subparagraph (B) of
18 paragraph (1) of subsection (c) of this Section is applied
19 to such policy with respect to mental, emotional, nervous,
20 or substance use disorder or condition benefits by
21 substituting for the applicable annual limit an average
22 annual limit that is computed taking into account the
23 weighted average of the annual limits applicable to such
24 categories.

25 (d) With respect to mental, emotional, nervous, or
26 substance use disorders or conditions, an insurer shall use

1 policies and procedures for the election and placement of
2 mental, emotional, nervous, or substance use disorder or
3 condition treatment drugs on their formulary that are no less
4 favorable to the insured as those policies and procedures the
5 insurer uses for the selection and placement of drugs for
6 medical or surgical conditions and shall follow the expedited
7 coverage determination requirements for substance abuse
8 treatment drugs set forth in Section 45.2 of the Managed Care
9 Reform and Patient Rights Act.

10 (e) This Section shall be interpreted in a manner
11 consistent with all applicable federal parity regulations
12 including, but not limited to, the Paul Wellstone and Pete
13 Domenici Mental Health Parity and Addiction Equity Act of
14 2008, final regulations issued under the Paul Wellstone and
15 Pete Domenici Mental Health Parity and Addiction Equity Act of
16 2008 and final regulations applying the Paul Wellstone and
17 Pete Domenici Mental Health Parity and Addiction Equity Act of
18 2008 to Medicaid managed care organizations, the Children's
19 Health Insurance Program, and alternative benefit plans.

20 (f) The provisions of subsections (b) and (c) of this
21 Section shall not be interpreted to allow the use of lifetime
22 or annual limits otherwise prohibited by State or federal law.

23 (g) As used in this Section:

24 "Financial requirement" includes deductibles, copayments,
25 coinsurance, and out-of-pocket maximums, but does not include
26 an aggregate lifetime limit or an annual limit subject to

1 subsections (b) and (c).

2 "Mental, emotional, nervous, or substance use disorder or
3 condition" means a condition or disorder that involves a
4 mental health condition or substance use disorder that falls
5 under any of the diagnostic categories listed in the mental
6 and behavioral disorders chapter of the current edition of the
7 International Classification of Disease or that is listed in
8 the most recent version of the Diagnostic and Statistical
9 Manual of Mental Disorders.

10 "Treatment limitation" includes limits on benefits based
11 on the frequency of treatment, number of visits, days of
12 coverage, days in a waiting period, or other similar limits on
13 the scope or duration of treatment. "Treatment limitation"
14 includes both quantitative treatment limitations, which are
15 expressed numerically (such as 50 outpatient visits per year),
16 and nonquantitative treatment limitations, which otherwise
17 limit the scope or duration of treatment. A permanent
18 exclusion of all benefits for a particular condition or
19 disorder shall not be considered a treatment limitation.

20 "Nonquantitative treatment" means those limitations as
21 described under federal regulations (26 CFR 54.9812-1).

22 "Nonquantitative treatment limitations" include, but are not
23 limited to, those limitations described under federal
24 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
25 146.136.

26 (h) The Department of Insurance shall implement the

1 following education initiatives:

2 (1) By January 1, 2016, the Department shall develop a
3 plan for a Consumer Education Campaign on parity. The
4 Consumer Education Campaign shall focus its efforts
5 throughout the State and include trainings in the
6 northern, southern, and central regions of the State, as
7 defined by the Department, as well as each of the 5 managed
8 care regions of the State as identified by the Department
9 of Healthcare and Family Services. Under this Consumer
10 Education Campaign, the Department shall: (1) by January
11 1, 2017, provide at least one live training in each region
12 on parity for consumers and providers and one webinar
13 training to be posted on the Department website and (2)
14 establish a consumer hotline to assist consumers in
15 navigating the parity process by March 1, 2017. By January
16 1, 2018 the Department shall issue a report to the General
17 Assembly on the success of the Consumer Education
18 Campaign, which shall indicate whether additional training
19 is necessary or would be recommended.

20 (2) (Blank). ~~The Department, in coordination with the~~
21 ~~Department of Human Services and the Department of~~
22 ~~Healthcare and Family Services, shall convene a working~~
23 ~~group of health care insurance carriers, mental health~~
24 ~~advocacy groups, substance abuse patient advocacy groups,~~
25 ~~and mental health physician groups for the purpose of~~
26 ~~discussing issues related to the treatment and coverage of~~

~~mental, emotional, nervous, or substance use disorders or conditions and compliance with parity obligations under State and federal law. Compliance shall be measured, tracked, and shared during the meetings of the working group. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any legislative recommendations developed by the working group.~~

(3) Not later than January 1 of each year, the Department, in conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone

1 and Pete Domenici Mental Health Parity and Addiction
2 Equity Act of 2008 and 42 U.S.C. 18031(j).

3 (B) Cover the methodology the Departments use to
4 check for compliance with this Section and Sections
5 356z.23 and 370c of this Code.

6 (C) Identify market conduct examinations or, in
7 the case of the Department of Healthcare and Family
8 Services, audits conducted or completed during the
9 preceding 12-month period regarding compliance with
10 parity in mental, emotional, nervous, and substance
11 use disorder or condition benefits under State and
12 federal laws and summarize the results of such market
13 conduct examinations and audits. This shall include:

14 (i) the number of market conduct examinations
15 and audits initiated and completed;

16 (ii) the benefit classifications examined by
17 each market conduct examination and audit;

18 (iii) the subject matter of each market
19 conduct examination and audit, including
20 quantitative and nonquantitative treatment
21 limitations; and

22 (iv) a summary of the basis for the final
23 decision rendered in each market conduct
24 examination and audit.

25 Individually identifiable information shall be
26 excluded from the reports consistent with federal

1 privacy protections.

2 (D) Detail any educational or corrective actions
3 the Departments have taken to ensure compliance with
4 the federal Paul Wellstone and Pete Domenici Mental
5 Health Parity and Addiction Equity Act of 2008, 42
6 U.S.C. 18031(j), this Section, and Sections 356z.23
7 and 370c of this Code.

8 (E) The report must be written in non-technical,
9 readily understandable language and shall be made
10 available to the public by, among such other means as
11 the Departments find appropriate, posting the report
12 on the Departments' websites.

13 (i) The Parity Advancement Fund is created as a special
14 fund in the State treasury. Moneys from fines and penalties
15 collected from insurers for violations of this Section shall
16 be deposited into the Fund. Moneys deposited into the Fund for
17 appropriation by the General Assembly to the Department shall
18 be used for the purpose of providing financial support of the
19 Consumer Education Campaign, parity compliance advocacy, and
20 other initiatives that support parity implementation and
21 enforcement on behalf of consumers.

22 (j) (Blank).

23 (j-5) The Department of Insurance shall collect the
24 following information:

25 (1) The number of employment disability insurance
26 plans offered in this State, including, but not limited

1 to:

2 (A) individual short-term policies;

3 (B) individual long-term policies;

4 (C) group short-term policies; and

5 (D) group long-term policies.

6 (2) The number of policies referenced in paragraph (1)
7 of this subsection that limit mental health and substance
8 use disorder benefits.

9 (3) The average defined benefit period for the
10 policies referenced in paragraph (1) of this subsection,
11 both for those policies that limit and those policies that
12 have no limitation on mental health and substance use
13 disorder benefits.

14 (4) Whether the policies referenced in paragraph (1)
15 of this subsection are purchased on a voluntary or
16 non-voluntary basis.

17 (5) The identities of the individuals, entities, or a
18 combination of the 2 that assume the cost associated with
19 covering the policies referenced in paragraph (1) of this
20 subsection.

21 (6) The average defined benefit period for plans that
22 cover physical disability and mental health and substance
23 abuse without limitation, including, but not limited to:

24 (A) individual short-term policies;

25 (B) individual long-term policies;

26 (C) group short-term policies; and

1 (D) group long-term policies.

2 (7) The average premiums for disability income
3 insurance issued in this State for:

4 (A) individual short-term policies that limit
5 mental health and substance use disorder benefits;

6 (B) individual long-term policies that limit
7 mental health and substance use disorder benefits;

8 (C) group short-term policies that limit mental
9 health and substance use disorder benefits;

10 (D) group long-term policies that limit mental
11 health and substance use disorder benefits;

12 (E) individual short-term policies that include
13 mental health and substance use disorder benefits
14 without limitation;

15 (F) individual long-term policies that include
16 mental health and substance use disorder benefits
17 without limitation;

18 (G) group short-term policies that include mental
19 health and substance use disorder benefits without
20 limitation; and

21 (H) group long-term policies that include mental
22 health and substance use disorder benefits without
23 limitation.

24 The Department shall present its findings regarding
25 information collected under this subsection (j-5) to the
26 General Assembly no later than April 30, 2024. Information

1 regarding a specific insurance provider's contributions to the
2 Department's report shall be exempt from disclosure under
3 paragraph (t) of subsection (1) of Section 7 of the Freedom of
4 Information Act. The aggregated information gathered by the
5 Department shall not be exempt from disclosure under paragraph
6 (t) of subsection (1) of Section 7 of the Freedom of
7 Information Act.

8 (k) An insurer that amends, delivers, issues, or renews a
9 group or individual policy of accident and health insurance or
10 a qualified health plan offered through the health insurance
11 marketplace in this State providing coverage for hospital or
12 medical treatment and for the treatment of mental, emotional,
13 nervous, or substance use disorders or conditions shall submit
14 an annual report, the format and definitions for which will be
15 determined by the Department and the Department of Healthcare
16 and Family Services and posted on their respective websites,
17 starting on September 1, 2023 and annually thereafter, that
18 contains the following information separately for inpatient
19 in-network benefits, inpatient out-of-network benefits,
20 outpatient in-network benefits, outpatient out-of-network
21 benefits, emergency care benefits, and prescription drug
22 benefits in the case of accident and health insurance or
23 qualified health plans, or inpatient, outpatient, emergency
24 care, and prescription drug benefits in the case of medical
25 assistance:

26 (1) A summary of the plan's pharmacy management

1 processes for mental, emotional, nervous, or substance use
2 disorder or condition benefits compared to those for other
3 medical benefits.

4 (2) A summary of the internal processes of review for
5 experimental benefits and unproven technology for mental,
6 emotional, nervous, or substance use disorder or condition
7 benefits and those for other medical benefits.

8 (3) A summary of how the plan's policies and
9 procedures for utilization management for mental,
10 emotional, nervous, or substance use disorder or condition
11 benefits compare to those for other medical benefits.

12 (4) A description of the process used to develop or
13 select the medical necessity criteria for mental,
14 emotional, nervous, or substance use disorder or condition
15 benefits and the process used to develop or select the
16 medical necessity criteria for medical and surgical
17 benefits.

18 (5) Identification of all nonquantitative treatment
19 limitations that are applied to both mental, emotional,
20 nervous, or substance use disorder or condition benefits
21 and medical and surgical benefits within each
22 classification of benefits.

23 (6) The results of an analysis that demonstrates that
24 for the medical necessity criteria described in
25 subparagraph (A) and for each nonquantitative treatment
26 limitation identified in subparagraph (B), as written and

1 in operation, the processes, strategies, evidentiary
2 standards, or other factors used in applying the medical
3 necessity criteria and each nonquantitative treatment
4 limitation to mental, emotional, nervous, or substance use
5 disorder or condition benefits within each classification
6 of benefits are comparable to, and are applied no more
7 stringently than, the processes, strategies, evidentiary
8 standards, or other factors used in applying the medical
9 necessity criteria and each nonquantitative treatment
10 limitation to medical and surgical benefits within the
11 corresponding classification of benefits; at a minimum,
12 the results of the analysis shall:

13 (A) identify the factors used to determine that a
14 nonquantitative treatment limitation applies to a
15 benefit, including factors that were considered but
16 rejected;

17 (B) identify and define the specific evidentiary
18 standards used to define the factors and any other
19 evidence relied upon in designing each nonquantitative
20 treatment limitation;

21 (C) provide the comparative analyses, including
22 the results of the analyses, performed to determine
23 that the processes and strategies used to design each
24 nonquantitative treatment limitation, as written, for
25 mental, emotional, nervous, or substance use disorder
26 or condition benefits are comparable to, and are

1 applied no more stringently than, the processes and
2 strategies used to design each nonquantitative
3 treatment limitation, as written, for medical and
4 surgical benefits;

5 (D) provide the comparative analyses, including
6 the results of the analyses, performed to determine
7 that the processes and strategies used to apply each
8 nonquantitative treatment limitation, in operation,
9 for mental, emotional, nervous, or substance use
10 disorder or condition benefits are comparable to, and
11 applied no more stringently than, the processes or
12 strategies used to apply each nonquantitative
13 treatment limitation, in operation, for medical and
14 surgical benefits; and

15 (E) disclose the specific findings and conclusions
16 reached by the insurer that the results of the
17 analyses described in subparagraphs (C) and (D)
18 indicate that the insurer is in compliance with this
19 Section and the Mental Health Parity and Addiction
20 Equity Act of 2008 and its implementing regulations,
21 which includes 42 CFR Parts 438, 440, and 457 and 45
22 CFR 146.136 and any other related federal regulations
23 found in the Code of Federal Regulations.

24 (7) Any other information necessary to clarify data
25 provided in accordance with this Section requested by the
26 Director, including information that may be proprietary or

1 have commercial value, under the requirements of Section
2 30 of the Viatical Settlements Act of 2009.

3 (1) An insurer that amends, delivers, issues, or renews a
4 group or individual policy of accident and health insurance or
5 a qualified health plan offered through the health insurance
6 marketplace in this State providing coverage for hospital or
7 medical treatment and for the treatment of mental, emotional,
8 nervous, or substance use disorders or conditions on or after
9 January 1, 2019 (the effective date of Public Act 100-1024)
10 shall, in advance of the plan year, make available to the
11 Department or, with respect to medical assistance, the
12 Department of Healthcare and Family Services and to all plan
13 participants and beneficiaries the information required in
14 subparagraphs (C) through (E) of paragraph (6) of subsection
15 (k). For plan participants and medical assistance
16 beneficiaries, the information required in subparagraphs (C)
17 through (E) of paragraph (6) of subsection (k) shall be made
18 available on a publicly available website whose web address is
19 prominently displayed in plan and managed care organization
20 informational and marketing materials.

21 (m) In conjunction with its compliance examination program
22 conducted in accordance with the Illinois State Auditing Act,
23 the Auditor General shall undertake a review of compliance by
24 the Department and the Department of Healthcare and Family
25 Services with Section 370c and this Section. Any findings
26 resulting from the review conducted under this Section shall

1 be included in the applicable State agency's compliance
2 examination report. Each compliance examination report shall
3 be issued in accordance with Section 3-14 of the Illinois
4 State Auditing Act. A copy of each report shall also be
5 delivered to the head of the applicable State agency and
6 posted on the Auditor General's website.

7 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;
8 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff.
9 6-27-23; 103-605, eff. 7-1-24.)

10 (215 ILCS 5/1563)

11 Sec. 1563. Fees. The fees required by this Article are as
12 follows:

13 (1) Public adjuster license fee of \$250 for a person
14 who is a resident of Illinois and \$500 for a person who is
15 not a resident of Illinois, payable once every 2 years.

16 (2) Business entity license fee of \$250, payable once
17 every 2 years.

18 (3) Application fee of \$50 for processing each request
19 to take the written examination for a public adjuster
20 license.

21 (Source: P.A. 100-863, eff. 8-14-18.)

22 Section 10. The Dental Care Patient Protection Act is
23 amended by changing Section 75 as follows:

1 (215 ILCS 109/75)

2 Sec. 75. Application of other law.

3 (a) All provisions of this Act and other applicable law
4 that are not in conflict with this Act shall apply to managed
5 care dental plans and other persons subject to this Act. To the
6 extent that any provision of this Act or rule under this Act
7 would prevent the application of any standard or requirement
8 under the Network Adequacy and Transparency Act to a plan that
9 is subject to both statutes, the Network Adequacy and
10 Transparency Act shall supersede this Act.

11 (b) Solicitation of enrollees by a managed care entity
12 granted a certificate of authority or its representatives
13 shall not be construed to violate any provision of law
14 relating to solicitation or advertising by health
15 professionals.

16 (Source: P.A. 91-355, eff. 1-1-00.)

17 Section 15. The Network Adequacy and Transparency Act is
18 amended by changing Sections 5, 10, and 25 as follows:

19 (215 ILCS 124/5)

20 (Text of Section from P.A. 103-650)

21 Sec. 5. Definitions. In this Act:

22 "Authorized representative" means a person to whom a
23 beneficiary has given express written consent to represent the
24 beneficiary; a person authorized by law to provide substituted

1 consent for a beneficiary; or the beneficiary's treating
2 provider only when the beneficiary or his or her family member
3 is unable to provide consent.

4 "Beneficiary" means an individual, an enrollee, an
5 insured, a participant, or any other person entitled to
6 reimbursement for covered expenses of or the discounting of
7 provider fees for health care services under a program in
8 which the beneficiary has an incentive to utilize the services
9 of a provider that has entered into an agreement or
10 arrangement with an issuer.

11 "Department" means the Department of Insurance.

12 "Essential community provider" has the meaning ascribed to
13 that term in 45 CFR 156.235.

14 "Excepted benefits" has the meaning ascribed to that term
15 in 42 U.S.C. 300gg-91(c) and implementing regulations.
16 "Excepted benefits" includes individual, group, or blanket
17 coverage.

18 "Exchange" has the meaning ascribed to that term in 45 CFR
19 155.20.

20 "Director" means the Director of Insurance.

21 "Family caregiver" means a relative, partner, friend, or
22 neighbor who has a significant relationship with the patient
23 and administers or assists the patient with activities of
24 daily living, instrumental activities of daily living, or
25 other medical or nursing tasks for the quality and welfare of
26 that patient.

1 "Group health plan" has the meaning ascribed to that term
2 in Section 5 of the Illinois Health Insurance Portability and
3 Accountability Act.

4 "Health insurance coverage" has the meaning ascribed to
5 that term in Section 5 of the Illinois Health Insurance
6 Portability and Accountability Act. "Health insurance
7 coverage" does not include any coverage or benefits under
8 Medicare or under the medical assistance program established
9 under Article V of the Illinois Public Aid Code.

10 "Issuer" means a "health insurance issuer" as defined in
11 Section 5 of the Illinois Health Insurance Portability and
12 Accountability Act.

13 "Material change" means a significant reduction in the
14 number of providers available in a network plan, including,
15 but not limited to, a reduction of 10% or more in a specific
16 type of providers within any county, the removal of a major
17 health system that causes a network to be significantly
18 different within any county from the network when the
19 beneficiary purchased the network plan, or any change that
20 would cause the network to no longer satisfy the requirements
21 of this Act or the Department's rules for network adequacy and
22 transparency.

23 "Network" means the group or groups of preferred providers
24 providing services to a network plan.

25 "Network plan" means an individual or group policy of
26 health insurance coverage that either requires a covered

1 person to use or creates incentives, including financial
2 incentives, for a covered person to use providers managed,
3 owned, under contract with, or employed by the issuer or by a
4 third party contracted to arrange, contract for, or administer
5 such provider-related incentives for the issuer.

6 "Ongoing course of treatment" means (1) treatment for a
7 life-threatening condition, which is a disease or condition
8 for which likelihood of death is probable unless the course of
9 the disease or condition is interrupted; (2) treatment for a
10 serious acute condition, defined as a disease or condition
11 requiring complex ongoing care that the covered person is
12 currently receiving, such as chemotherapy, radiation therapy,
13 post-operative visits, or a serious and complex condition as
14 defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of
15 treatment for a health condition that a treating provider
16 attests that discontinuing care by that provider would worsen
17 the condition or interfere with anticipated outcomes; (4) the
18 third trimester of pregnancy through the post-partum period;
19 (5) undergoing a course of institutional or inpatient care
20 from the provider within the meaning of 42 U.S.C.
21 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective
22 surgery from the provider, including receipt of preoperative
23 or postoperative care from such provider with respect to such
24 a surgery; (7) being determined to be terminally ill, as
25 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
26 treatment for such illness from such provider; or (8) any

1 other treatment of a condition or disease that requires
2 repeated health care services pursuant to a plan of treatment
3 by a provider because of the potential for changes in the
4 therapeutic regimen or because of the potential for a
5 recurrence of symptoms.

6 "Preferred provider" means any provider who has entered,
7 either directly or indirectly, into an agreement with an
8 employer or risk-bearing entity relating to health care
9 services that may be rendered to beneficiaries under a network
10 plan.

11 "Providers" means physicians licensed to practice medicine
12 in all its branches, other health care professionals,
13 hospitals, or other health care institutions or facilities
14 that provide health care services.

15 ~~"Short term, limited duration insurance" means any type of~~
16 ~~accident and health insurance offered or provided within this~~
17 ~~State pursuant to a group or individual policy or individual~~
18 ~~certificate by a company, regardless of the situs state of the~~
19 ~~delivery of the policy, that has an expiration date specified~~
20 ~~in the contract that is fewer than 365 days after the original~~
21 ~~effective date. Regardless of the duration of coverage,~~
22 ~~"short term, limited duration insurance" does not include~~
23 ~~excepted benefits or any student health insurance coverage.~~

24 "Stand-alone dental plan" has the meaning ascribed to that
25 term in 45 CFR 156.400.

26 "Telehealth" has the meaning given to that term in Section

1 356z.22 of the Illinois Insurance Code.

2 "Telemedicine" has the meaning given to that term in
3 Section 49.5 of the Medical Practice Act of 1987.

4 "Tiered network" means a network that identifies and
5 groups some or all types of provider and facilities into
6 specific groups to which different provider reimbursement,
7 covered person cost-sharing or provider access requirements,
8 or any combination thereof, apply for the same services.

9 "Woman's principal health care provider" means a physician
10 licensed to practice medicine in all of its branches
11 specializing in obstetrics, gynecology, or family practice.

12 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
13 103-650, eff. 1-1-25.)

14 (Text of Section from P.A. 103-718)

15 Sec. 5. Definitions. In this Act:

16 "Authorized representative" means a person to whom a
17 beneficiary has given express written consent to represent the
18 beneficiary; a person authorized by law to provide substituted
19 consent for a beneficiary; or the beneficiary's treating
20 provider only when the beneficiary or his or her family member
21 is unable to provide consent.

22 "Beneficiary" means an individual, an enrollee, an
23 insured, a participant, or any other person entitled to
24 reimbursement for covered expenses of or the discounting of
25 provider fees for health care services under a program in

1 which the beneficiary has an incentive to utilize the services
2 of a provider that has entered into an agreement or
3 arrangement with an issuer ~~insurer~~.

4 "Department" means the Department of Insurance.

5 "Director" means the Director of Insurance.

6 "Family caregiver" means a relative, partner, friend, or
7 neighbor who has a significant relationship with the patient
8 and administers or assists the patient with activities of
9 daily living, instrumental activities of daily living, or
10 other medical or nursing tasks for the quality and welfare of
11 that patient.

12 "Issuer" means a "health insurance issuer" as defined in
13 Section 5 of the Illinois Health Insurance Portability and
14 Accountability Act. ~~"Insurer" means any entity that offers~~
15 ~~individual or group accident and health insurance, including,~~
16 ~~but not limited to, health maintenance organizations,~~
17 ~~preferred provider organizations, exclusive provider~~
18 ~~organizations, and other plan structures requiring network~~
19 ~~participation, excluding the medical assistance program under~~
20 ~~the Illinois Public Aid Code, the State employees group health~~
21 ~~insurance program, workers compensation insurance, and~~
22 ~~pharmacy benefit managers.~~

23 "Material change" means a significant reduction in the
24 number of providers available in a network plan, including,
25 but not limited to, a reduction of 10% or more in a specific
26 type of providers, the removal of a major health system that

1 causes a network to be significantly different from the
2 network when the beneficiary purchased the network plan, or
3 any change that would cause the network to no longer satisfy
4 the requirements of this Act or the Department's rules for
5 network adequacy and transparency.

6 "Network" means the group or groups of preferred providers
7 providing services to a network plan.

8 "Network plan" means an individual or group policy of
9 accident and health insurance that either requires a covered
10 person to use or creates incentives, including financial
11 incentives, for a covered person to use providers managed,
12 owned, under contract with, or employed by the issuer ~~insurer~~.

13 "Ongoing course of treatment" means (1) treatment for a
14 life-threatening condition, which is a disease or condition
15 for which likelihood of death is probable unless the course of
16 the disease or condition is interrupted; (2) treatment for a
17 serious acute condition, defined as a disease or condition
18 requiring complex ongoing care that the covered person is
19 currently receiving, such as chemotherapy, radiation therapy,
20 or post-operative visits; (3) a course of treatment for a
21 health condition that a treating provider attests that
22 discontinuing care by that provider would worsen the condition
23 or interfere with anticipated outcomes; or (4) the third
24 trimester of pregnancy through the post-partum period.

25 "Preferred provider" means any provider who has entered,
26 either directly or indirectly, into an agreement with an

1 employer or risk-bearing entity relating to health care
2 services that may be rendered to beneficiaries under a network
3 plan.

4 "Providers" means physicians licensed to practice medicine
5 in all its branches, other health care professionals,
6 hospitals, or other health care institutions that provide
7 health care services.

8 "Telehealth" has the meaning given to that term in Section
9 356z.22 of the Illinois Insurance Code.

10 "Telemedicine" has the meaning given to that term in
11 Section 49.5 of the Medical Practice Act of 1987.

12 "Tiered network" means a network that identifies and
13 groups some or all types of provider and facilities into
14 specific groups to which different provider reimbursement,
15 covered person cost-sharing or provider access requirements,
16 or any combination thereof, apply for the same services.

17 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
18 103-718, eff. 7-19-24.)

19 (Text of Section from P.A. 103-777)

20 Sec. 5. Definitions. In this Act:

21 "Authorized representative" means a person to whom a
22 beneficiary has given express written consent to represent the
23 beneficiary; a person authorized by law to provide substituted
24 consent for a beneficiary; or the beneficiary's treating
25 provider only when the beneficiary or his or her family member

1 is unable to provide consent.

2 "Beneficiary" means an individual, an enrollee, an
3 insured, a participant, or any other person entitled to
4 reimbursement for covered expenses of or the discounting of
5 provider fees for health care services under a program in
6 which the beneficiary has an incentive to utilize the services
7 of a provider that has entered into an agreement or
8 arrangement with an issuer ~~insurer~~.

9 "Department" means the Department of Insurance.

10 "Director" means the Director of Insurance.

11 "Excepted benefits" has the meaning given to that term in
12 42 U.S.C. 300gg-91(c).

13 "Family caregiver" means a relative, partner, friend, or
14 neighbor who has a significant relationship with the patient
15 and administers or assists the patient with activities of
16 daily living, instrumental activities of daily living, or
17 other medical or nursing tasks for the quality and welfare of
18 that patient.

19 "Issuer" means a "health insurance issuer" as defined in
20 Section 5 of the Illinois Health Insurance Portability and
21 Accountability Act. ~~"Insurer" means any entity that offers~~
22 ~~individual or group accident and health insurance, including,~~
23 ~~but not limited to, health maintenance organizations,~~
24 ~~preferred provider organizations, exclusive provider~~
25 ~~organizations, and other plan structures requiring network~~
26 ~~participation, excluding the medical assistance program under~~

1 ~~the Illinois Public Aid Code, the State employees group health~~
2 ~~insurance program, workers compensation insurance, and~~
3 ~~pharmacy benefit managers.~~

4 "Material change" means a significant reduction in the
5 number of providers available in a network plan, including,
6 but not limited to, a reduction of 10% or more in a specific
7 type of providers, the removal of a major health system that
8 causes a network to be significantly different from the
9 network when the beneficiary purchased the network plan, or
10 any change that would cause the network to no longer satisfy
11 the requirements of this Act or the Department's rules for
12 network adequacy and transparency.

13 "Network" means the group or groups of preferred providers
14 providing services to a network plan.

15 "Network plan" means an individual or group policy of
16 accident and health insurance that either requires a covered
17 person to use or creates incentives, including financial
18 incentives, for a covered person to use providers managed,
19 owned, under contract with, or employed by the issuer ~~insurer~~.

20 "Ongoing course of treatment" means (1) treatment for a
21 life-threatening condition, which is a disease or condition
22 for which likelihood of death is probable unless the course of
23 the disease or condition is interrupted; (2) treatment for a
24 serious acute condition, defined as a disease or condition
25 requiring complex ongoing care that the covered person is
26 currently receiving, such as chemotherapy, radiation therapy,

1 or post-operative visits; (3) a course of treatment for a
2 health condition that a treating provider attests that
3 discontinuing care by that provider would worsen the condition
4 or interfere with anticipated outcomes; or (4) the third
5 trimester of pregnancy through the post-partum period.

6 "Preferred provider" means any provider who has entered,
7 either directly or indirectly, into an agreement with an
8 employer or risk-bearing entity relating to health care
9 services that may be rendered to beneficiaries under a network
10 plan.

11 "Providers" means physicians licensed to practice medicine
12 in all its branches, other health care professionals,
13 hospitals, or other health care institutions that provide
14 health care services.

15 ~~"Short term, limited duration health insurance coverage~~
16 ~~has the meaning given to that term in Section 5 of the~~
17 ~~Short Term, Limited Duration Health Insurance Coverage Act.~~

18 "Stand-alone dental plan" has the meaning given to that
19 term in 45 CFR 156.400.

20 "Telehealth" has the meaning given to that term in Section
21 356z.22 of the Illinois Insurance Code.

22 "Telemedicine" has the meaning given to that term in
23 Section 49.5 of the Medical Practice Act of 1987.

24 "Tiered network" means a network that identifies and
25 groups some or all types of provider and facilities into
26 specific groups to which different provider reimbursement,

1 covered person cost-sharing or provider access requirements,
2 or any combination thereof, apply for the same services.

3 "Woman's principal health care provider" means a physician
4 licensed to practice medicine in all of its branches
5 specializing in obstetrics, gynecology, or family practice.

6 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
7 103-777, eff. 1-1-25.)

8 (215 ILCS 124/10)

9 (Text of Section from P.A. 103-650)

10 Sec. 10. Network adequacy.

11 (a) Before issuing, delivering, or renewing a network
12 plan, an issuer providing a network plan shall file a
13 description of all of the following with the Director:

14 (1) The written policies and procedures for adding
15 providers to meet patient needs based on increases in the
16 number of beneficiaries, changes in the
17 patient-to-provider ratio, changes in medical and health
18 care capabilities, and increased demand for services.

19 (2) The written policies and procedures for making
20 referrals within and outside the network.

21 (3) The written policies and procedures on how the
22 network plan will provide 24-hour, 7-day per week access
23 to network-affiliated primary care, emergency services,
24 and women's principal health care providers.

25 An issuer shall not prohibit a preferred provider from

1 discussing any specific or all treatment options with
2 beneficiaries irrespective of the issuer's ~~insurer's~~ position
3 on those treatment options or from advocating on behalf of
4 beneficiaries within the utilization review, grievance, or
5 appeals processes established by the issuer in accordance with
6 any rights or remedies available under applicable State or
7 federal law.

8 (b) Before issuing, delivering, or renewing a network
9 plan, an issuer must file for review a description of the
10 services to be offered through a network plan. The description
11 shall include all of the following:

12 (1) A geographic map of the area proposed to be served
13 by the plan by county service area and zip code, including
14 marked locations for preferred providers.

15 (2) As deemed necessary by the Department, the names,
16 addresses, phone numbers, and specialties of the providers
17 who have entered into preferred provider agreements under
18 the network plan.

19 (3) The number of beneficiaries anticipated to be
20 covered by the network plan.

21 (4) An Internet website and toll-free telephone number
22 for beneficiaries and prospective beneficiaries to access
23 current and accurate lists of preferred providers in each
24 plan, additional information about the plan, as well as
25 any other information required by Department rule.

26 (5) A description of how health care services to be

1 rendered under the network plan are reasonably accessible
2 and available to beneficiaries. The description shall
3 address all of the following:

4 (A) the type of health care services to be
5 provided by the network plan;

6 (B) the ratio of physicians and other providers to
7 beneficiaries, by specialty and including primary care
8 physicians and facility-based physicians when
9 applicable under the contract, necessary to meet the
10 health care needs and service demands of the currently
11 enrolled population;

12 (C) the travel and distance standards for plan
13 beneficiaries in county service areas; and

14 (D) a description of how the use of telemedicine,
15 telehealth, or mobile care services may be used to
16 partially meet the network adequacy standards, if
17 applicable.

18 (6) A provision ensuring that whenever a beneficiary
19 has made a good faith effort, as evidenced by accessing
20 the provider directory, calling the network plan, and
21 calling the provider, to utilize preferred providers for a
22 covered service and it is determined the issuer ~~insurer~~
23 does not have the appropriate preferred providers due to
24 insufficient number, type, unreasonable travel distance or
25 delay, or preferred providers refusing to provide a
26 covered service because it is contrary to the conscience

1 of the preferred providers, as protected by the Health
2 Care Right of Conscience Act, the issuer shall ensure,
3 directly or indirectly, by terms contained in the payer
4 contract, that the beneficiary will be provided the
5 covered service at no greater cost to the beneficiary than
6 if the service had been provided by a preferred provider.
7 This paragraph (6) does not apply to: (A) a beneficiary
8 who willfully chooses to access a non-preferred provider
9 for health care services available through the panel of
10 preferred providers, or (B) a beneficiary enrolled in a
11 health maintenance organization. In these circumstances,
12 the contractual requirements for non-preferred provider
13 reimbursements shall apply unless Section 356z.3a of the
14 Illinois Insurance Code requires otherwise. In no event
15 shall a beneficiary who receives care at a participating
16 health care facility be required to search for
17 participating providers under the circumstances described
18 in subsection (b) or (b-5) of Section 356z.3a of the
19 Illinois Insurance Code except under the circumstances
20 described in paragraph (2) of subsection (b-5).

21 (7) A provision that the beneficiary shall receive
22 emergency care coverage such that payment for this
23 coverage is not dependent upon whether the emergency
24 services are performed by a preferred or non-preferred
25 provider and the coverage shall be at the same benefit
26 level as if the service or treatment had been rendered by a

1 preferred provider. For purposes of this paragraph (7),
2 "the same benefit level" means that the beneficiary is
3 provided the covered service at no greater cost to the
4 beneficiary than if the service had been provided by a
5 preferred provider. This provision shall be consistent
6 with Section 356z.3a of the Illinois Insurance Code.

7 (8) A limitation that, if the plan provides that the
8 beneficiary will incur a penalty for failing to
9 pre-certify inpatient hospital treatment, the penalty may
10 not exceed \$1,000 per occurrence in addition to the plan
11 cost sharing provisions.

12 (9) For a network plan to be offered through the
13 Exchange in the individual or small group market, as well
14 as any off-Exchange mirror of such a network plan,
15 evidence that the network plan includes essential
16 community providers in accordance with rules established
17 by the Exchange that will operate in this State for the
18 applicable plan year.

19 (c) The issuer shall demonstrate to the Director a minimum
20 ratio of providers to plan beneficiaries as required by the
21 Department for each network plan.

22 (1) The minimum ratio of physicians or other providers
23 to plan beneficiaries shall be established by the
24 Department in consultation with the Department of Public
25 Health based upon the guidance from the federal Centers
26 for Medicare and Medicaid Services. The Department shall

1 not establish ratios for vision or dental providers who
2 provide services under dental-specific or vision-specific
3 benefits, except to the extent provided under federal law
4 for stand-alone dental plans. The Department shall
5 consider establishing ratios for the following physicians
6 or other providers:

7 (A) Primary Care;

8 (B) Pediatrics;

9 (C) Cardiology;

10 (D) Gastroenterology;

11 (E) General Surgery;

12 (F) Neurology;

13 (G) OB/GYN;

14 (H) Oncology/Radiation;

15 (I) Ophthalmology;

16 (J) Urology;

17 (K) Behavioral Health;

18 (L) Allergy/Immunology;

19 (M) Chiropractic;

20 (N) Dermatology;

21 (O) Endocrinology;

22 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

23 (Q) Infectious Disease;

24 (R) Nephrology;

25 (S) Neurosurgery;

26 (T) Orthopedic Surgery;

1 (U) Physiatry/Rehabilitative;
2 (V) Plastic Surgery;
3 (W) Pulmonary;
4 (X) Rheumatology;
5 (Y) Anesthesiology;
6 (Z) Pain Medicine;
7 (AA) Pediatric Specialty Services;
8 (BB) Outpatient Dialysis; and
9 (CC) HIV.

10 (2) The Director shall establish a process for the
11 review of the adequacy of these standards, along with an
12 assessment of additional specialties to be included in the
13 list under this subsection (c).

14 (3) Notwithstanding any other law or rule, the minimum
15 ratio for each provider type shall be no less than any such
16 ratio established for qualified health plans in
17 Federally-Facilitated Exchanges by federal law or by the
18 federal Centers for Medicare and Medicaid Services, even
19 if the network plan is issued in the large group market or
20 is otherwise not issued through an exchange. Federal
21 standards for stand-alone dental plans shall only apply to
22 such network plans. In the absence of an applicable
23 Department rule, the federal standards shall apply for the
24 time period specified in the federal law, regulation, or
25 guidance. If the Centers for Medicare and Medicaid
26 Services establish standards that are more stringent than

1 the standards in effect under any Department rule, the
2 Department may amend its rules to conform to the more
3 stringent federal standards.

4 (d) The network plan shall demonstrate to the Director
5 maximum travel and distance standards and appointment wait
6 time standards for plan beneficiaries, which shall be
7 established by the Department in consultation with the
8 Department of Public Health based upon the guidance from the
9 federal Centers for Medicare and Medicaid Services. These
10 standards shall consist of the maximum minutes or miles to be
11 traveled by a plan beneficiary for each county type, such as
12 large counties, metro counties, or rural counties as defined
13 by Department rule.

14 The maximum travel time and distance standards must
15 include standards for each physician and other provider
16 category listed for which ratios have been established.

17 The Director shall establish a process for the review of
18 the adequacy of these standards along with an assessment of
19 additional specialties to be included in the list under this
20 subsection (d).

21 Notwithstanding any other law or Department rule, the
22 maximum travel time and distance standards and appointment
23 wait time standards shall be no greater than any such
24 standards established for qualified health plans in
25 Federally-Facilitated Exchanges by federal law or by the
26 federal Centers for Medicare and Medicaid Services, even if

1 the network plan is issued in the large group market or is
2 otherwise not issued through an exchange. Federal standards
3 for stand-alone dental plans shall only apply to such network
4 plans. In the absence of an applicable Department rule, the
5 federal standards shall apply for the time period specified in
6 the federal law, regulation, or guidance. If the Centers for
7 Medicare and Medicaid Services establish standards that are
8 more stringent than the standards in effect under any
9 Department rule, the Department may amend its rules to conform
10 to the more stringent federal standards.

11 If the federal area designations for the maximum time or
12 distance or appointment wait time standards required are
13 changed by the most recent Letter to Issuers in the
14 Federally-facilitated Marketplaces, the Department shall post
15 on its website notice of such changes and may amend its rules
16 to conform to those designations if the Director deems
17 appropriate.

18 (d-5) (1) Every issuer shall ensure that beneficiaries have
19 timely and proximate access to treatment for mental,
20 emotional, nervous, or substance use disorders or conditions
21 in accordance with the provisions of paragraph (4) of
22 subsection (a) of Section 370c of the Illinois Insurance Code.
23 Issuers shall use a comparable process, strategy, evidentiary
24 standard, and other factors in the development and application
25 of the network adequacy standards for timely and proximate
26 access to treatment for mental, emotional, nervous, or

1 substance use disorders or conditions and those for the access
2 to treatment for medical and surgical conditions. As such, the
3 network adequacy standards for timely and proximate access
4 shall equally be applied to treatment facilities and providers
5 for mental, emotional, nervous, or substance use disorders or
6 conditions and specialists providing medical or surgical
7 benefits pursuant to the parity requirements of Section 370c.1
8 of the Illinois Insurance Code and the federal Paul Wellstone
9 and Pete Domenici Mental Health Parity and Addiction Equity
10 Act of 2008. Notwithstanding the foregoing, the network
11 adequacy standards for timely and proximate access to
12 treatment for mental, emotional, nervous, or substance use
13 disorders or conditions shall, at a minimum, satisfy the
14 following requirements:

15 (A) For beneficiaries residing in the metropolitan
16 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
17 network adequacy standards for timely and proximate access
18 to treatment for mental, emotional, nervous, or substance
19 use disorders or conditions means a beneficiary shall not
20 have to travel longer than 30 minutes or 30 miles from the
21 beneficiary's residence to receive outpatient treatment
22 for mental, emotional, nervous, or substance use disorders
23 or conditions. Beneficiaries shall not be required to wait
24 longer than 10 business days between requesting an initial
25 appointment and being seen by the facility or provider of
26 mental, emotional, nervous, or substance use disorders or

1 conditions for outpatient treatment or to wait longer than
2 20 business days between requesting a repeat or follow-up
3 appointment and being seen by the facility or provider of
4 mental, emotional, nervous, or substance use disorders or
5 conditions for outpatient treatment; however, subject to
6 the protections of paragraph (3) of this subsection, a
7 network plan shall not be held responsible if the
8 beneficiary or provider voluntarily chooses to schedule an
9 appointment outside of these required time frames.

10 (B) For beneficiaries residing in Illinois counties
11 other than those counties listed in subparagraph (A) of
12 this paragraph, network adequacy standards for timely and
13 proximate access to treatment for mental, emotional,
14 nervous, or substance use disorders or conditions means a
15 beneficiary shall not have to travel longer than 60
16 minutes or 60 miles from the beneficiary's residence to
17 receive outpatient treatment for mental, emotional,
18 nervous, or substance use disorders or conditions.
19 Beneficiaries shall not be required to wait longer than 10
20 business days between requesting an initial appointment
21 and being seen by the facility or provider of mental,
22 emotional, nervous, or substance use disorders or
23 conditions for outpatient treatment or to wait longer than
24 20 business days between requesting a repeat or follow-up
25 appointment and being seen by the facility or provider of
26 mental, emotional, nervous, or substance use disorders or

1 conditions for outpatient treatment; however, subject to
2 the protections of paragraph (3) of this subsection, a
3 network plan shall not be held responsible if the
4 beneficiary or provider voluntarily chooses to schedule an
5 appointment outside of these required time frames.

6 (2) For beneficiaries residing in all Illinois counties,
7 network adequacy standards for timely and proximate access to
8 treatment for mental, emotional, nervous, or substance use
9 disorders or conditions means a beneficiary shall not have to
10 travel longer than 60 minutes or 60 miles from the
11 beneficiary's residence to receive inpatient or residential
12 treatment for mental, emotional, nervous, or substance use
13 disorders or conditions.

14 (3) If there is no in-network facility or provider
15 available for a beneficiary to receive timely and proximate
16 access to treatment for mental, emotional, nervous, or
17 substance use disorders or conditions in accordance with the
18 network adequacy standards outlined in this subsection, the
19 issuer shall provide necessary exceptions to its network to
20 ensure admission and treatment with a provider or at a
21 treatment facility in accordance with the network adequacy
22 standards in this subsection.

23 (4) If the federal Centers for Medicare and Medicaid
24 Services establishes or law requires more stringent standards
25 for qualified health plans in the Federally-Facilitated
26 Exchanges, the federal standards shall control for all network

1 plans for the time period specified in the federal law,
2 regulation, or guidance, even if the network plan is issued in
3 the large group market, is issued through a different type of
4 Exchange, or is otherwise not issued through an Exchange.

5 (e) Except for network plans solely offered as a group
6 health plan, these ratio and time and distance standards apply
7 to the lowest cost-sharing tier of any tiered network.

8 (f) The network plan may consider use of other health care
9 service delivery options, such as telemedicine or telehealth,
10 mobile clinics, and centers of excellence, or other ways of
11 delivering care to partially meet the requirements set under
12 this Section.

13 (g) Except for the requirements set forth in subsection
14 (d-5), issuers who are not able to comply with the provider
15 ratios, ~~and~~ time and distance standards, and ~~or~~ appointment
16 wait-time ~~wait-time~~ standards established under this Act or
17 federal law may request an exception to these requirements
18 from the Department. The Department may grant an exception in
19 the following circumstances:

20 (1) if no providers or facilities meet the specific
21 time and distance standard in a specific service area and
22 the issuer (i) discloses information on the distance and
23 travel time points that beneficiaries would have to travel
24 beyond the required criterion to reach the next closest
25 contracted provider outside of the service area and (ii)
26 provides contact information, including names, addresses,

1 and phone numbers for the next closest contracted provider
2 or facility;

3 (2) if patterns of care in the service area do not
4 support the need for the requested number of provider or
5 facility type and the issuer provides data on local
6 patterns of care, such as claims data, referral patterns,
7 or local provider interviews, indicating where the
8 beneficiaries currently seek this type of care or where
9 the physicians currently refer beneficiaries, or both; or

10 (3) other circumstances deemed appropriate by the
11 Department consistent with the requirements of this Act.

12 (h) Issuers are required to report to the Director any
13 material change to an approved network plan within 15 business
14 days after the change occurs and any change that would result
15 in failure to meet the requirements of this Act. The issuer
16 shall submit a revised version of the portions of the network
17 adequacy filing affected by the material change, as determined
18 by the Director by rule, and the issuer shall attach versions
19 with the changes indicated for each document that was revised
20 from the previous version of the filing. Upon notice from the
21 issuer, the Director shall reevaluate the network plan's
22 compliance with the network adequacy and transparency
23 standards of this Act. For every day past 15 business days that
24 the issuer fails to submit a revised network adequacy filing
25 to the Director, the Director may order a fine of \$5,000 per
26 day.

1 (i) If a network plan is inadequate under this Act with
2 respect to a provider type in a county, and if the network plan
3 does not have an approved exception for that provider type in
4 that county pursuant to subsection (g), an issuer shall cover
5 out-of-network claims for covered health care services
6 received from that provider type within that county at the
7 in-network benefit level and shall retroactively adjudicate
8 and reimburse beneficiaries to achieve that objective if their
9 claims were processed at the out-of-network level contrary to
10 this subsection. Nothing in this subsection shall be construed
11 to supersede Section 356z.3a of the Illinois Insurance Code.

12 (j) If the Director determines that a network is
13 inadequate in any county and no exception has been granted
14 under subsection (g) and the issuer does not have a process in
15 place to comply with subsection (d-5), the Director may
16 prohibit the network plan from being issued or renewed within
17 that county until the Director determines that the network is
18 adequate apart from processes and exceptions described in
19 subsections (d-5) and (g). Nothing in this subsection shall be
20 construed to terminate any beneficiary's health insurance
21 coverage under a network plan before the expiration of the
22 beneficiary's policy period if the Director makes a
23 determination under this subsection after the issuance or
24 renewal of the beneficiary's policy or certificate because of
25 a material change. Policies or certificates issued or renewed
26 in violation of this subsection may subject the issuer to a

1 civil penalty of \$5,000 per policy.

2 (k) For the Department to enforce any new or modified
3 federal standard before the Department adopts the standard by
4 rule, the Department must, no later than May 15 before the
5 start of the plan year, give public notice to the affected
6 health insurance issuers through a bulletin.

7 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
8 102-1117, eff. 1-13-23; 103-650, eff. 1-1-25.)

9 (Text of Section from P.A. 103-656)

10 Sec. 10. Network adequacy.

11 (a) An issuer ~~insurer~~ providing a network plan shall file
12 a description of all of the following with the Director:

13 (1) The written policies and procedures for adding
14 providers to meet patient needs based on increases in the
15 number of beneficiaries, changes in the
16 patient-to-provider ratio, changes in medical and health
17 care capabilities, and increased demand for services.

18 (2) The written policies and procedures for making
19 referrals within and outside the network.

20 (3) The written policies and procedures on how the
21 network plan will provide 24-hour, 7-day per week access
22 to network-affiliated primary care, emergency services,
23 and women's principal health care providers.

24 An issuer ~~insurer~~ shall not prohibit a preferred provider
25 from discussing any specific or all treatment options with

1 beneficiaries irrespective of the issuer's ~~insurer's~~ position
2 on those treatment options or from advocating on behalf of
3 beneficiaries within the utilization review, grievance, or
4 appeals processes established by the issuer ~~insurer~~ in
5 accordance with any rights or remedies available under
6 applicable State or federal law.

7 (b) Issuers ~~Insurers~~ must file for review a description of
8 the services to be offered through a network plan. The
9 description shall include all of the following:

10 (1) A geographic map of the area proposed to be served
11 by the plan by county service area and zip code, including
12 marked locations for preferred providers.

13 (2) As deemed necessary by the Department, the names,
14 addresses, phone numbers, and specialties of the providers
15 who have entered into preferred provider agreements under
16 the network plan.

17 (3) The number of beneficiaries anticipated to be
18 covered by the network plan.

19 (4) An Internet website and toll-free telephone number
20 for beneficiaries and prospective beneficiaries to access
21 current and accurate lists of preferred providers,
22 additional information about the plan, as well as any
23 other information required by Department rule.

24 (5) A description of how health care services to be
25 rendered under the network plan are reasonably accessible
26 and available to beneficiaries. The description shall

1 address all of the following:

2 (A) the type of health care services to be
3 provided by the network plan;

4 (B) the ratio of physicians and other providers to
5 beneficiaries, by specialty and including primary care
6 physicians and facility-based physicians when
7 applicable under the contract, necessary to meet the
8 health care needs and service demands of the currently
9 enrolled population;

10 (C) the travel and distance standards for plan
11 beneficiaries in county service areas; and

12 (D) a description of how the use of telemedicine,
13 telehealth, or mobile care services may be used to
14 partially meet the network adequacy standards, if
15 applicable.

16 (6) A provision ensuring that whenever a beneficiary
17 has made a good faith effort, as evidenced by accessing
18 the provider directory, calling the network plan, and
19 calling the provider, to utilize preferred providers for a
20 covered service and it is determined the issuer ~~insurer~~
21 does not have the appropriate preferred providers due to
22 insufficient number, type, unreasonable travel distance or
23 delay, or preferred providers refusing to provide a
24 covered service because it is contrary to the conscience
25 of the preferred providers, as protected by the Health
26 Care Right of Conscience Act, the issuer ~~insurer~~ shall

1 ensure, directly or indirectly, by terms contained in the
2 payer contract, that the beneficiary will be provided the
3 covered service at no greater cost to the beneficiary than
4 if the service had been provided by a preferred provider.
5 This paragraph (6) does not apply to: (A) a beneficiary
6 who willfully chooses to access a non-preferred provider
7 for health care services available through the panel of
8 preferred providers, or (B) a beneficiary enrolled in a
9 health maintenance organization. In these circumstances,
10 the contractual requirements for non-preferred provider
11 reimbursements shall apply unless Section 356z.3a of the
12 Illinois Insurance Code requires otherwise. In no event
13 shall a beneficiary who receives care at a participating
14 health care facility be required to search for
15 participating providers under the circumstances described
16 in subsection (b) or (b-5) of Section 356z.3a of the
17 Illinois Insurance Code except under the circumstances
18 described in paragraph (2) of subsection (b-5).

19 (7) A provision that the beneficiary shall receive
20 emergency care coverage such that payment for this
21 coverage is not dependent upon whether the emergency
22 services are performed by a preferred or non-preferred
23 provider and the coverage shall be at the same benefit
24 level as if the service or treatment had been rendered by a
25 preferred provider. For purposes of this paragraph (7),
26 "the same benefit level" means that the beneficiary is

1 provided the covered service at no greater cost to the
2 beneficiary than if the service had been provided by a
3 preferred provider. This provision shall be consistent
4 with Section 356z.3a of the Illinois Insurance Code.

5 (8) A limitation that complies with subsections (d)
6 and (e) of Section 55 of the Prior Authorization Reform
7 Act.

8 (c) The network plan shall demonstrate to the Director a
9 minimum ratio of providers to plan beneficiaries as required
10 by the Department.

11 (1) The ratio of physicians or other providers to plan
12 beneficiaries shall be established annually by the
13 Department in consultation with the Department of Public
14 Health based upon the guidance from the federal Centers
15 for Medicare and Medicaid Services. The Department shall
16 not establish ratios for vision or dental providers who
17 provide services under dental-specific or vision-specific
18 benefits. The Department shall consider establishing
19 ratios for the following physicians or other providers:

20 (A) Primary Care;

21 (B) Pediatrics;

22 (C) Cardiology;

23 (D) Gastroenterology;

24 (E) General Surgery;

25 (F) Neurology;

26 (G) OB/GYN;

1 (H) Oncology/Radiation;
2 (I) Ophthalmology;
3 (J) Urology;
4 (K) Behavioral Health;
5 (L) Allergy/Immunology;
6 (M) Chiropractic;
7 (N) Dermatology;
8 (O) Endocrinology;
9 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
10 (Q) Infectious Disease;
11 (R) Nephrology;
12 (S) Neurosurgery;
13 (T) Orthopedic Surgery;
14 (U) Physiatry/Rehabilitative;
15 (V) Plastic Surgery;
16 (W) Pulmonary;
17 (X) Rheumatology;
18 (Y) Anesthesiology;
19 (Z) Pain Medicine;
20 (AA) Pediatric Specialty Services;
21 (BB) Outpatient Dialysis; and
22 (CC) HIV.

23 (2) The Director shall establish a process for the
24 review of the adequacy of these standards, along with an
25 assessment of additional specialties to be included in the
26 list under this subsection (c).

1 (d) The network plan shall demonstrate to the Director
2 maximum travel and distance standards for plan beneficiaries,
3 which shall be established annually by the Department in
4 consultation with the Department of Public Health based upon
5 the guidance from the federal Centers for Medicare and
6 Medicaid Services. These standards shall consist of the
7 maximum minutes or miles to be traveled by a plan beneficiary
8 for each county type, such as large counties, metro counties,
9 or rural counties as defined by Department rule.

10 The maximum travel time and distance standards must
11 include standards for each physician and other provider
12 category listed for which ratios have been established.

13 The Director shall establish a process for the review of
14 the adequacy of these standards along with an assessment of
15 additional specialties to be included in the list under this
16 subsection (d).

17 (d-5)(1) Every issuer ~~insurer~~ shall ensure that
18 beneficiaries have timely and proximate access to treatment
19 for mental, emotional, nervous, or substance use disorders or
20 conditions in accordance with the provisions of paragraph (4)
21 of subsection (a) of Section 370c of the Illinois Insurance
22 Code. Issuers ~~Insurers~~ shall use a comparable process,
23 strategy, evidentiary standard, and other factors in the
24 development and application of the network adequacy standards
25 for timely and proximate access to treatment for mental,
26 emotional, nervous, or substance use disorders or conditions

1 and those for the access to treatment for medical and surgical
2 conditions. As such, the network adequacy standards for timely
3 and proximate access shall equally be applied to treatment
4 facilities and providers for mental, emotional, nervous, or
5 substance use disorders or conditions and specialists
6 providing medical or surgical benefits pursuant to the parity
7 requirements of Section 370c.1 of the Illinois Insurance Code
8 and the federal Paul Wellstone and Pete Domenici Mental Health
9 Parity and Addiction Equity Act of 2008. Notwithstanding the
10 foregoing, the network adequacy standards for timely and
11 proximate access to treatment for mental, emotional, nervous,
12 or substance use disorders or conditions shall, at a minimum,
13 satisfy the following requirements:

14 (A) For beneficiaries residing in the metropolitan
15 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
16 network adequacy standards for timely and proximate access
17 to treatment for mental, emotional, nervous, or substance
18 use disorders or conditions means a beneficiary shall not
19 have to travel longer than 30 minutes or 30 miles from the
20 beneficiary's residence to receive outpatient treatment
21 for mental, emotional, nervous, or substance use disorders
22 or conditions. Beneficiaries shall not be required to wait
23 longer than 10 business days between requesting an initial
24 appointment and being seen by the facility or provider of
25 mental, emotional, nervous, or substance use disorders or
26 conditions for outpatient treatment or to wait longer than

1 20 business days between requesting a repeat or follow-up
2 appointment and being seen by the facility or provider of
3 mental, emotional, nervous, or substance use disorders or
4 conditions for outpatient treatment; however, subject to
5 the protections of paragraph (3) of this subsection, a
6 network plan shall not be held responsible if the
7 beneficiary or provider voluntarily chooses to schedule an
8 appointment outside of these required time frames.

9 (B) For beneficiaries residing in Illinois counties
10 other than those counties listed in subparagraph (A) of
11 this paragraph, network adequacy standards for timely and
12 proximate access to treatment for mental, emotional,
13 nervous, or substance use disorders or conditions means a
14 beneficiary shall not have to travel longer than 60
15 minutes or 60 miles from the beneficiary's residence to
16 receive outpatient treatment for mental, emotional,
17 nervous, or substance use disorders or conditions.
18 Beneficiaries shall not be required to wait longer than 10
19 business days between requesting an initial appointment
20 and being seen by the facility or provider of mental,
21 emotional, nervous, or substance use disorders or
22 conditions for outpatient treatment or to wait longer than
23 20 business days between requesting a repeat or follow-up
24 appointment and being seen by the facility or provider of
25 mental, emotional, nervous, or substance use disorders or
26 conditions for outpatient treatment; however, subject to

1 the protections of paragraph (3) of this subsection, a
2 network plan shall not be held responsible if the
3 beneficiary or provider voluntarily chooses to schedule an
4 appointment outside of these required time frames.

5 (2) For beneficiaries residing in all Illinois counties,
6 network adequacy standards for timely and proximate access to
7 treatment for mental, emotional, nervous, or substance use
8 disorders or conditions means a beneficiary shall not have to
9 travel longer than 60 minutes or 60 miles from the
10 beneficiary's residence to receive inpatient or residential
11 treatment for mental, emotional, nervous, or substance use
12 disorders or conditions.

13 (3) If there is no in-network facility or provider
14 available for a beneficiary to receive timely and proximate
15 access to treatment for mental, emotional, nervous, or
16 substance use disorders or conditions in accordance with the
17 network adequacy standards outlined in this subsection, the
18 issuer ~~insurer~~ shall provide necessary exceptions to its
19 network to ensure admission and treatment with a provider or
20 at a treatment facility in accordance with the network
21 adequacy standards in this subsection.

22 (e) Except for network plans solely offered as a group
23 health plan, these ratio and time and distance standards apply
24 to the lowest cost-sharing tier of any tiered network.

25 (f) The network plan may consider use of other health care
26 service delivery options, such as telemedicine or telehealth,

1 mobile clinics, and centers of excellence, or other ways of
2 delivering care to partially meet the requirements set under
3 this Section.

4 (g) Except for the requirements set forth in subsection
5 (d-5), issuers ~~insurers~~ who are not able to comply with the
6 provider ratios, and time and distance standards, and
7 appointment wait-time standards established under this Act or
8 federal law ~~by the Department~~ may request an exception to
9 these requirements from the Department. The Department may
10 grant an exception in the following circumstances:

11 (1) if no providers or facilities meet the specific
12 time and distance standard in a specific service area and
13 the issuer ~~insurer~~ (i) discloses information on the
14 distance and travel time points that beneficiaries would
15 have to travel beyond the required criterion to reach the
16 next closest contracted provider outside of the service
17 area and (ii) provides contact information, including
18 names, addresses, and phone numbers for the next closest
19 contracted provider or facility;

20 (2) if patterns of care in the service area do not
21 support the need for the requested number of provider or
22 facility type and the issuer ~~insurer~~ provides data on
23 local patterns of care, such as claims data, referral
24 patterns, or local provider interviews, indicating where
25 the beneficiaries currently seek this type of care or
26 where the physicians currently refer beneficiaries, or

1 both; or

2 (3) other circumstances deemed appropriate by the
3 Department consistent with the requirements of this Act.

4 (h) Issuers ~~Insurers~~ are required to report to the
5 Director any material change to an approved network plan
6 within 15 days after the change occurs and any change that
7 would result in failure to meet the requirements of this Act.
8 Upon notice from the issuer ~~insurer~~, the Director shall
9 reevaluate the network plan's compliance with the network
10 adequacy and transparency standards of this Act.

11 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
12 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

13 (Text of Section from P.A. 103-718)

14 Sec. 10. Network adequacy.

15 (a) An issuer ~~insurer~~ providing a network plan shall file
16 a description of all of the following with the Director:

17 (1) The written policies and procedures for adding
18 providers to meet patient needs based on increases in the
19 number of beneficiaries, changes in the
20 patient-to-provider ratio, changes in medical and health
21 care capabilities, and increased demand for services.

22 (2) The written policies and procedures for making
23 referrals within and outside the network.

24 (3) The written policies and procedures on how the
25 network plan will provide 24-hour, 7-day per week access

1 to network-affiliated primary care, emergency services,
2 and obstetrical and gynecological health care
3 professionals.

4 An issuer ~~insurer~~ shall not prohibit a preferred provider
5 from discussing any specific or all treatment options with
6 beneficiaries irrespective of the issuer's ~~insurer's~~ position
7 on those treatment options or from advocating on behalf of
8 beneficiaries within the utilization review, grievance, or
9 appeals processes established by the issuer ~~insurer~~ in
10 accordance with any rights or remedies available under
11 applicable State or federal law.

12 (b) Issuers ~~Insurers~~ must file for review a description of
13 the services to be offered through a network plan. The
14 description shall include all of the following:

15 (1) A geographic map of the area proposed to be served
16 by the plan by county service area and zip code, including
17 marked locations for preferred providers.

18 (2) As deemed necessary by the Department, the names,
19 addresses, phone numbers, and specialties of the providers
20 who have entered into preferred provider agreements under
21 the network plan.

22 (3) The number of beneficiaries anticipated to be
23 covered by the network plan.

24 (4) An Internet website and toll-free telephone number
25 for beneficiaries and prospective beneficiaries to access
26 current and accurate lists of preferred providers,

1 additional information about the plan, as well as any
2 other information required by Department rule.

3 (5) A description of how health care services to be
4 rendered under the network plan are reasonably accessible
5 and available to beneficiaries. The description shall
6 address all of the following:

7 (A) the type of health care services to be
8 provided by the network plan;

9 (B) the ratio of physicians and other providers to
10 beneficiaries, by specialty and including primary care
11 physicians and facility-based physicians when
12 applicable under the contract, necessary to meet the
13 health care needs and service demands of the currently
14 enrolled population;

15 (C) the travel and distance standards for plan
16 beneficiaries in county service areas; and

17 (D) a description of how the use of telemedicine,
18 telehealth, or mobile care services may be used to
19 partially meet the network adequacy standards, if
20 applicable.

21 (6) A provision ensuring that whenever a beneficiary
22 has made a good faith effort, as evidenced by accessing
23 the provider directory, calling the network plan, and
24 calling the provider, to utilize preferred providers for a
25 covered service and it is determined the issuer ~~insurer~~
26 does not have the appropriate preferred providers due to

1 insufficient number, type, unreasonable travel distance or
2 delay, or preferred providers refusing to provide a
3 covered service because it is contrary to the conscience
4 of the preferred providers, as protected by the Health
5 Care Right of Conscience Act, the issuer ~~insurer~~ shall
6 ensure, directly or indirectly, by terms contained in the
7 payer contract, that the beneficiary will be provided the
8 covered service at no greater cost to the beneficiary than
9 if the service had been provided by a preferred provider.
10 This paragraph (6) does not apply to: (A) a beneficiary
11 who willfully chooses to access a non-preferred provider
12 for health care services available through the panel of
13 preferred providers, or (B) a beneficiary enrolled in a
14 health maintenance organization. In these circumstances,
15 the contractual requirements for non-preferred provider
16 reimbursements shall apply unless Section 356z.3a of the
17 Illinois Insurance Code requires otherwise. In no event
18 shall a beneficiary who receives care at a participating
19 health care facility be required to search for
20 participating providers under the circumstances described
21 in subsection (b) or (b-5) of Section 356z.3a of the
22 Illinois Insurance Code except under the circumstances
23 described in paragraph (2) of subsection (b-5).

24 (7) A provision that the beneficiary shall receive
25 emergency care coverage such that payment for this
26 coverage is not dependent upon whether the emergency

1 services are performed by a preferred or non-preferred
2 provider and the coverage shall be at the same benefit
3 level as if the service or treatment had been rendered by a
4 preferred provider. For purposes of this paragraph (7),
5 "the same benefit level" means that the beneficiary is
6 provided the covered service at no greater cost to the
7 beneficiary than if the service had been provided by a
8 preferred provider. This provision shall be consistent
9 with Section 356z.3a of the Illinois Insurance Code.

10 (8) A limitation that, if the plan provides that the
11 beneficiary will incur a penalty for failing to
12 pre-certify inpatient hospital treatment, the penalty may
13 not exceed \$1,000 per occurrence in addition to the plan
14 cost-sharing provisions.

15 (c) The network plan shall demonstrate to the Director a
16 minimum ratio of providers to plan beneficiaries as required
17 by the Department.

18 (1) The ratio of physicians or other providers to plan
19 beneficiaries shall be established annually by the
20 Department in consultation with the Department of Public
21 Health based upon the guidance from the federal Centers
22 for Medicare and Medicaid Services. The Department shall
23 not establish ratios for vision or dental providers who
24 provide services under dental-specific or vision-specific
25 benefits. The Department shall consider establishing
26 ratios for the following physicians or other providers:

1 (A) Primary Care;
2 (B) Pediatrics;
3 (C) Cardiology;
4 (D) Gastroenterology;
5 (E) General Surgery;
6 (F) Neurology;
7 (G) OB/GYN;
8 (H) Oncology/Radiation;
9 (I) Ophthalmology;
10 (J) Urology;
11 (K) Behavioral Health;
12 (L) Allergy/Immunology;
13 (M) Chiropractic;
14 (N) Dermatology;
15 (O) Endocrinology;
16 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
17 (Q) Infectious Disease;
18 (R) Nephrology;
19 (S) Neurosurgery;
20 (T) Orthopedic Surgery;
21 (U) Physiatry/Rehabilitative;
22 (V) Plastic Surgery;
23 (W) Pulmonary;
24 (X) Rheumatology;
25 (Y) Anesthesiology;
26 (Z) Pain Medicine;

1 (AA) Pediatric Specialty Services;

2 (BB) Outpatient Dialysis; and

3 (CC) HIV.

4 (2) The Director shall establish a process for the
5 review of the adequacy of these standards, along with an
6 assessment of additional specialties to be included in the
7 list under this subsection (c).

8 (d) The network plan shall demonstrate to the Director
9 maximum travel and distance standards for plan beneficiaries,
10 which shall be established annually by the Department in
11 consultation with the Department of Public Health based upon
12 the guidance from the federal Centers for Medicare and
13 Medicaid Services. These standards shall consist of the
14 maximum minutes or miles to be traveled by a plan beneficiary
15 for each county type, such as large counties, metro counties,
16 or rural counties as defined by Department rule.

17 The maximum travel time and distance standards must
18 include standards for each physician and other provider
19 category listed for which ratios have been established.

20 The Director shall establish a process for the review of
21 the adequacy of these standards along with an assessment of
22 additional specialties to be included in the list under this
23 subsection (d).

24 (d-5) (1) Every issuer ~~insurer~~ shall ensure that
25 beneficiaries have timely and proximate access to treatment
26 for mental, emotional, nervous, or substance use disorders or

1 conditions in accordance with the provisions of paragraph (4)
2 of subsection (a) of Section 370c of the Illinois Insurance
3 Code. Issuers ~~Insurers~~ shall use a comparable process,
4 strategy, evidentiary standard, and other factors in the
5 development and application of the network adequacy standards
6 for timely and proximate access to treatment for mental,
7 emotional, nervous, or substance use disorders or conditions
8 and those for the access to treatment for medical and surgical
9 conditions. As such, the network adequacy standards for timely
10 and proximate access shall equally be applied to treatment
11 facilities and providers for mental, emotional, nervous, or
12 substance use disorders or conditions and specialists
13 providing medical or surgical benefits pursuant to the parity
14 requirements of Section 370c.1 of the Illinois Insurance Code
15 and the federal Paul Wellstone and Pete Domenici Mental Health
16 Parity and Addiction Equity Act of 2008. Notwithstanding the
17 foregoing, the network adequacy standards for timely and
18 proximate access to treatment for mental, emotional, nervous,
19 or substance use disorders or conditions shall, at a minimum,
20 satisfy the following requirements:

21 (A) For beneficiaries residing in the metropolitan
22 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
23 network adequacy standards for timely and proximate access
24 to treatment for mental, emotional, nervous, or substance
25 use disorders or conditions means a beneficiary shall not
26 have to travel longer than 30 minutes or 30 miles from the

1 beneficiary's residence to receive outpatient treatment
2 for mental, emotional, nervous, or substance use disorders
3 or conditions. Beneficiaries shall not be required to wait
4 longer than 10 business days between requesting an initial
5 appointment and being seen by the facility or provider of
6 mental, emotional, nervous, or substance use disorders or
7 conditions for outpatient treatment or to wait longer than
8 20 business days between requesting a repeat or follow-up
9 appointment and being seen by the facility or provider of
10 mental, emotional, nervous, or substance use disorders or
11 conditions for outpatient treatment; however, subject to
12 the protections of paragraph (3) of this subsection, a
13 network plan shall not be held responsible if the
14 beneficiary or provider voluntarily chooses to schedule an
15 appointment outside of these required time frames.

16 (B) For beneficiaries residing in Illinois counties
17 other than those counties listed in subparagraph (A) of
18 this paragraph, network adequacy standards for timely and
19 proximate access to treatment for mental, emotional,
20 nervous, or substance use disorders or conditions means a
21 beneficiary shall not have to travel longer than 60
22 minutes or 60 miles from the beneficiary's residence to
23 receive outpatient treatment for mental, emotional,
24 nervous, or substance use disorders or conditions.
25 Beneficiaries shall not be required to wait longer than 10
26 business days between requesting an initial appointment

1 and being seen by the facility or provider of mental,
2 emotional, nervous, or substance use disorders or
3 conditions for outpatient treatment or to wait longer than
4 20 business days between requesting a repeat or follow-up
5 appointment and being seen by the facility or provider of
6 mental, emotional, nervous, or substance use disorders or
7 conditions for outpatient treatment; however, subject to
8 the protections of paragraph (3) of this subsection, a
9 network plan shall not be held responsible if the
10 beneficiary or provider voluntarily chooses to schedule an
11 appointment outside of these required time frames.

12 (2) For beneficiaries residing in all Illinois counties,
13 network adequacy standards for timely and proximate access to
14 treatment for mental, emotional, nervous, or substance use
15 disorders or conditions means a beneficiary shall not have to
16 travel longer than 60 minutes or 60 miles from the
17 beneficiary's residence to receive inpatient or residential
18 treatment for mental, emotional, nervous, or substance use
19 disorders or conditions.

20 (3) If there is no in-network facility or provider
21 available for a beneficiary to receive timely and proximate
22 access to treatment for mental, emotional, nervous, or
23 substance use disorders or conditions in accordance with the
24 network adequacy standards outlined in this subsection, the
25 issuer ~~insurer~~ shall provide necessary exceptions to its
26 network to ensure admission and treatment with a provider or

1 at a treatment facility in accordance with the network
2 adequacy standards in this subsection.

3 (e) Except for network plans solely offered as a group
4 health plan, these ratio and time and distance standards apply
5 to the lowest cost-sharing tier of any tiered network.

6 (f) The network plan may consider use of other health care
7 service delivery options, such as telemedicine or telehealth,
8 mobile clinics, and centers of excellence, or other ways of
9 delivering care to partially meet the requirements set under
10 this Section.

11 (g) Except for the requirements set forth in subsection
12 (d-5), issuers ~~insurers~~ who are not able to comply with the
13 provider ratios, and time and distance standards, and
14 appointment wait-time standards established under this Act or
15 federal law ~~by the Department~~ may request an exception to
16 these requirements from the Department. The Department may
17 grant an exception in the following circumstances:

18 (1) if no providers or facilities meet the specific
19 time and distance standard in a specific service area and
20 the issuer ~~insurer~~ (i) discloses information on the
21 distance and travel time points that beneficiaries would
22 have to travel beyond the required criterion to reach the
23 next closest contracted provider outside of the service
24 area and (ii) provides contact information, including
25 names, addresses, and phone numbers for the next closest
26 contracted provider or facility;

1 (2) if patterns of care in the service area do not
2 support the need for the requested number of provider or
3 facility type and the issuer ~~insurer~~ provides data on
4 local patterns of care, such as claims data, referral
5 patterns, or local provider interviews, indicating where
6 the beneficiaries currently seek this type of care or
7 where the physicians currently refer beneficiaries, or
8 both; or

9 (3) other circumstances deemed appropriate by the
10 Department consistent with the requirements of this Act.

11 (h) Issuers ~~Insurers~~ are required to report to the
12 Director any material change to an approved network plan
13 within 15 days after the change occurs and any change that
14 would result in failure to meet the requirements of this Act.
15 Upon notice from the issuer ~~insurer~~, the Director shall
16 reevaluate the network plan's compliance with the network
17 adequacy and transparency standards of this Act.

18 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
19 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

20 (Text of Section from P.A. 103-777)

21 Sec. 10. Network adequacy.

22 (a) An issuer ~~insurer~~ providing a network plan shall file
23 a description of all of the following with the Director:

24 (1) The written policies and procedures for adding
25 providers to meet patient needs based on increases in the

1 number of beneficiaries, changes in the
2 patient-to-provider ratio, changes in medical and health
3 care capabilities, and increased demand for services.

4 (2) The written policies and procedures for making
5 referrals within and outside the network.

6 (3) The written policies and procedures on how the
7 network plan will provide 24-hour, 7-day per week access
8 to network-affiliated primary care, emergency services,
9 and women's principal health care providers.

10 An issuer ~~insurer~~ shall not prohibit a preferred provider
11 from discussing any specific or all treatment options with
12 beneficiaries irrespective of the issuer's ~~insurer's~~ position
13 on those treatment options or from advocating on behalf of
14 beneficiaries within the utilization review, grievance, or
15 appeals processes established by the issuer ~~insurer~~ in
16 accordance with any rights or remedies available under
17 applicable State or federal law.

18 (b) Issuers ~~Insurers~~ must file for review a description of
19 the services to be offered through a network plan. The
20 description shall include all of the following:

21 (1) A geographic map of the area proposed to be served
22 by the plan by county service area and zip code, including
23 marked locations for preferred providers.

24 (2) As deemed necessary by the Department, the names,
25 addresses, phone numbers, and specialties of the providers
26 who have entered into preferred provider agreements under

1 the network plan.

2 (3) The number of beneficiaries anticipated to be
3 covered by the network plan.

4 (4) An Internet website and toll-free telephone number
5 for beneficiaries and prospective beneficiaries to access
6 current and accurate lists of preferred providers,
7 additional information about the plan, as well as any
8 other information required by Department rule.

9 (5) A description of how health care services to be
10 rendered under the network plan are reasonably accessible
11 and available to beneficiaries. The description shall
12 address all of the following:

13 (A) the type of health care services to be
14 provided by the network plan;

15 (B) the ratio of physicians and other providers to
16 beneficiaries, by specialty and including primary care
17 physicians and facility-based physicians when
18 applicable under the contract, necessary to meet the
19 health care needs and service demands of the currently
20 enrolled population;

21 (C) the travel and distance standards for plan
22 beneficiaries in county service areas; and

23 (D) a description of how the use of telemedicine,
24 telehealth, or mobile care services may be used to
25 partially meet the network adequacy standards, if
26 applicable.

1 (6) A provision ensuring that whenever a beneficiary
2 has made a good faith effort, as evidenced by accessing
3 the provider directory, calling the network plan, and
4 calling the provider, to utilize preferred providers for a
5 covered service and it is determined the issuer ~~insurer~~
6 does not have the appropriate preferred providers due to
7 insufficient number, type, unreasonable travel distance or
8 delay, or preferred providers refusing to provide a
9 covered service because it is contrary to the conscience
10 of the preferred providers, as protected by the Health
11 Care Right of Conscience Act, the issuer ~~insurer~~ shall
12 ensure, directly or indirectly, by terms contained in the
13 payer contract, that the beneficiary will be provided the
14 covered service at no greater cost to the beneficiary than
15 if the service had been provided by a preferred provider.
16 This paragraph (6) does not apply to: (A) a beneficiary
17 who willfully chooses to access a non-preferred provider
18 for health care services available through the panel of
19 preferred providers, or (B) a beneficiary enrolled in a
20 health maintenance organization. In these circumstances,
21 the contractual requirements for non-preferred provider
22 reimbursements shall apply unless Section 356z.3a of the
23 Illinois Insurance Code requires otherwise. In no event
24 shall a beneficiary who receives care at a participating
25 health care facility be required to search for
26 participating providers under the circumstances described

1 in subsection (b) or (b-5) of Section 356z.3a of the
2 Illinois Insurance Code except under the circumstances
3 described in paragraph (2) of subsection (b-5).

4 (7) A provision that the beneficiary shall receive
5 emergency care coverage such that payment for this
6 coverage is not dependent upon whether the emergency
7 services are performed by a preferred or non-preferred
8 provider and the coverage shall be at the same benefit
9 level as if the service or treatment had been rendered by a
10 preferred provider. For purposes of this paragraph (7),
11 "the same benefit level" means that the beneficiary is
12 provided the covered service at no greater cost to the
13 beneficiary than if the service had been provided by a
14 preferred provider. This provision shall be consistent
15 with Section 356z.3a of the Illinois Insurance Code.

16 (8) A limitation that, if the plan provides that the
17 beneficiary will incur a penalty for failing to
18 pre-certify inpatient hospital treatment, the penalty may
19 not exceed \$1,000 per occurrence in addition to the plan
20 cost sharing provisions.

21 (c) The network plan shall demonstrate to the Director a
22 minimum ratio of providers to plan beneficiaries as required
23 by the Department.

24 (1) The ratio of physicians or other providers to plan
25 beneficiaries shall be established annually by the
26 Department in consultation with the Department of Public

1 Health based upon the guidance from the federal Centers
2 for Medicare and Medicaid Services. The Department shall
3 not establish ratios for vision or dental providers who
4 provide services under dental-specific or vision-specific
5 benefits, except to the extent provided under federal law
6 for stand-alone dental plans. The Department shall
7 consider establishing ratios for the following physicians
8 or other providers:

- 9 (A) Primary Care;
- 10 (B) Pediatrics;
- 11 (C) Cardiology;
- 12 (D) Gastroenterology;
- 13 (E) General Surgery;
- 14 (F) Neurology;
- 15 (G) OB/GYN;
- 16 (H) Oncology/Radiation;
- 17 (I) Ophthalmology;
- 18 (J) Urology;
- 19 (K) Behavioral Health;
- 20 (L) Allergy/Immunology;
- 21 (M) Chiropractic;
- 22 (N) Dermatology;
- 23 (O) Endocrinology;
- 24 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 25 (Q) Infectious Disease;
- 26 (R) Nephrology;

1 (S) Neurosurgery;
2 (T) Orthopedic Surgery;
3 (U) Physiatry/Rehabilitative;
4 (V) Plastic Surgery;
5 (W) Pulmonary;
6 (X) Rheumatology;
7 (Y) Anesthesiology;
8 (Z) Pain Medicine;
9 (AA) Pediatric Specialty Services;
10 (BB) Outpatient Dialysis; and
11 (CC) HIV.

12 (2) The Director shall establish a process for the
13 review of the adequacy of these standards, along with an
14 assessment of additional specialties to be included in the
15 list under this subsection (c).

16 (3) If the federal Centers for Medicare and Medicaid
17 Services establishes minimum provider ratios for
18 stand-alone dental plans in the type of exchange in use in
19 this State for a given plan year, the Department shall
20 enforce those standards for stand-alone dental plans for
21 that plan year.

22 (d) The network plan shall demonstrate to the Director
23 maximum travel and distance standards for plan beneficiaries,
24 which shall be established annually by the Department in
25 consultation with the Department of Public Health based upon
26 the guidance from the federal Centers for Medicare and

1 Medicaid Services. These standards shall consist of the
2 maximum minutes or miles to be traveled by a plan beneficiary
3 for each county type, such as large counties, metro counties,
4 or rural counties as defined by Department rule.

5 The maximum travel time and distance standards must
6 include standards for each physician and other provider
7 category listed for which ratios have been established.

8 The Director shall establish a process for the review of
9 the adequacy of these standards along with an assessment of
10 additional specialties to be included in the list under this
11 subsection (d).

12 If the federal Centers for Medicare and Medicaid Services
13 establishes appointment wait-time standards for qualified
14 health plans, including stand-alone dental plans, in the type
15 of exchange in use in this State for a given plan year, the
16 Department shall enforce those standards for the same types of
17 qualified health plans for that plan year. If the federal
18 Centers for Medicare and Medicaid Services establishes time
19 and distance standards for stand-alone dental plans in the
20 type of exchange in use in this State for a given plan year,
21 the Department shall enforce those standards for stand-alone
22 dental plans for that plan year.

23 (d-5) (1) Every issuer ~~insurer~~ shall ensure that
24 beneficiaries have timely and proximate access to treatment
25 for mental, emotional, nervous, or substance use disorders or
26 conditions in accordance with the provisions of paragraph (4)

1 of subsection (a) of Section 370c of the Illinois Insurance
2 Code. Issuers ~~Insurers~~ shall use a comparable process,
3 strategy, evidentiary standard, and other factors in the
4 development and application of the network adequacy standards
5 for timely and proximate access to treatment for mental,
6 emotional, nervous, or substance use disorders or conditions
7 and those for the access to treatment for medical and surgical
8 conditions. As such, the network adequacy standards for timely
9 and proximate access shall equally be applied to treatment
10 facilities and providers for mental, emotional, nervous, or
11 substance use disorders or conditions and specialists
12 providing medical or surgical benefits pursuant to the parity
13 requirements of Section 370c.1 of the Illinois Insurance Code
14 and the federal Paul Wellstone and Pete Domenici Mental Health
15 Parity and Addiction Equity Act of 2008. Notwithstanding the
16 foregoing, the network adequacy standards for timely and
17 proximate access to treatment for mental, emotional, nervous,
18 or substance use disorders or conditions shall, at a minimum,
19 satisfy the following requirements:

20 (A) For beneficiaries residing in the metropolitan
21 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
22 network adequacy standards for timely and proximate access
23 to treatment for mental, emotional, nervous, or substance
24 use disorders or conditions means a beneficiary shall not
25 have to travel longer than 30 minutes or 30 miles from the
26 beneficiary's residence to receive outpatient treatment

1 for mental, emotional, nervous, or substance use disorders
2 or conditions. Beneficiaries shall not be required to wait
3 longer than 10 business days between requesting an initial
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment or to wait longer than
7 20 business days between requesting a repeat or follow-up
8 appointment and being seen by the facility or provider of
9 mental, emotional, nervous, or substance use disorders or
10 conditions for outpatient treatment; however, subject to
11 the protections of paragraph (3) of this subsection, a
12 network plan shall not be held responsible if the
13 beneficiary or provider voluntarily chooses to schedule an
14 appointment outside of these required time frames.

15 (B) For beneficiaries residing in Illinois counties
16 other than those counties listed in subparagraph (A) of
17 this paragraph, network adequacy standards for timely and
18 proximate access to treatment for mental, emotional,
19 nervous, or substance use disorders or conditions means a
20 beneficiary shall not have to travel longer than 60
21 minutes or 60 miles from the beneficiary's residence to
22 receive outpatient treatment for mental, emotional,
23 nervous, or substance use disorders or conditions.
24 Beneficiaries shall not be required to wait longer than 10
25 business days between requesting an initial appointment
26 and being seen by the facility or provider of mental,

1 emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (2) For beneficiaries residing in all Illinois counties,
12 network adequacy standards for timely and proximate access to
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions means a beneficiary shall not have to
15 travel longer than 60 minutes or 60 miles from the
16 beneficiary's residence to receive inpatient or residential
17 treatment for mental, emotional, nervous, or substance use
18 disorders or conditions.

19 (3) If there is no in-network facility or provider
20 available for a beneficiary to receive timely and proximate
21 access to treatment for mental, emotional, nervous, or
22 substance use disorders or conditions in accordance with the
23 network adequacy standards outlined in this subsection, the
24 issuer ~~insurer~~ shall provide necessary exceptions to its
25 network to ensure admission and treatment with a provider or
26 at a treatment facility in accordance with the network

1 adequacy standards in this subsection.

2 (4) If the federal Centers for Medicare and Medicaid
3 Services establishes a more stringent standard in any county
4 than specified in paragraph (1) or (2) of this subsection
5 (d-5) for qualified health plans in the type of exchange in use
6 in this State for a given plan year, the federal standard shall
7 apply in lieu of the standard in paragraph (1) or (2) of this
8 subsection (d-5) for qualified health plans for that plan
9 year.

10 (e) Except for network plans solely offered as a group
11 health plan, these ratio and time and distance standards apply
12 to the lowest cost-sharing tier of any tiered network.

13 (f) The network plan may consider use of other health care
14 service delivery options, such as telemedicine or telehealth,
15 mobile clinics, and centers of excellence, or other ways of
16 delivering care to partially meet the requirements set under
17 this Section.

18 (g) Except for the requirements set forth in subsection
19 (d-5), issuers ~~insurers~~ who are not able to comply with the
20 provider ratios, time and distance standards, and appointment
21 wait-time standards established under this Act or federal law
22 may request an exception to these requirements from the
23 Department. The Department may grant an exception in the
24 following circumstances:

25 (1) if no providers or facilities meet the specific
26 time and distance standard in a specific service area and

1 the issuer ~~insurer~~ (i) discloses information on the
2 distance and travel time points that beneficiaries would
3 have to travel beyond the required criterion to reach the
4 next closest contracted provider outside of the service
5 area and (ii) provides contact information, including
6 names, addresses, and phone numbers for the next closest
7 contracted provider or facility;

8 (2) if patterns of care in the service area do not
9 support the need for the requested number of provider or
10 facility type and the issuer ~~insurer~~ provides data on
11 local patterns of care, such as claims data, referral
12 patterns, or local provider interviews, indicating where
13 the beneficiaries currently seek this type of care or
14 where the physicians currently refer beneficiaries, or
15 both; or

16 (3) other circumstances deemed appropriate by the
17 Department consistent with the requirements of this Act.

18 (h) Issuers ~~Insurers~~ are required to report to the
19 Director any material change to an approved network plan
20 within 15 days after the change occurs and any change that
21 would result in failure to meet the requirements of this Act.
22 Upon notice from the insurer, the Director shall reevaluate
23 the network plan's compliance with the network adequacy and
24 transparency standards of this Act.

25 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
26 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

1 (Text of Section from P.A. 103-906)

2 Sec. 10. Network adequacy.

3 (a) An issuer ~~insurer~~ providing a network plan shall file
4 a description of all of the following with the Director:

5 (1) The written policies and procedures for adding
6 providers to meet patient needs based on increases in the
7 number of beneficiaries, changes in the
8 patient-to-provider ratio, changes in medical and health
9 care capabilities, and increased demand for services.

10 (2) The written policies and procedures for making
11 referrals within and outside the network.

12 (3) The written policies and procedures on how the
13 network plan will provide 24-hour, 7-day per week access
14 to network-affiliated primary care, emergency services,
15 and women's principal health care providers.

16 An issuer ~~insurer~~ shall not prohibit a preferred provider
17 from discussing any specific or all treatment options with
18 beneficiaries irrespective of the issuer's ~~insurer's~~ position
19 on those treatment options or from advocating on behalf of
20 beneficiaries within the utilization review, grievance, or
21 appeals processes established by the issuer ~~insurer~~ in
22 accordance with any rights or remedies available under
23 applicable State or federal law.

24 (b) Issuers ~~Insurers~~ must file for review a description of
25 the services to be offered through a network plan. The

1 description shall include all of the following:

2 (1) A geographic map of the area proposed to be served
3 by the plan by county service area and zip code, including
4 marked locations for preferred providers.

5 (2) As deemed necessary by the Department, the names,
6 addresses, phone numbers, and specialties of the providers
7 who have entered into preferred provider agreements under
8 the network plan.

9 (3) The number of beneficiaries anticipated to be
10 covered by the network plan.

11 (4) An Internet website and toll-free telephone number
12 for beneficiaries and prospective beneficiaries to access
13 current and accurate lists of preferred providers,
14 additional information about the plan, as well as any
15 other information required by Department rule.

16 (5) A description of how health care services to be
17 rendered under the network plan are reasonably accessible
18 and available to beneficiaries. The description shall
19 address all of the following:

20 (A) the type of health care services to be
21 provided by the network plan;

22 (B) the ratio of physicians and other providers to
23 beneficiaries, by specialty and including primary care
24 physicians and facility-based physicians when
25 applicable under the contract, necessary to meet the
26 health care needs and service demands of the currently

1 enrolled population;

2 (C) the travel and distance standards for plan
3 beneficiaries in county service areas; and

4 (D) a description of how the use of telemedicine,
5 telehealth, or mobile care services may be used to
6 partially meet the network adequacy standards, if
7 applicable.

8 (6) A provision ensuring that whenever a beneficiary
9 has made a good faith effort, as evidenced by accessing
10 the provider directory, calling the network plan, and
11 calling the provider, to utilize preferred providers for a
12 covered service and it is determined the issuer ~~insurer~~
13 does not have the appropriate preferred providers due to
14 insufficient number, type, unreasonable travel distance or
15 delay, or preferred providers refusing to provide a
16 covered service because it is contrary to the conscience
17 of the preferred providers, as protected by the Health
18 Care Right of Conscience Act, the issuer ~~insurer~~ shall
19 ensure, directly or indirectly, by terms contained in the
20 payer contract, that the beneficiary will be provided the
21 covered service at no greater cost to the beneficiary than
22 if the service had been provided by a preferred provider.
23 This paragraph (6) does not apply to: (A) a beneficiary
24 who willfully chooses to access a non-preferred provider
25 for health care services available through the panel of
26 preferred providers, or (B) a beneficiary enrolled in a

1 health maintenance organization. In these circumstances,
2 the contractual requirements for non-preferred provider
3 reimbursements shall apply unless Section 356z.3a of the
4 Illinois Insurance Code requires otherwise. In no event
5 shall a beneficiary who receives care at a participating
6 health care facility be required to search for
7 participating providers under the circumstances described
8 in subsection (b) or (b-5) of Section 356z.3a of the
9 Illinois Insurance Code except under the circumstances
10 described in paragraph (2) of subsection (b-5).

11 (7) A provision that the beneficiary shall receive
12 emergency care coverage such that payment for this
13 coverage is not dependent upon whether the emergency
14 services are performed by a preferred or non-preferred
15 provider and the coverage shall be at the same benefit
16 level as if the service or treatment had been rendered by a
17 preferred provider. For purposes of this paragraph (7),
18 "the same benefit level" means that the beneficiary is
19 provided the covered service at no greater cost to the
20 beneficiary than if the service had been provided by a
21 preferred provider. This provision shall be consistent
22 with Section 356z.3a of the Illinois Insurance Code.

23 (8) A limitation that, if the plan provides that the
24 beneficiary will incur a penalty for failing to
25 pre-certify inpatient hospital treatment, the penalty may
26 not exceed \$1,000 per occurrence in addition to the plan

1 cost sharing provisions.

2 (c) The network plan shall demonstrate to the Director a
3 minimum ratio of providers to plan beneficiaries as required
4 by the Department.

5 (1) The ratio of physicians or other providers to plan
6 beneficiaries shall be established annually by the
7 Department in consultation with the Department of Public
8 Health based upon the guidance from the federal Centers
9 for Medicare and Medicaid Services. The Department shall
10 not establish ratios for vision or dental providers who
11 provide services under dental-specific or vision-specific
12 benefits. The Department shall consider establishing
13 ratios for the following physicians or other providers:

- 14 (A) Primary Care;
- 15 (B) Pediatrics;
- 16 (C) Cardiology;
- 17 (D) Gastroenterology;
- 18 (E) General Surgery;
- 19 (F) Neurology;
- 20 (G) OB/GYN;
- 21 (H) Oncology/Radiation;
- 22 (I) Ophthalmology;
- 23 (J) Urology;
- 24 (K) Behavioral Health;
- 25 (L) Allergy/Immunology;
- 26 (M) Chiropractic;

1 (N) Dermatology;
2 (O) Endocrinology;
3 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
4 (Q) Infectious Disease;
5 (R) Nephrology;
6 (S) Neurosurgery;
7 (T) Orthopedic Surgery;
8 (U) Physiatry/Rehabilitative;
9 (V) Plastic Surgery;
10 (W) Pulmonary;
11 (X) Rheumatology;
12 (Y) Anesthesiology;
13 (Z) Pain Medicine;
14 (AA) Pediatric Specialty Services;
15 (BB) Outpatient Dialysis; and
16 (CC) HIV.

17 (1.5) Beginning January 1, 2026, every issuer ~~insurer~~
18 shall demonstrate to the Director that each in-network
19 hospital has at least one radiologist, pathologist,
20 anesthesiologist, and emergency room physician as a
21 preferred provider in a network plan. The Department may,
22 by rule, require additional types of hospital-based
23 medical specialists to be included as preferred providers
24 in each in-network hospital in a network plan.

25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).

3 (d) The network plan shall demonstrate to the Director
4 maximum travel and distance standards for plan beneficiaries,
5 which shall be established annually by the Department in
6 consultation with the Department of Public Health based upon
7 the guidance from the federal Centers for Medicare and
8 Medicaid Services. These standards shall consist of the
9 maximum minutes or miles to be traveled by a plan beneficiary
10 for each county type, such as large counties, metro counties,
11 or rural counties as defined by Department rule.

12 The maximum travel time and distance standards must
13 include standards for each physician and other provider
14 category listed for which ratios have been established.

15 The Director shall establish a process for the review of
16 the adequacy of these standards along with an assessment of
17 additional specialties to be included in the list under this
18 subsection (d).

19 (d-5)(1) Every issuer ~~insurer~~ shall ensure that
20 beneficiaries have timely and proximate access to treatment
21 for mental, emotional, nervous, or substance use disorders or
22 conditions in accordance with the provisions of paragraph (4)
23 of subsection (a) of Section 370c of the Illinois Insurance
24 Code. Issuers ~~Insurers~~ shall use a comparable process,
25 strategy, evidentiary standard, and other factors in the
26 development and application of the network adequacy standards

1 for timely and proximate access to treatment for mental,
2 emotional, nervous, or substance use disorders or conditions
3 and those for the access to treatment for medical and surgical
4 conditions. As such, the network adequacy standards for timely
5 and proximate access shall equally be applied to treatment
6 facilities and providers for mental, emotional, nervous, or
7 substance use disorders or conditions and specialists
8 providing medical or surgical benefits pursuant to the parity
9 requirements of Section 370c.1 of the Illinois Insurance Code
10 and the federal Paul Wellstone and Pete Domenici Mental Health
11 Parity and Addiction Equity Act of 2008. Notwithstanding the
12 foregoing, the network adequacy standards for timely and
13 proximate access to treatment for mental, emotional, nervous,
14 or substance use disorders or conditions shall, at a minimum,
15 satisfy the following requirements:

16 (A) For beneficiaries residing in the metropolitan
17 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
18 network adequacy standards for timely and proximate access
19 to treatment for mental, emotional, nervous, or substance
20 use disorders or conditions means a beneficiary shall not
21 have to travel longer than 30 minutes or 30 miles from the
22 beneficiary's residence to receive outpatient treatment
23 for mental, emotional, nervous, or substance use disorders
24 or conditions. Beneficiaries shall not be required to wait
25 longer than 10 business days between requesting an initial
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (B) For beneficiaries residing in Illinois counties
12 other than those counties listed in subparagraph (A) of
13 this paragraph, network adequacy standards for timely and
14 proximate access to treatment for mental, emotional,
15 nervous, or substance use disorders or conditions means a
16 beneficiary shall not have to travel longer than 60
17 minutes or 60 miles from the beneficiary's residence to
18 receive outpatient treatment for mental, emotional,
19 nervous, or substance use disorders or conditions.
20 Beneficiaries shall not be required to wait longer than 10
21 business days between requesting an initial appointment
22 and being seen by the facility or provider of mental,
23 emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment; however, subject to
3 the protections of paragraph (3) of this subsection, a
4 network plan shall not be held responsible if the
5 beneficiary or provider voluntarily chooses to schedule an
6 appointment outside of these required time frames.

7 (2) For beneficiaries residing in all Illinois counties,
8 network adequacy standards for timely and proximate access to
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions means a beneficiary shall not have to
11 travel longer than 60 minutes or 60 miles from the
12 beneficiary's residence to receive inpatient or residential
13 treatment for mental, emotional, nervous, or substance use
14 disorders or conditions.

15 (3) If there is no in-network facility or provider
16 available for a beneficiary to receive timely and proximate
17 access to treatment for mental, emotional, nervous, or
18 substance use disorders or conditions in accordance with the
19 network adequacy standards outlined in this subsection, the
20 issuer ~~insurer~~ shall provide necessary exceptions to its
21 network to ensure admission and treatment with a provider or
22 at a treatment facility in accordance with the network
23 adequacy standards in this subsection.

24 (e) Except for network plans solely offered as a group
25 health plan, these ratio and time and distance standards apply
26 to the lowest cost-sharing tier of any tiered network.

1 (f) The network plan may consider use of other health care
2 service delivery options, such as telemedicine or telehealth,
3 mobile clinics, and centers of excellence, or other ways of
4 delivering care to partially meet the requirements set under
5 this Section.

6 (g) Except for the requirements set forth in subsection
7 (d-5), issuers ~~insurers~~ who are not able to comply with the
8 provider ratios, and time and distance standards, and
9 appointment wait-time standards established under this Act or
10 federal law ~~by the Department~~ may request an exception to
11 these requirements from the Department. The Department may
12 grant an exception in the following circumstances:

13 (1) if no providers or facilities meet the specific
14 time and distance standard in a specific service area and
15 the issuer ~~insurer~~ (i) discloses information on the
16 distance and travel time points that beneficiaries would
17 have to travel beyond the required criterion to reach the
18 next closest contracted provider outside of the service
19 area and (ii) provides contact information, including
20 names, addresses, and phone numbers for the next closest
21 contracted provider or facility;

22 (2) if patterns of care in the service area do not
23 support the need for the requested number of provider or
24 facility type and the issuer ~~insurer~~ provides data on
25 local patterns of care, such as claims data, referral
26 patterns, or local provider interviews, indicating where

1 the beneficiaries currently seek this type of care or
2 where the physicians currently refer beneficiaries, or
3 both; or

4 (3) other circumstances deemed appropriate by the
5 Department consistent with the requirements of this Act.

6 (h) Issuers ~~Insurers~~ are required to report to the
7 Director any material change to an approved network plan
8 within 15 days after the change occurs and any change that
9 would result in failure to meet the requirements of this Act.
10 Upon notice from the issuer ~~insurer~~, the Director shall
11 reevaluate the network plan's compliance with the network
12 adequacy and transparency standards of this Act.

13 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
14 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

15 (215 ILCS 124/25)

16 (Text of Section from P.A. 103-605)

17 Sec. 25. Network transparency.

18 (a) A network plan shall post electronically an
19 up-to-date, accurate, and complete provider directory for each
20 of its network plans, with the information and search
21 functions, as described in this Section.

22 (1) In making the directory available electronically,
23 the network plans shall ensure that the general public is
24 able to view all of the current providers for a plan
25 through a clearly identifiable link or tab and without

1 creating or accessing an account or entering a policy or
2 contract number.

3 (2) The network plan shall update the online provider
4 directory at least monthly. Providers shall notify the
5 network plan electronically or in writing of any changes
6 to their information as listed in the provider directory,
7 including the information required in subparagraph (K) of
8 paragraph (1) of subsection (b). The network plan shall
9 update its online provider directory in a manner
10 consistent with the information provided by the provider
11 within 10 business days after being notified of the change
12 by the provider. Nothing in this paragraph (2) shall void
13 any contractual relationship between the provider and the
14 plan.

15 (3) The network plan shall audit periodically at least
16 25% of its provider directories for accuracy, make any
17 corrections necessary, and retain documentation of the
18 audit. The network plan shall submit the audit to the
19 Director upon request. As part of these audits, the
20 network plan shall contact any provider in its network
21 that has not submitted a claim to the plan or otherwise
22 communicated his or her intent to continue participation
23 in the plan's network.

24 (4) A network plan shall provide a printed copy of a
25 current provider directory or a printed copy of the
26 requested directory information upon request of a

1 beneficiary or a prospective beneficiary. Printed copies
2 must be updated quarterly and an errata that reflects
3 changes in the provider network must be updated quarterly.

4 (5) For each network plan, a network plan shall
5 include, in plain language in both the electronic and
6 print directory, the following general information:

7 (A) in plain language, a description of the
8 criteria the plan has used to build its provider
9 network;

10 (B) if applicable, in plain language, a
11 description of the criteria the issuer ~~insurer~~ or
12 network plan has used to create tiered networks;

13 (C) if applicable, in plain language, how the
14 network plan designates the different provider tiers
15 or levels in the network and identifies for each
16 specific provider, hospital, or other type of facility
17 in the network which tier each is placed, for example,
18 by name, symbols, or grouping, in order for a
19 beneficiary-covered person or a prospective
20 beneficiary-covered person to be able to identify the
21 provider tier; and

22 (D) if applicable, a notation that authorization
23 or referral may be required to access some providers.

24 (6) A network plan shall make it clear for both its
25 electronic and print directories what provider directory
26 applies to which network plan, such as including the

1 specific name of the network plan as marketed and issued
2 in this State. The network plan shall include in both its
3 electronic and print directories a customer service email
4 address and telephone number or electronic link that
5 beneficiaries or the general public may use to notify the
6 network plan of inaccurate provider directory information
7 and contact information for the Department's Office of
8 Consumer Health Insurance.

9 (7) A provider directory, whether in electronic or
10 print format, shall accommodate the communication needs of
11 individuals with disabilities, and include a link to or
12 information regarding available assistance for persons
13 with limited English proficiency.

14 (b) For each network plan, a network plan shall make
15 available through an electronic provider directory the
16 following information in a searchable format:

17 (1) for health care professionals:

18 (A) name;

19 (B) gender;

20 (C) participating office locations;

21 (D) specialty, if applicable;

22 (E) medical group affiliations, if applicable;

23 (F) facility affiliations, if applicable;

24 (G) participating facility affiliations, if
25 applicable;

26 (H) languages spoken other than English, if

1 applicable;

2 (I) whether accepting new patients;

3 (J) board certifications, if applicable; and

4 (K) use of telehealth or telemedicine, including,
5 but not limited to:

6 (i) whether the provider offers the use of
7 telehealth or telemedicine to deliver services to
8 patients for whom it would be clinically
9 appropriate;

10 (ii) what modalities are used and what types
11 of services may be provided via telehealth or
12 telemedicine; and

13 (iii) whether the provider has the ability and
14 willingness to include in a telehealth or
15 telemedicine encounter a family caregiver who is
16 in a separate location than the patient if the
17 patient wishes and provides his or her consent;

18 (2) for hospitals:

19 (A) hospital name;

20 (B) hospital type (such as acute, rehabilitation,
21 children's, or cancer);

22 (C) participating hospital location; and

23 (D) hospital accreditation status; and

24 (3) for facilities, other than hospitals, by type:

25 (A) facility name;

26 (B) facility type;

1 (C) types of services performed; and

2 (D) participating facility location or locations.

3 (c) For the electronic provider directories, for each
4 network plan, a network plan shall make available all of the
5 following information in addition to the searchable
6 information required in this Section:

7 (1) for health care professionals:

8 (A) contact information; and

9 (B) languages spoken other than English by
10 clinical staff, if applicable;

11 (2) for hospitals, telephone number; and

12 (3) for facilities other than hospitals, telephone
13 number.

14 (d) The issuer ~~insurer~~ or network plan shall make
15 available in print, upon request, the following provider
16 directory information for the applicable network plan:

17 (1) for health care professionals:

18 (A) name;

19 (B) contact information;

20 (C) participating office location or locations;

21 (D) specialty, if applicable;

22 (E) languages spoken other than English, if
23 applicable;

24 (F) whether accepting new patients; and

25 (G) use of telehealth or telemedicine, including,
26 but not limited to:

1 (i) whether the provider offers the use of
2 telehealth or telemedicine to deliver services to
3 patients for whom it would be clinically
4 appropriate;

5 (ii) what modalities are used and what types
6 of services may be provided via telehealth or
7 telemedicine; and

8 (iii) whether the provider has the ability and
9 willingness to include in a telehealth or
10 telemedicine encounter a family caregiver who is
11 in a separate location than the patient if the
12 patient wishes and provides his or her consent;

13 (2) for hospitals:

14 (A) hospital name;

15 (B) hospital type (such as acute, rehabilitation,
16 children's, or cancer); and

17 (C) participating hospital location and telephone
18 number; and

19 (3) for facilities, other than hospitals, by type:

20 (A) facility name;

21 (B) facility type;

22 (C) types of services performed; and

23 (D) participating facility location or locations
24 and telephone numbers.

25 (e) The network plan shall include a disclosure in the
26 print format provider directory that the information included

1 in the directory is accurate as of the date of printing and
2 that beneficiaries or prospective beneficiaries should consult
3 the issuer's ~~insurer's~~ electronic provider directory on its
4 website and contact the provider. The network plan shall also
5 include a telephone number in the print format provider
6 directory for a customer service representative where the
7 beneficiary can obtain current provider directory information.

8 (f) The Director may conduct periodic audits of the
9 accuracy of provider directories. A network plan shall not be
10 subject to any fines or penalties for information required in
11 this Section that a provider submits that is inaccurate or
12 incomplete.

13 (Source: P.A. 102-92, eff. 7-9-21; 103-605, eff. 7-1-24.)

14 (Text of Section from P.A. 103-650)

15 Sec. 25. Network transparency.

16 (a) A network plan shall post electronically an
17 up-to-date, accurate, and complete provider directory for each
18 of its network plans, with the information and search
19 functions, as described in this Section.

20 (1) In making the directory available electronically,
21 the network plans shall ensure that the general public is
22 able to view all of the current providers for a plan
23 through a clearly identifiable link or tab and without
24 creating or accessing an account or entering a policy or
25 contract number.

1 (2) An issuer's failure to update a network plan's
2 directory shall subject the issuer to a civil penalty of
3 \$5,000 per month. Providers shall notify the network plan
4 electronically or in writing within 10 business days of
5 any changes to their information as listed in the provider
6 directory, including the information required in
7 subsections (b), (c), and (d). With regard to subparagraph
8 (I) of paragraph (1) of subsection (b), the provider must
9 give notice to the issuer within 20 business days of
10 deciding to cease accepting new patients covered by the
11 plan if the new patient limitation is expected to last 40
12 business days or longer. The network plan shall update its
13 online provider directory in a manner consistent with the
14 information provided by the provider within 2 business
15 days after being notified of the change by the provider.
16 Nothing in this paragraph (2) shall void any contractual
17 relationship between the provider and the plan.

18 (3) At least once every 90 days, the issuer shall
19 self-audit each network plan's provider directories for
20 accuracy, make any corrections necessary, and retain
21 documentation of the audit. The issuer shall submit the
22 self-audit and a summary to the Department, and the
23 Department shall make the summary of each self-audit
24 publicly available. The Department shall specify the
25 requirements of the summary, which shall be statistical in
26 nature except for a high-level narrative evaluating the

1 impact of internal and external factors on the accuracy of
2 the directory and the timeliness of updates. As part of
3 these self-audits, the network plan shall contact any
4 provider in its network that has not submitted a claim to
5 the plan or otherwise communicated his or her intent to
6 continue participation in the plan's network. The
7 self-audits shall comply with 42 U.S.C. 300gg-115(a)(2),
8 except that "provider directory information" shall include
9 all information required to be included in a provider
10 directory pursuant to this Act.

11 (4) A network plan shall provide a print copy of a
12 current provider directory or a print copy of the
13 requested directory information upon request of a
14 beneficiary or a prospective beneficiary. Except when an
15 issuer's print copies use the same provider information as
16 the electronic provider directory on each print copy's
17 date of printing, print copies must be updated at least
18 every 90 days and errata that reflects changes in the
19 provider network must be included in each update.

20 (5) For each network plan, a network plan shall
21 include, in plain language in both the electronic and
22 print directory, the following general information:

23 (A) in plain language, a description of the
24 criteria the plan has used to build its provider
25 network;

26 (B) if applicable, in plain language, a

1 description of the criteria the issuer or network plan
2 has used to create tiered networks;

3 (C) if applicable, in plain language, how the
4 network plan designates the different provider tiers
5 or levels in the network and identifies for each
6 specific provider, hospital, or other type of facility
7 in the network which tier each is placed, for example,
8 by name, symbols, or grouping, in order for a
9 beneficiary-covered person or a prospective
10 beneficiary-covered person to be able to identify the
11 provider tier;

12 (D) if applicable, a notation that authorization
13 or referral may be required to access some providers;

14 (E) a telephone number and email address for a
15 customer service representative to whom directory
16 inaccuracies may be reported; and

17 (F) a detailed description of the process to
18 dispute charges for out-of-network providers,
19 hospitals, or facilities that were incorrectly listed
20 as in-network prior to the provision of care and a
21 telephone number and email address to dispute such
22 charges.

23 (6) A network plan shall make it clear for both its
24 electronic and print directories what provider directory
25 applies to which network plan, such as including the
26 specific name of the network plan as marketed and issued

1 in this State. The network plan shall include in both its
2 electronic and print directories a customer service email
3 address and telephone number or electronic link that
4 beneficiaries or the general public may use to notify the
5 network plan of inaccurate provider directory information
6 and contact information for the Department's Office of
7 Consumer Health Insurance.

8 (7) A provider directory, whether in electronic or
9 print format, shall accommodate the communication needs of
10 individuals with disabilities, and include a link to or
11 information regarding available assistance for persons
12 with limited English proficiency.

13 (b) For each network plan, a network plan shall make
14 available through an electronic provider directory the
15 following information in a searchable format:

16 (1) for health care professionals:

17 (A) name;

18 (B) gender;

19 (C) participating office locations;

20 (D) patient population served (such as pediatric,
21 adult, elderly, or women) and specialty or
22 subspecialty, if applicable;

23 (E) medical group affiliations, if applicable;

24 (F) facility affiliations, if applicable;

25 (G) participating facility affiliations, if
26 applicable;

1 (H) languages spoken other than English, if
2 applicable;

3 (I) whether accepting new patients;

4 (J) board certifications, if applicable;

5 (K) use of telehealth or telemedicine, including,
6 but not limited to:

7 (i) whether the provider offers the use of
8 telehealth or telemedicine to deliver services to
9 patients for whom it would be clinically
10 appropriate;

11 (ii) what modalities are used and what types
12 of services may be provided via telehealth or
13 telemedicine; and

14 (iii) whether the provider has the ability and
15 willingness to include in a telehealth or
16 telemedicine encounter a family caregiver who is
17 in a separate location than the patient if the
18 patient wishes and provides his or her consent;

19 (L) whether the health care professional accepts
20 appointment requests from patients; and

21 (M) the anticipated date the provider will leave
22 the network, if applicable, which shall be included no
23 more than 10 days after the issuer confirms that the
24 provider is scheduled to leave the network;

25 (2) for hospitals:

26 (A) hospital name;

1 (B) hospital type (such as acute, rehabilitation,
2 children's, or cancer);

3 (C) participating hospital location;

4 (D) hospital accreditation status; and

5 (E) the anticipated date the hospital will leave
6 the network, if applicable, which shall be included no
7 more than 10 days after the issuer confirms the
8 hospital is scheduled to leave the network; and

9 (3) for facilities, other than hospitals, by type:

10 (A) facility name;

11 (B) facility type;

12 (C) types of services performed;

13 (D) participating facility location or locations;

14 and

15 (E) the anticipated date the facility will leave
16 the network, if applicable, which shall be included no
17 more than 10 days after the issuer confirms the
18 facility is scheduled to leave the network.

19 (c) For the electronic provider directories, for each
20 network plan, a network plan shall make available all of the
21 following information in addition to the searchable
22 information required in this Section:

23 (1) for health care professionals:

24 (A) contact information, including both a
25 telephone number and digital contact information if
26 the provider has supplied digital contact information;

1 and

2 (B) languages spoken other than English by
3 clinical staff, if applicable;

4 (2) for hospitals, telephone number and digital
5 contact information; and

6 (3) for facilities other than hospitals, telephone
7 number.

8 (d) The issuer or network plan shall make available in
9 print, upon request, the following provider directory
10 information for the applicable network plan:

11 (1) for health care professionals:

12 (A) name;

13 (B) contact information, including a telephone
14 number and digital contact information if the provider
15 has supplied digital contact information;

16 (C) participating office location or locations;

17 (D) patient population (such as pediatric, adult,
18 elderly, or women) and specialty or subspecialty, if
19 applicable;

20 (E) languages spoken other than English, if
21 applicable;

22 (F) whether accepting new patients;

23 (G) use of telehealth or telemedicine, including,
24 but not limited to:

25 (i) whether the provider offers the use of
26 telehealth or telemedicine to deliver services to

1 patients for whom it would be clinically
2 appropriate;

3 (ii) what modalities are used and what types
4 of services may be provided via telehealth or
5 telemedicine; and

6 (iii) whether the provider has the ability and
7 willingness to include in a telehealth or
8 telemedicine encounter a family caregiver who is
9 in a separate location than the patient if the
10 patient wishes and provides his or her consent;
11 and

12 (H) whether the health care professional accepts
13 appointment requests from patients.

14 (2) for hospitals:

15 (A) hospital name;

16 (B) hospital type (such as acute, rehabilitation,
17 children's, or cancer); and

18 (C) participating hospital location, telephone
19 number, and digital contact information; and

20 (3) for facilities, other than hospitals, by type:

21 (A) facility name;

22 (B) facility type;

23 (C) patient population (such as pediatric, adult,
24 elderly, or women) served, if applicable, and types of
25 services performed; and

26 (D) participating facility location or locations,

1 telephone numbers, and digital contact information for
2 each location.

3 (e) The network plan shall include a disclosure in the
4 print format provider directory that the information included
5 in the directory is accurate as of the date of printing and
6 that beneficiaries or prospective beneficiaries should consult
7 the issuer's electronic provider directory on its website and
8 contact the provider. The network plan shall also include a
9 telephone number and email address in the print format
10 provider directory for a customer service representative where
11 the beneficiary can obtain current provider directory
12 information or report provider directory inaccuracies. The
13 printed provider directory shall include a detailed
14 description of the process to dispute charges for
15 out-of-network providers, hospitals, or facilities that were
16 incorrectly listed as in-network prior to the provision of
17 care and a telephone number and email address to dispute those
18 charges.

19 (f) The Director may conduct periodic audits of the
20 accuracy of provider directories. A network plan shall not be
21 subject to any fines or penalties for information required in
22 this Section that a provider submits that is inaccurate or
23 incomplete.

24 (g) To the extent not otherwise provided in this Act, an
25 issuer shall comply with the requirements of 42 U.S.C.
26 300gg-115, except that "provider directory information" shall

1 include all information required to be included in a provider
2 directory pursuant to this Section.

3 (h) If the issuer or the Department identifies a provider
4 incorrectly listed in the provider directory, the issuer shall
5 check each of the issuer's network plan provider directories
6 for the provider within 2 business days to ascertain whether
7 the provider is a preferred provider in that network plan and,
8 if the provider is incorrectly listed in the provider
9 directory, remove the provider from the provider directory
10 without delay.

11 (i) If the Director determines that an issuer violated
12 this Section, the Director may assess a fine up to \$5,000 per
13 violation, except for inaccurate information given by a
14 provider to the issuer. If an issuer, or any entity or person
15 acting on the issuer's behalf, knew or reasonably should have
16 known that a provider was incorrectly included in a provider
17 directory, the Director may assess a fine of up to \$25,000 per
18 violation against the issuer.

19 (j) This Section applies to network plans not otherwise
20 exempt under Section 3, including stand-alone dental plans.

21 (Source: P.A. 102-92, eff. 7-9-21; 103-650, eff. 1-1-25.)

22 (Text of Section from P.A. 103-777)

23 Sec. 25. Network transparency.

24 (a) A network plan shall post electronically an
25 up-to-date, accurate, and complete provider directory for each

1 of its network plans, with the information and search
2 functions, as described in this Section.

3 (1) In making the directory available electronically,
4 the network plans shall ensure that the general public is
5 able to view all of the current providers for a plan
6 through a clearly identifiable link or tab and without
7 creating or accessing an account or entering a policy or
8 contract number.

9 (2) The network plan shall update the online provider
10 directory at least monthly. Providers shall notify the
11 network plan electronically or in writing of any changes
12 to their information as listed in the provider directory,
13 including the information required in subparagraph (K) of
14 paragraph (1) of subsection (b). The network plan shall
15 update its online provider directory in a manner
16 consistent with the information provided by the provider
17 within 10 business days after being notified of the change
18 by the provider. Nothing in this paragraph (2) shall void
19 any contractual relationship between the provider and the
20 plan.

21 (3) The network plan shall audit periodically at least
22 25% of its provider directories for accuracy, make any
23 corrections necessary, and retain documentation of the
24 audit. The network plan shall submit the audit to the
25 Director upon request. As part of these audits, the
26 network plan shall contact any provider in its network

1 that has not submitted a claim to the plan or otherwise
2 communicated his or her intent to continue participation
3 in the plan's network.

4 (4) A network plan shall provide a printed copy of a
5 current provider directory or a printed copy of the
6 requested directory information upon request of a
7 beneficiary or a prospective beneficiary. Printed copies
8 must be updated quarterly and an errata that reflects
9 changes in the provider network must be updated quarterly.

10 (5) For each network plan, a network plan shall
11 include, in plain language in both the electronic and
12 print directory, the following general information:

13 (A) in plain language, a description of the
14 criteria the plan has used to build its provider
15 network;

16 (B) if applicable, in plain language, a
17 description of the criteria the issuer ~~insurer~~ or
18 network plan has used to create tiered networks;

19 (C) if applicable, in plain language, how the
20 network plan designates the different provider tiers
21 or levels in the network and identifies for each
22 specific provider, hospital, or other type of facility
23 in the network which tier each is placed, for example,
24 by name, symbols, or grouping, in order for a
25 beneficiary-covered person or a prospective
26 beneficiary-covered person to be able to identify the

1 provider tier; and

2 (D) if applicable, a notation that authorization
3 or referral may be required to access some providers.

4 (6) A network plan shall make it clear for both its
5 electronic and print directories what provider directory
6 applies to which network plan, such as including the
7 specific name of the network plan as marketed and issued
8 in this State. The network plan shall include in both its
9 electronic and print directories a customer service email
10 address and telephone number or electronic link that
11 beneficiaries or the general public may use to notify the
12 network plan of inaccurate provider directory information
13 and contact information for the Department's Office of
14 Consumer Health Insurance.

15 (7) A provider directory, whether in electronic or
16 print format, shall accommodate the communication needs of
17 individuals with disabilities, and include a link to or
18 information regarding available assistance for persons
19 with limited English proficiency.

20 (b) For each network plan, a network plan shall make
21 available through an electronic provider directory the
22 following information in a searchable format:

23 (1) for health care professionals:

24 (A) name;

25 (B) gender;

26 (C) participating office locations;

1 (D) specialty, if applicable;

2 (E) medical group affiliations, if applicable;

3 (F) facility affiliations, if applicable;

4 (G) participating facility affiliations, if
5 applicable;

6 (H) languages spoken other than English, if
7 applicable;

8 (I) whether accepting new patients;

9 (J) board certifications, if applicable; and

10 (K) use of telehealth or telemedicine, including,
11 but not limited to:

12 (i) whether the provider offers the use of
13 telehealth or telemedicine to deliver services to
14 patients for whom it would be clinically
15 appropriate;

16 (ii) what modalities are used and what types
17 of services may be provided via telehealth or
18 telemedicine; and

19 (iii) whether the provider has the ability and
20 willingness to include in a telehealth or
21 telemedicine encounter a family caregiver who is
22 in a separate location than the patient if the
23 patient wishes and provides his or her consent;

24 (2) for hospitals:

25 (A) hospital name;

26 (B) hospital type (such as acute, rehabilitation,

1 children's, or cancer);

2 (C) participating hospital location; and

3 (D) hospital accreditation status; and

4 (3) for facilities, other than hospitals, by type:

5 (A) facility name;

6 (B) facility type;

7 (C) types of services performed; and

8 (D) participating facility location or locations.

9 (c) For the electronic provider directories, for each
10 network plan, a network plan shall make available all of the
11 following information in addition to the searchable
12 information required in this Section:

13 (1) for health care professionals:

14 (A) contact information; and

15 (B) languages spoken other than English by
16 clinical staff, if applicable;

17 (2) for hospitals, telephone number; and

18 (3) for facilities other than hospitals, telephone
19 number.

20 (d) The issuer ~~insurer~~ or network plan shall make
21 available in print, upon request, the following provider
22 directory information for the applicable network plan:

23 (1) for health care professionals:

24 (A) name;

25 (B) contact information;

26 (C) participating office location or locations;

1 (D) specialty, if applicable;

2 (E) languages spoken other than English, if
3 applicable;

4 (F) whether accepting new patients; and

5 (G) use of telehealth or telemedicine, including,
6 but not limited to:

7 (i) whether the provider offers the use of
8 telehealth or telemedicine to deliver services to
9 patients for whom it would be clinically
10 appropriate;

11 (ii) what modalities are used and what types
12 of services may be provided via telehealth or
13 telemedicine; and

14 (iii) whether the provider has the ability and
15 willingness to include in a telehealth or
16 telemedicine encounter a family caregiver who is
17 in a separate location than the patient if the
18 patient wishes and provides his or her consent;

19 (2) for hospitals:

20 (A) hospital name;

21 (B) hospital type (such as acute, rehabilitation,
22 children's, or cancer); and

23 (C) participating hospital location and telephone
24 number; and

25 (3) for facilities, other than hospitals, by type:

26 (A) facility name;

1 (B) facility type;

2 (C) types of services performed; and

3 (D) participating facility location or locations
4 and telephone numbers.

5 (e) The network plan shall include a disclosure in the
6 print format provider directory that the information included
7 in the directory is accurate as of the date of printing and
8 that beneficiaries or prospective beneficiaries should consult
9 the issuer's ~~insurer's~~ electronic provider directory on its
10 website and contact the provider. The network plan shall also
11 include a telephone number in the print format provider
12 directory for a customer service representative where the
13 beneficiary can obtain current provider directory information.

14 (f) The Director may conduct periodic audits of the
15 accuracy of provider directories. A network plan shall not be
16 subject to any fines or penalties for information required in
17 this Section that a provider submits that is inaccurate or
18 incomplete.

19 (g) This Section applies to network plans ~~that are~~ not
20 otherwise exempt under Section 3, including stand-alone dental
21 plans ~~that are subject to provider directory requirements~~
22 ~~under federal law.~~

23 (Source: P.A. 102-92, eff. 7-9-21; 103-777, eff. 1-1-25.)

24 Section 20. The Health Maintenance Organization Act is
25 amended by changing Section 5-3 as follows:

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

2 (Text of Section before amendment by P.A. 103-808)

3 Sec. 5-3. Insurance Code provisions.

4 (a) Health Maintenance Organizations shall be subject to
5 the provisions of Sections 133, 134, 136, 137, 139, 140,
6 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
7 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
8 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1,
9 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a,
10 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
11 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,
12 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25,
13 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33,
14 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40,
15 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47,
16 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55,
17 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62,
18 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69,
19 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.76,
20 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
21 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
22 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
23 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
24 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
25 Illinois Insurance Code.

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

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

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

9 (3) a corporation organized under the laws of another
10 state, 30% or more of the enrollees of which are residents
11 of this State, except a corporation subject to
12 substantially the same requirements in its state of
13 organization as is a "domestic company" under Article VIII
14 1/2 of the Illinois Insurance Code.

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

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

23 (2) (i) the criteria specified in subsection (1) (b) of
24 Section 131.8 of the Illinois Insurance Code shall not
25 apply and (ii) the Director, in making his determination
26 with respect to the merger, consolidation, or other

1 acquisition of control, need not take into account the
2 effect on competition of the merger, consolidation, or
3 other acquisition of control;

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

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

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

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

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

22 (d) The provisions of Article VIII 1/2 of the Illinois
23 Insurance Code and this Section 5-3 shall apply to the sale by
24 any health maintenance organization of greater than 10% of its
25 enrollee population (including, without limitation, the health
26 maintenance organization's right, title, and interest in and

1 to its health care certificates).

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

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

19 (i) the amount of, and other terms and conditions with
20 respect to, the refund or additional premium are set forth
21 in the group or enrollment unit contract agreed in advance
22 of the period for which a refund is to be paid or
23 additional premium is to be charged (which period shall
24 not be less than one year); and

25 (ii) the amount of the refund or additional premium
26 shall not exceed 20% of the Health Maintenance

1 Organization's profitable or unprofitable experience with
2 respect to the group or other enrollment unit for the
3 period (and, for purposes of a refund or additional
4 premium, the profitable or unprofitable experience shall
5 be calculated taking into account a pro rata share of the
6 Health Maintenance Organization's administrative and
7 marketing expenses, but shall not include any refund to be
8 made or additional premium to be paid pursuant to this
9 subsection (f)). The Health Maintenance Organization and
10 the group or enrollment unit may agree that the profitable
11 or unprofitable experience may be calculated taking into
12 account the refund period and the immediately preceding 2
13 plan years.

14 The Health Maintenance Organization shall include a
15 statement in the evidence of coverage issued to each enrollee
16 describing the possibility of a refund or additional premium,
17 and upon request of any group or enrollment unit, provide to
18 the group or enrollment unit a description of the method used
19 to calculate (1) the Health Maintenance Organization's
20 profitable experience with respect to the group or enrollment
21 unit and the resulting refund to the group or enrollment unit
22 or (2) the Health Maintenance Organization's unprofitable
23 experience with respect to the group or enrollment unit and
24 the resulting additional premium to be paid by the group or
25 enrollment unit.

26 In no event shall the Illinois Health Maintenance

1 Organization Guaranty Association be liable to pay any
2 contractual obligation of an insolvent organization to pay any
3 refund authorized under this Section.

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

10 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
11 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
12 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
13 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
14 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
15 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
16 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
17 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
18 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
19 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
20 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
21 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
22 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
23 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff.
24 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

25 (Text of Section after amendment by P.A. 103-808)

1 Sec. 5-3. Insurance Code provisions.

2 (a) Health Maintenance Organizations shall be subject to
3 the provisions of Sections 133, 134, 136, 137, 139, 140,
4 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
5 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
6 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g,
7 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
8 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
9 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
10 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
11 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
12 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
13 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
14 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
15 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
16 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
17 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
18 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5,
19 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
20 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
21 paragraph (c) of subsection (2) of Section 367, and Articles
22 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
23 XXXIIB of the Illinois Insurance Code.

24 (b) For purposes of the Illinois Insurance Code, except
25 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
26 Health Maintenance Organizations in the following categories

1 are deemed to be "domestic companies":

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

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

6 (3) a corporation organized under the laws of another
7 state, 30% or more of the enrollees of which are residents
8 of this State, except a corporation subject to
9 substantially the same requirements in its state of
10 organization as is a "domestic company" under Article VIII
11 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

19 (d) The provisions of Article VIII 1/2 of the Illinois
20 Insurance Code and this Section 5-3 shall apply to the sale by
21 any health maintenance organization of greater than 10% of its
22 enrollee population (including, without limitation, the health
23 maintenance organization's right, title, and interest in and
24 to its health care certificates).

25 (e) In considering any management contract or service
26 agreement subject to Section 141.1 of the Illinois Insurance

1 Code, the Director (i) shall, in addition to the criteria
2 specified in Section 141.2 of the Illinois Insurance Code,
3 take into account the effect of the management contract or
4 service agreement on the continuation of benefits to enrollees
5 and the financial condition of the health maintenance
6 organization to be managed or serviced, and (ii) need not take
7 into account the effect of the management contract or service
8 agreement on competition.

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

16 (i) the amount of, and other terms and conditions with
17 respect to, the refund or additional premium are set forth
18 in the group or enrollment unit contract agreed in advance
19 of the period for which a refund is to be paid or
20 additional premium is to be charged (which period shall
21 not be less than one year); and

22 (ii) the amount of the refund or additional premium
23 shall not exceed 20% of the Health Maintenance
24 Organization's profitable or unprofitable experience with
25 respect to the group or other enrollment unit for the
26 period (and, for purposes of a refund or additional

1 premium, the profitable or unprofitable experience shall
2 be calculated taking into account a pro rata share of the
3 Health Maintenance Organization's administrative and
4 marketing expenses, but shall not include any refund to be
5 made or additional premium to be paid pursuant to this
6 subsection (f)). The Health Maintenance Organization and
7 the group or enrollment unit may agree that the profitable
8 or unprofitable experience may be calculated taking into
9 account the refund period and the immediately preceding 2
10 plan years.

11 The Health Maintenance Organization shall include a
12 statement in the evidence of coverage issued to each enrollee
13 describing the possibility of a refund or additional premium,
14 and upon request of any group or enrollment unit, provide to
15 the group or enrollment unit a description of the method used
16 to calculate (1) the Health Maintenance Organization's
17 profitable experience with respect to the group or enrollment
18 unit and the resulting refund to the group or enrollment unit
19 or (2) the Health Maintenance Organization's unprofitable
20 experience with respect to the group or enrollment unit and
21 the resulting additional premium to be paid by the group or
22 enrollment unit.

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

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

7 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
8 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
9 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
10 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
11 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
12 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
13 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
14 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
15 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
16 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
17 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
18 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
19 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
20 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
21 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
22 11-26-24.)

23 Section 25. The Limited Health Service Organization Act is
24 amended by changing Section 4003 as follows:

1 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

2 Sec. 4003. Illinois Insurance Code provisions. Limited
3 health service organizations shall be subject to the
4 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
5 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153,
6 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c,
7 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a,
8 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32,
9 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,
10 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71,
11 356z.73, 356z.74, 356z.75, 364.3, 368a, 401, 401.1, 402, 403,
12 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA,
13 VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, ~~and~~ XXVI, and
14 XXXIIB of the Illinois Insurance Code. Nothing in this Section
15 shall require a limited health care plan to cover any service
16 that is not a limited health service. For purposes of the
17 Illinois Insurance Code, except for Sections 444 and 444.1 and
18 Articles XIII and XIII 1/2, limited health service
19 organizations in the following categories are deemed to be
20 domestic companies:

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

22 (2) a corporation organized under the laws of another
23 state, 30% or more of the enrollees of which are residents
24 of this State, except a corporation subject to
25 substantially the same requirements in its state of
26 organization as is a domestic company under Article VIII

1 1/2 of the Illinois Insurance Code.

2 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
3 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
4 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
5 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
6 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
7 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
8 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;
9 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.
10 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,
11 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

12 Section 30. The Criminal Code of 2012 is amended by
13 changing Section 17-0.5 as follows:

14 (720 ILCS 5/17-0.5)

15 Sec. 17-0.5. Definitions. In this Article:

16 "Altered credit card or debit card" means any instrument
17 or device, whether known as a credit card or debit card, which
18 has been changed in any respect by addition or deletion of any
19 material, except for the signature by the person to whom the
20 card is issued.

21 "Cardholder" means the person or organization named on the
22 face of a credit card or debit card to whom or for whose
23 benefit the credit card or debit card is issued by an issuer.

24 "Computer" means a device that accepts, processes, stores,

1 retrieves, or outputs data and includes, but is not limited
2 to, auxiliary storage, including cloud-based networks of
3 remote services hosted on the Internet, and telecommunications
4 devices connected to computers.

5 "Computer network" means a set of related, remotely
6 connected devices and any communications facilities including
7 more than one computer with the capability to transmit data
8 between them through the communications facilities.

9 "Computer program" or "program" means a series of coded
10 instructions or statements in a form acceptable to a computer
11 which causes the computer to process data and supply the
12 results of the data processing.

13 "Computer services" means computer time or services,
14 including data processing services, Internet services,
15 electronic mail services, electronic message services, or
16 information or data stored in connection therewith.

17 "Counterfeit" means to manufacture, produce or create, by
18 any means, a credit card or debit card without the purported
19 issuer's consent or authorization.

20 "Credit card" means any instrument or device, whether
21 known as a credit card, credit plate, charge plate or any other
22 name, issued with or without fee by an issuer for the use of
23 the cardholder in obtaining money, goods, services or anything
24 else of value on credit or in consideration or an undertaking
25 or guaranty by the issuer of the payment of a check drawn by
26 the cardholder.

1 "Data" means a representation in any form of information,
2 knowledge, facts, concepts, or instructions, including program
3 documentation, which is prepared or has been prepared in a
4 formalized manner and is stored or processed in or transmitted
5 by a computer or in a system or network. Data is considered
6 property and may be in any form, including, but not limited to,
7 printouts, magnetic or optical storage media, punch cards, or
8 data stored internally in the memory of the computer.

9 "Debit card" means any instrument or device, known by any
10 name, issued with or without fee by an issuer for the use of
11 the cardholder in obtaining money, goods, services, and
12 anything else of value, payment of which is made against funds
13 previously deposited by the cardholder. A debit card which
14 also can be used to obtain money, goods, services and anything
15 else of value on credit shall not be considered a debit card
16 when it is being used to obtain money, goods, services or
17 anything else of value on credit.

18 "Document" includes, but is not limited to, any document,
19 representation, or image produced manually, electronically, or
20 by computer.

21 "Electronic fund transfer terminal" means any machine or
22 device that, when properly activated, will perform any of the
23 following services:

24 (1) Dispense money as a debit to the cardholder's
25 account; or

26 (2) Print the cardholder's account balances on a

1 statement; or

2 (3) Transfer funds between a cardholder's accounts; or

3 (4) Accept payments on a cardholder's loan; or

4 (5) Dispense cash advances on an open end credit or a
5 revolving charge agreement; or

6 (6) Accept deposits to a customer's account; or

7 (7) Receive inquiries of verification of checks and
8 dispense information that verifies that funds are
9 available to cover such checks; or

10 (8) Cause money to be transferred electronically from
11 a cardholder's account to an account held by any business,
12 firm, retail merchant, corporation, or any other
13 organization.

14 "Electronic funds transfer system", hereafter referred to
15 as "EFT System", means that system whereby funds are
16 transferred electronically from a cardholder's account to any
17 other account.

18 "Electronic mail service provider" means any person who
19 (i) is an intermediary in sending or receiving electronic mail
20 and (ii) provides to end-users of electronic mail services the
21 ability to send or receive electronic mail.

22 "Expired credit card or debit card" means a credit card or
23 debit card which is no longer valid because the term on it has
24 elapsed.

25 "False academic degree" means a certificate, diploma,
26 transcript, or other document purporting to be issued by an

1 institution of higher learning or purporting to indicate that
2 a person has completed an organized academic program of study
3 at an institution of higher learning when the person has not
4 completed the organized academic program of study indicated on
5 the certificate, diploma, transcript, or other document.

6 "False claim" means any statement made to any insurer,
7 purported insurer, servicing corporation, insurance broker, or
8 insurance agent, or any agent or employee of one of those
9 entities, and made as part of, or in support of, a claim for
10 payment or other benefit under a policy of insurance, or as
11 part of, or in support of, an application for the issuance of,
12 or the rating of, any insurance policy, when the statement
13 does any of the following:

14 (1) Contains any false, incomplete, or misleading
15 information concerning any fact or thing material to the
16 claim.

17 (2) Conceals (i) the occurrence of an event that is
18 material to any person's initial or continued right or
19 entitlement to any insurance benefit or payment or (ii)
20 the amount of any benefit or payment to which the person is
21 entitled.

22 "Financial institution" means any bank, savings and loan
23 association, credit union, or other depository of money or
24 medium of savings and collective investment.

25 "Governmental entity" means: each officer, board,
26 commission, and agency created by the Constitution, whether in

1 the executive, legislative, or judicial branch of State
2 government; each officer, department, board, commission,
3 agency, institution, authority, university, and body politic
4 and corporate of the State; each administrative unit or
5 corporate outgrowth of State government that is created by or
6 pursuant to statute, including units of local government and
7 their officers, school districts, and boards of election
8 commissioners; and each administrative unit or corporate
9 outgrowth of the foregoing items and as may be created by
10 executive order of the Governor.

11 "Incomplete credit card or debit card" means a credit card
12 or debit card which is missing part of the matter other than
13 the signature of the cardholder which an issuer requires to
14 appear on the credit card or debit card before it can be used
15 by a cardholder, and this includes credit cards or debit cards
16 which have not been stamped, embossed, imprinted or written
17 on.

18 "Institution of higher learning" means a public or private
19 college, university, or community college located in the State
20 of Illinois that is authorized by the Board of Higher
21 Education or the Illinois Community College Board to issue
22 post-secondary degrees, or a public or private college,
23 university, or community college located anywhere in the
24 United States that is or has been legally constituted to offer
25 degrees and instruction in its state of origin or
26 incorporation.

1 "Insurance company" means any "company" as defined under
2 Section 2 of the Illinois Insurance Code, "dental service plan
3 corporation" as defined in Section 3 of the Dental Service
4 Plan Act, "health maintenance organization" as defined in
5 Section 1-2 of the Health Maintenance Organization Act,
6 "limited health service organization" as defined in Section
7 1002 of the Limited Health Service Organization Act, "health
8 services plan corporation" as defined in Section 2 of the
9 Voluntary Health Services Plans Act, or any trust fund
10 organized under the Religious and Charitable Risk Pooling
11 Trust Act.

12 "Issuer" means the business organization or financial
13 institution which issues a credit card or debit card, or its
14 duly authorized agent.

15 "Merchant" has the meaning ascribed to it in Section
16 16-0.1 of this Code.

17 "Person" means any individual, corporation, government,
18 governmental subdivision or agency, business trust, estate,
19 trust, partnership or association or any other entity.

20 "Receives" or "receiving" means acquiring possession or
21 control.

22 "Record of charge form" means any document submitted or
23 intended to be submitted to an issuer as evidence of a credit
24 transaction for which the issuer has agreed to reimburse
25 persons providing money, goods, property, services or other
26 things of value.

1 "Revoked credit card or debit card" means a credit card or
2 debit card which is no longer valid because permission to use
3 it has been suspended or terminated by the issuer.

4 "Sale" means any delivery for value.

5 "Scheme or artifice to defraud" includes a scheme or
6 artifice to deprive another of the intangible right to honest
7 services.

8 "Self-insured entity" means any person, business,
9 partnership, corporation, or organization that sets aside
10 funds to meet his, her, or its losses or to absorb fluctuations
11 in the amount of loss, the losses being charged against the
12 funds set aside or accumulated.

13 "Social networking website" means an Internet website
14 containing profile web pages of the members of the website
15 that include the names or nicknames of such members,
16 photographs placed on the profile web pages by such members,
17 or any other personal or personally identifying information
18 about such members and links to other profile web pages on
19 social networking websites of friends or associates of such
20 members that can be accessed by other members or visitors to
21 the website. A social networking website provides members of
22 or visitors to such website the ability to leave messages or
23 comments on the profile web page that are visible to all or
24 some visitors to the profile web page and may also include a
25 form of electronic mail for members of the social networking
26 website.

1 "Statement" means any assertion, oral, written, or
2 otherwise, and includes, but is not limited to: any notice,
3 letter, or memorandum; proof of loss; bill of lading; receipt
4 for payment; invoice, account, or other financial statement;
5 estimate of property damage; bill for services; diagnosis or
6 prognosis; prescription; hospital, medical, or dental chart or
7 other record, x-ray, photograph, videotape, or movie film;
8 test result; other evidence of loss, injury, or expense;
9 computer-generated document; and data in any form.

10 "Universal Price Code Label" means a unique symbol that
11 consists of a machine-readable code and human-readable
12 numbers.

13 "With intent to defraud" means to act knowingly, and with
14 the specific intent to deceive or cheat, for the purpose of
15 causing financial loss to another or bringing some financial
16 gain to oneself, regardless of whether any person was actually
17 defrauded or deceived. This includes an intent to cause
18 another to assume, create, transfer, alter, or terminate any
19 right, obligation, or power with reference to any person or
20 property.

21 (Source: P.A. 101-87, eff. 1-1-20.)

22 Section 95. No acceleration or delay. Where this Act makes
23 changes in a statute that is represented in this Act by text
24 that is not yet or no longer in effect (for example, a Section
25 represented by multiple versions), the use of that text does

1 not accelerate or delay the taking effect of (i) the changes
2 made by this Act or (ii) provisions derived from any other
3 Public Act.

4 Section 99. Effective date. This Act takes effect upon
5 becoming law, except that the changes to Section 1563 of the
6 Illinois Insurance Code take effect January 1, 2026, and the
7 changes to Section 174 of the Illinois Insurance Code take
8 effect 60 days after becoming law.".