

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Sections 121-2.08, 155.04, 174, 194, 368d, 370c.1,
6 and 1563 and by renumbering and changing Section 356z.71 (as
7 amended by 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
17 subsection (1) of Section 445 of this Code.

18 "Industrial insured" means an insured:

19 (i) that procures the insurance of any risk or risks
20 of the kinds specified in Classes 2 and 3 of Section 4 of
21 this Code by use of the services of a full-time employee
22 who is a qualified risk manager or the services of a
23 regularly and continuously retained consultant who is a

1 qualified risk manager;

2 (ii) that procures the insurance ~~directly from an~~
3 ~~unauthorized insurer~~ without the services of an
4 intermediary insurance producer; and

5 (iii) that is an exempt commercial purchaser whose
6 home state is Illinois.

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

9 "Qualified risk manager" means qualified risk manager as
10 the term is defined in subsection (1) of Section 445 of this
11 Code.

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

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

17 (b) For contracts of insurance procured directly from an
18 unauthorized insurer effective January 1, 2015 or later,
19 within 90 days after the effective date of each contract of
20 insurance issued under this Section, the insured shall file a
21 report with the Director by submitting the report to the
22 Surplus Line Association of Illinois in writing or in a
23 computer readable format and provide information as designated
24 by the Surplus Line Association of Illinois. The information
25 in the report shall be substantially similar to that required
26 for surplus line submissions as described in subsection (5) of

1 Section 445 of this Code. Where applicable, the report shall
2 satisfy, with respect to the subject insurance, the reporting
3 requirement of Section 12 of the Fire Investigation Act.

4 (c) For contracts of insurance procured directly from an
5 unauthorized insurer effective January 1, 2015 through
6 December 31, 2017, within 30 days after filing the report, the
7 insured shall pay to the Director for the use and benefit of
8 the State a sum equal to the gross premium of the contract of
9 insurance multiplied by the surplus line tax rate, as
10 described in paragraph (3) of subsection (a) of Section 445 of
11 this Code, and shall pay the fire marshal tax that would
12 otherwise be due annually in March for insurance subject to
13 tax under Section 12 of the Fire Investigation Act. For
14 contracts of insurance procured directly from an unauthorized
15 insurer effective January 1, 2018 or later, within 30 days
16 after filing the report, the insured shall pay to the Director
17 for the use and benefit of the State a sum equal to 0.5% of the
18 gross premium of the contract of insurance, and shall pay the
19 fire marshal tax that would otherwise be due annually in March
20 for insurance subject to tax under Section 12 of the Fire
21 Investigation Act. For contracts of insurance procured
22 directly from an unauthorized insurer effective January 1,
23 2015 or later, within 30 days after filing the report, the
24 insured shall pay to the Surplus Line Association of Illinois
25 a countersigning fee that shall be assessed at the same rate
26 charged to members pursuant to subsection (4) of Section 445.1

1 of this Code.

2 (d) For contracts of insurance procured directly from an
3 unauthorized insurer effective January 1, 2015 or later, the
4 insured shall withhold the amount of the taxes and
5 countersignature fee from the amount of premium charged by and
6 otherwise payable to the insurer for the insurance. If the
7 insured fails to withhold the tax and countersignature fee
8 from the premium, then the insured shall be liable for the
9 amounts thereof and shall pay the amounts as prescribed in
10 subsection (c) of this Section.

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

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

15 (215 ILCS 5/155.04) (from Ch. 73, par. 767.4)

16 Sec. 155.04. Standards for companies and officials.

17 (1) The Director shall not approve any declaration of
18 organization or Articles of Incorporation or issue a
19 Certificate of Authority to any company until he has found
20 that:

21 (a) the company has submitted a sound plan of
22 operation; ~~and~~

23 (b) the ~~general character and experience of the~~
24 ~~incorporators, directors, and proposed officers is such as~~
25 ~~to assure reasonable promise of a successful operation,~~

1 ~~based on the fact that such persons~~ are of known good
2 character and that there is no good reason to believe that
3 they are affiliated, directly or indirectly, through
4 ownership, control, management, reinsurance transactions
5 or other insurance of business relations with any person
6 or persons known to have been involved in the improper
7 manipulation of assets, accounts or reinsurance;~~i-~~

8 (c) the general experience of the incorporators,
9 directors, and proposed officers is enough to ensure the
10 reasonable promise of a successful operation; and

11 (d) no financial concerns related to the company, its
12 ownership, its associated group, or its affiliates have
13 been identified that raise the possibility that the
14 company will have solvency concerns or problems generating
15 the necessary levels of capital and surplus.

16 The Director may require, in substantially the same form,
17 the information required under Section 131.5 of this Code.

18 (2) All companies licensed to do business in this state
19 must notify the Director within 30 days of the appointment or
20 election of any new officers or directors.

21 (3) Except in cases where the Director deems that any
22 officer or director meets the standards set forth in this
23 section, he shall, after notice and hearing afforded to the
24 officer or director, and after a finding that the officer or
25 director is incompetent or untrustworthy or of known bad
26 character, order the removal of the person. If a company does

1 not comply with a removal order within 30 days, the Director
2 shall suspend that company's Certificate of Authority until
3 such time as the order is complied with.

4 (4) It shall be unlawful for a company to borrow money or
5 receive a loan or advance from anyone convicted of a felony,
6 anyone who is untrustworthy or of known bad character or
7 anyone convicted of a criminal offense involving the
8 conversion or misappropriation of fiduciary funds or insurance
9 accounts, theft, deceit, fraud, misrepresentation or
10 corruption.

11 (Source: P.A. 89-97, eff. 7-7-95.)

12 (215 ILCS 5/174) (from Ch. 73, par. 786)

13 Sec. 174. Kinds of agreements requiring approval.

14 (1) The following kinds of reinsurance agreements shall
15 not be entered into by any domestic company unless such
16 agreements are approved in writing by the Director:

17 (a) Agreements of reinsurance of any such company
18 transacting the kind or kinds of business enumerated in
19 Class 1 of Section 4, or as a Fraternal Benefit Society
20 under Article XVII, a Mutual Benefit Association under
21 Article XVIII, a Burial Society under Article XIX or an
22 Assessment Accident and Assessment Accident and Health
23 Company under Article XXI, cedes previously issued and
24 outstanding risks to any company, or cedes any risks to a
25 company not authorized to transact business in this State,

1 or assumes any outstanding risks on which the aggregate
2 reserves and claim liabilities exceed 20% ~~20 percent~~ of
3 the aggregate reserves and claim liabilities of the
4 assuming company, as reported in the preceding annual
5 statement, for the business of either life or accident and
6 health insurance.

7 (b) Any agreement or agreements of reinsurance whereby
8 any company transacting the kind or kinds of business
9 enumerated in either Class 2 or Class 3 of Section 4 cedes
10 to any company or companies at one time, or during a period
11 of six consecutive months more than 20% ~~twenty per centum~~
12 of the total amount of its net ~~previously retained~~
13 unearned premium reserve liability. The Director has the
14 right to request additional filing review and approval of
15 all contracts that contribute to the statutory threshold
16 trigger. As used in this Section, "net unearned premium
17 reserve liability" means a liability associated with
18 existing or in-force business that is not ceded to any
19 reinsurer before the effective date of the proposed
20 reinsurance contract.

21 (c) (Blank).

22 (2) Requests for approval shall be filed at least 30
23 working days prior to the stated effective date of the
24 agreement. An agreement which is not disapproved by the
25 Director within 30 working ~~thirty~~ days after its complete
26 submission shall be deemed approved.

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

2 (215 ILCS 5/194) (from Ch. 73, par. 806)

3 Sec. 194. Rights and liabilities of creditors fixed upon
4 liquidation.

5 (a) The rights and liabilities of the company and of its
6 creditors, policyholders, stockholders or members and all
7 other persons interested in its assets, except persons
8 entitled to file contingent claims, shall be fixed as of the
9 date of the entry of the Order directing liquidation or
10 rehabilitation unless otherwise provided by Order of the
11 Court. The rights of claimants entitled to file contingent
12 claims or to have their claims estimated shall be determined
13 as provided in Section 209.

14 (b) The Director may, within 2 years after the entry of an
15 order for rehabilitation or liquidation or within such further
16 time as applicable law permits, institute an action, claim,
17 suit, or proceeding upon any cause of action against which the
18 period of limitation fixed by applicable law has not expired
19 at the time of filing of the complaint upon which the order is
20 entered.

21 (c) The time between the filing of a complaint for
22 conservation, rehabilitation, or liquidation against the
23 company and the denial of the complaint shall not be
24 considered to be a part of the time within which any action may
25 be commenced against the company. Any action against the

1 company that might have been commenced when the complaint was
2 filed may be commenced for at least 180 days after the
3 complaint is denied.

4 (d) Notwithstanding subsection (a) of this Section,
5 policies of life, disability income, long-term care, health
6 insurance or annuities covered by a guaranty association, or
7 portions of such policies covered by one or more guaranty
8 associations under applicable law shall continue in force,
9 subject to the terms of the policy (including any terms
10 restructured pursuant to a court-approved rehabilitation plan)
11 to the extent necessary to permit the guaranty associations to
12 discharge their statutory obligations. Policies of life,
13 disability income, long-term care, health insurance or
14 annuities, or portions of such policies not covered by one or
15 more guaranty associations shall terminate as provided under
16 subsection (a) of this Section and paragraph (6) of Section
17 193 of this Article, except to the extent the Director
18 proposes and the court approves the use of property of the
19 liquidation estate for the purpose of either (1) continuing
20 the contracts or coverage by transferring them to an assuming
21 reinsurer, or (2) distributing dividends under Section 210 of
22 this Article. Claims incurred during the extension of coverage
23 provided for in this Article shall be classified at priority
24 level (d) under paragraph (1) of Section 205 of this Article.

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

1 (215 ILCS 5/356z.73)

2 Sec. 356z.73 ~~356z.71~~. Insurance coverage for dependent
3 parents.

4 (a) A group or individual policy of accident and health
5 insurance issued, amended, delivered, or renewed on or after
6 January 1, 2026 that provides dependent coverage shall make
7 that dependent coverage available to the parent or stepparent
8 of the insured if the parent or stepparent meets the
9 definition of a qualifying relative under 26 U.S.C. 152(d) and
10 lives or resides within the accident and health insurance
11 policy's service area.

12 (b) This Section does not apply to specialized health care
13 service plans, Medicare supplement insurance, hospital-only
14 policies, accident-only policies, or specified disease
15 insurance policies that reimburse for hospital, medical, or
16 surgical expenses.

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

18 (215 ILCS 5/368d)

19 Sec. 368d. Recoupments.

20 (a) A health care professional or health care provider
21 shall be provided a remittance advice, which must include an
22 explanation of a recoupment or offset taken by an insurer,
23 health maintenance organization, independent practice
24 association, or physician hospital organization, if any. The
25 recoupment explanation shall, at a minimum, include the name

1 of the patient; the date of service; the service code or if no
2 service code is available a service description; the
3 recoupment amount; and the reason for the recoupment or
4 offset. In addition, an insurer, health maintenance
5 organization, independent practice association, or physician
6 hospital organization shall provide with the remittance
7 advice, or with any demand for recoupment or offset, a
8 telephone number or mailing address to initiate an appeal of
9 the recoupment or offset together with the deadline for
10 initiating an appeal. Such information shall be prominently
11 displayed on the remittance advice or written document
12 containing the demand for recoupment or offset. Any appeal of
13 a recoupment or offset by a health care professional or health
14 care provider must be made within 60 days after receipt of the
15 remittance advice.

16 (b) It is not a recoupment when a health care professional
17 or health care provider is paid an amount prospectively or
18 concurrently under a contract with an insurer, health
19 maintenance organization, independent practice association, or
20 physician hospital organization that requires a retrospective
21 reconciliation based upon specific conditions outlined in the
22 contract.

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

26 (1) a court, government administrative agency, other

1 tribunal, or independent third-party arbitrator makes or
2 has made a formal finding of fraud or material
3 misrepresentation;

4 (2) an insurer is acting as a plan administrator for
5 the Comprehensive Health Insurance Plan under the
6 Comprehensive Health Insurance Plan Act;

7 (3) the provider has already been paid in full by any
8 other payer, third party, or workers' compensation
9 insurer; ~~or~~

10 (4) an insurer contracted with the Department of
11 Healthcare and Family Services is required by the
12 Department of Healthcare and Family Services to recoup or
13 offset payments due to a federal Medicaid requirement; ~~or-~~

14 (5) the insurer has requested the recoupment or offset
15 within 12 months, but the insurer and the health care
16 professional or health care provider mutually agree to a
17 different time limit for the recoupment or offset to be
18 withheld from future payments.

19 No contract between an insurer and a health care professional
20 or health care provider may provide for recoupments in
21 violation of this Section. Nothing in this Section shall be
22 construed to preclude insurers, health maintenance
23 organizations, independent practice associations, or physician
24 hospital organizations from resolving coordination of benefits
25 between or among each other, including, but not limited to,
26 resolution of workers' compensation and third-party liability

1 cases, without recouping payment from the provider beyond the
2 12-month ~~18-month~~ time limit provided in this subsection (c).
3 (Source: P.A. 102-632, eff. 1-1-22.)

4 (215 ILCS 5/370c.1)

5 Sec. 370c.1. Mental, emotional, nervous, or substance use
6 disorder or condition parity.

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

16 (1) the financial requirements applicable to such
17 mental, emotional, nervous, or substance use disorder or
18 condition benefits are no more restrictive than the
19 predominant financial requirements applied to
20 substantially all hospital and medical benefits covered by
21 the policy and that there are no separate cost-sharing
22 requirements that are applicable only with respect to
23 mental, emotional, nervous, or substance use disorder or
24 condition benefits; and

25 (2) the treatment limitations applicable to such

1 mental, emotional, nervous, or substance use disorder or
2 condition benefits are no more restrictive than the
3 predominant treatment limitations applied to substantially
4 all hospital and medical benefits covered by the policy
5 and that there are no separate treatment limitations that
6 are applicable only with respect to mental, emotional,
7 nervous, or substance use disorder or condition benefits.

8 (b) The following provisions shall apply concerning
9 aggregate lifetime limits:

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

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

25 (B) if the policy includes an aggregate lifetime
26 limit on substantially all hospital and medical

1 benefits (in this subsection referred to as the
2 "applicable lifetime limit"), then the policy shall
3 either:

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

12 (ii) not include any aggregate lifetime limit
13 on mental, emotional, nervous, or substance use
14 disorder or condition benefits that is less than
15 the applicable lifetime limit.

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

1 lifetime limits applicable to such categories.

2 (c) The following provisions shall apply concerning annual
3 limits:

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

13 (A) if the policy does not include an annual limit
14 on substantially all hospital and medical benefits,
15 then the policy may not impose any annual limits on
16 mental, emotional, nervous, or substance use disorder
17 or condition benefits; or

18 (B) if the policy includes an annual limit on
19 substantially all hospital and medical benefits (in
20 this subsection referred to as the "applicable annual
21 limit"), then the policy shall either:

22 (i) apply the applicable annual limit both to
23 the hospital and medical benefits to which it
24 otherwise would apply and to mental, emotional,
25 nervous, or substance use disorder or condition
26 benefits and not distinguish in the application of

1 the limit between the hospital and medical
2 benefits and mental, emotional, nervous, or
3 substance use disorder or condition benefits; or

4 (ii) not include any annual limit on mental,
5 emotional, nervous, or substance use disorder or
6 condition benefits that is less than the
7 applicable annual limit.

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

20 (d) With respect to mental, emotional, nervous, or
21 substance use disorders or conditions, an insurer shall use
22 policies and procedures for the election and placement of
23 mental, emotional, nervous, or substance use disorder or
24 condition treatment drugs on their formulary that are no less
25 favorable to the insured as those policies and procedures the
26 insurer uses for the selection and placement of drugs for

1 medical or surgical conditions and shall follow the expedited
2 coverage determination requirements for substance abuse
3 treatment drugs set forth in Section 45.2 of the Managed Care
4 Reform and Patient Rights Act.

5 (e) This Section shall be interpreted in a manner
6 consistent with all applicable federal parity regulations
7 including, but not limited to, the Paul Wellstone and Pete
8 Domenici Mental Health Parity and Addiction Equity Act of
9 2008, final regulations issued under the Paul Wellstone and
10 Pete Domenici Mental Health Parity and Addiction Equity Act of
11 2008 and final regulations applying the Paul Wellstone and
12 Pete Domenici Mental Health Parity and Addiction Equity Act of
13 2008 to Medicaid managed care organizations, the Children's
14 Health Insurance Program, and alternative benefit plans.

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

18 (g) As used in this Section:

19 "Financial requirement" includes deductibles, copayments,
20 coinsurance, and out-of-pocket maximums, but does not include
21 an aggregate lifetime limit or an annual limit subject to
22 subsections (b) and (c).

23 "Mental, emotional, nervous, or substance use disorder or
24 condition" means a condition or disorder that involves a
25 mental health condition or substance use disorder that falls
26 under any of the diagnostic categories listed in the mental

1 and behavioral disorders chapter of the current edition of the
2 International Classification of Disease or that is listed in
3 the most recent version of the Diagnostic and Statistical
4 Manual of Mental Disorders.

5 "Treatment limitation" includes limits on benefits based
6 on the frequency of treatment, number of visits, days of
7 coverage, days in a waiting period, or other similar limits on
8 the scope or duration of treatment. "Treatment limitation"
9 includes both quantitative treatment limitations, which are
10 expressed numerically (such as 50 outpatient visits per year),
11 and nonquantitative treatment limitations, which otherwise
12 limit the scope or duration of treatment. A permanent
13 exclusion of all benefits for a particular condition or
14 disorder shall not be considered a treatment limitation.
15 "Nonquantitative treatment" means those limitations as
16 described under federal regulations (26 CFR 54.9812-1).
17 "Nonquantitative treatment limitations" include, but are not
18 limited to, those limitations described under federal
19 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
20 146.136.

21 (h) The Department of Insurance shall implement the
22 following education initiatives:

23 (1) By January 1, 2016, the Department shall develop a
24 plan for a Consumer Education Campaign on parity. The
25 Consumer Education Campaign shall focus its efforts
26 throughout the State and include trainings in the

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

15 (2) (Blank). ~~The Department, in coordination with the~~
16 ~~Department of Human Services and the Department of~~
17 ~~Healthcare and Family Services, shall convene a working~~
18 ~~group of health care insurance carriers, mental health~~
19 ~~advocacy groups, substance abuse patient advocacy groups,~~
20 ~~and mental health physician groups for the purpose of~~
21 ~~discussing issues related to the treatment and coverage of~~
22 ~~mental, emotional, nervous, or substance use disorders or~~
23 ~~conditions and compliance with parity obligations under~~
24 ~~State and federal law. Compliance shall be measured,~~
25 ~~tracked, and shared during the meetings of the working~~
26 ~~group. The working group shall meet once before January 1,~~

1 ~~2016 and shall meet semiannually thereafter. The~~
2 ~~Department shall issue an annual report to the General~~
3 ~~Assembly that includes a list of the health care insurance~~
4 ~~carriers, mental health advocacy groups, substance abuse~~
5 ~~patient advocacy groups, and mental health physician~~
6 ~~groups that participated in the working group meetings,~~
7 ~~details on the issues and topics covered, and any~~
8 ~~legislative recommendations developed by the working~~
9 ~~group.~~

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

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

24 (B) Cover the methodology the Departments use to
25 check for compliance with this Section and Sections
26 356z.23 and 370c of this Code.

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

9 (i) the number of market conduct examinations
10 and audits initiated and completed;

11 (ii) the benefit classifications examined by
12 each market conduct examination and audit;

13 (iii) the subject matter of each market
14 conduct examination and audit, including
15 quantitative and nonquantitative treatment
16 limitations; and

17 (iv) a summary of the basis for the final
18 decision rendered in each market conduct
19 examination and audit.

20 Individually identifiable information shall be
21 excluded from the reports consistent with federal
22 privacy protections.

23 (D) Detail any educational or corrective actions
24 the Departments have taken to ensure compliance with
25 the federal Paul Wellstone and Pete Domenici Mental
26 Health Parity and Addiction Equity Act of 2008, 42

1 U.S.C. 18031(j), this Section, and Sections 356z.23
2 and 370c of this Code.

3 (E) The report must be written in non-technical,
4 readily understandable language and shall be made
5 available to the public by, among such other means as
6 the Departments find appropriate, posting the report
7 on the Departments' websites.

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

17 (j) (Blank).

18 (j-5) The Department of Insurance shall collect the
19 following information:

20 (1) The number of employment disability insurance
21 plans offered in this State, including, but not limited
22 to:

23 (A) individual short-term policies;

24 (B) individual long-term policies;

25 (C) group short-term policies; and

26 (D) group long-term policies.

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

4 (3) The average defined benefit period for the
5 policies referenced in paragraph (1) of this subsection,
6 both for those policies that limit and those policies that
7 have no limitation on mental health and substance use
8 disorder benefits.

9 (4) Whether the policies referenced in paragraph (1)
10 of this subsection are purchased on a voluntary or
11 non-voluntary basis.

12 (5) The identities of the individuals, entities, or a
13 combination of the 2 that assume the cost associated with
14 covering the policies referenced in paragraph (1) of this
15 subsection.

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

19 (A) individual short-term policies;

20 (B) individual long-term policies;

21 (C) group short-term policies; and

22 (D) group long-term policies.

23 (7) The average premiums for disability income
24 insurance issued in this State for:

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

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

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

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

7 (E) individual short-term policies that include
8 mental health and substance use disorder benefits
9 without limitation;

10 (F) individual long-term policies that include
11 mental health and substance use disorder benefits
12 without limitation;

13 (G) group short-term policies that include mental
14 health and substance use disorder benefits without
15 limitation; and

16 (H) group long-term policies that include mental
17 health and substance use disorder benefits without
18 limitation.

19 The Department shall present its findings regarding
20 information collected under this subsection (j-5) to the
21 General Assembly no later than April 30, 2024. Information
22 regarding a specific insurance provider's contributions to the
23 Department's report shall be exempt from disclosure under
24 paragraph (t) of subsection (1) of Section 7 of the Freedom of
25 Information Act. The aggregated information gathered by the
26 Department shall not be exempt from disclosure under paragraph

1 (t) of subsection (1) of Section 7 of the Freedom of
2 Information Act.

3 (k) 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 shall submit
9 an annual report, the format and definitions for which will be
10 determined by the Department and the Department of Healthcare
11 and Family Services and posted on their respective websites,
12 starting on September 1, 2023 and annually thereafter, that
13 contains the following information separately for inpatient
14 in-network benefits, inpatient out-of-network benefits,
15 outpatient in-network benefits, outpatient out-of-network
16 benefits, emergency care benefits, and prescription drug
17 benefits in the case of accident and health insurance or
18 qualified health plans, or inpatient, outpatient, emergency
19 care, and prescription drug benefits in the case of medical
20 assistance:

21 (1) A summary of the plan's pharmacy management
22 processes for mental, emotional, nervous, or substance use
23 disorder or condition benefits compared to those for other
24 medical benefits.

25 (2) A summary of the internal processes of review for
26 experimental benefits and unproven technology for mental,

1 emotional, nervous, or substance use disorder or condition
2 benefits and those for other medical benefits.

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

7 (4) A description of the process used to develop or
8 select the medical necessity criteria for mental,
9 emotional, nervous, or substance use disorder or condition
10 benefits and the process used to develop or select the
11 medical necessity criteria for medical and surgical
12 benefits.

13 (5) Identification of all nonquantitative treatment
14 limitations that are applied to both mental, emotional,
15 nervous, or substance use disorder or condition benefits
16 and medical and surgical benefits within each
17 classification of benefits.

18 (6) The results of an analysis that demonstrates that
19 for the medical necessity criteria described in
20 subparagraph (A) and for each nonquantitative treatment
21 limitation identified in subparagraph (B), as written and
22 in operation, the processes, strategies, evidentiary
23 standards, or other factors used in applying the medical
24 necessity criteria and each nonquantitative treatment
25 limitation to mental, emotional, nervous, or substance use
26 disorder or condition benefits within each classification

1 of benefits are comparable to, and are applied no more
2 stringently than, the processes, strategies, evidentiary
3 standards, or other factors used in applying the medical
4 necessity criteria and each nonquantitative treatment
5 limitation to medical and surgical benefits within the
6 corresponding classification of benefits; at a minimum,
7 the results of the analysis shall:

8 (A) identify the factors used to determine that a
9 nonquantitative treatment limitation applies to a
10 benefit, including factors that were considered but
11 rejected;

12 (B) identify and define the specific evidentiary
13 standards used to define the factors and any other
14 evidence relied upon in designing each nonquantitative
15 treatment limitation;

16 (C) provide the comparative analyses, including
17 the results of the analyses, performed to determine
18 that the processes and strategies used to design each
19 nonquantitative treatment limitation, as written, for
20 mental, emotional, nervous, or substance use disorder
21 or condition benefits are comparable to, and are
22 applied no more stringently than, the processes and
23 strategies used to design each nonquantitative
24 treatment limitation, as written, for medical and
25 surgical benefits;

26 (D) provide the comparative analyses, including

1 the results of the analyses, performed to determine
2 that the processes and strategies used to apply each
3 nonquantitative treatment limitation, in operation,
4 for mental, emotional, nervous, or substance use
5 disorder or condition benefits are comparable to, and
6 applied no more stringently than, the processes or
7 strategies used to apply each nonquantitative
8 treatment limitation, in operation, for medical and
9 surgical benefits; and

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

19 (7) Any other information necessary to clarify data
20 provided in accordance with this Section requested by the
21 Director, including information that may be proprietary or
22 have commercial value, under the requirements of Section
23 30 of the Viatical Settlements Act of 2009.

24 (1) An insurer that amends, delivers, issues, or renews a
25 group or individual policy of accident and health insurance or
26 a qualified health plan offered through the health insurance

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

16 (m) In conjunction with its compliance examination program
17 conducted in accordance with the Illinois State Auditing Act,
18 the Auditor General shall undertake a review of compliance by
19 the Department and the Department of Healthcare and Family
20 Services with Section 370c and this Section. Any findings
21 resulting from the review conducted under this Section shall
22 be included in the applicable State agency's compliance
23 examination report. Each compliance examination report shall
24 be issued in accordance with Section 3-14 of the Illinois
25 State Auditing Act. A copy of each report shall also be
26 delivered to the head of the applicable State agency and

1 posted on the Auditor General's website.

2 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;
3 102-813, eff. 5-13-22; 103-94, eff. 1-1-24; 103-105, eff.
4 6-27-23; 103-605, eff. 7-1-24.)

5 (215 ILCS 5/1563)

6 Sec. 1563. Fees. The fees required by this Article are as
7 follows:

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

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

13 (3) Application fee of \$50 for processing each request
14 to take the written examination for a public adjuster
15 license.

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

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

19 (215 ILCS 109/75)

20 Sec. 75. Application of other law.

21 (a) All provisions of this Act and other applicable law
22 that are not in conflict with this Act shall apply to managed
23 care dental plans and other persons subject to this Act. To the

1 extent that any provision of this Act or rule under this Act
2 would prevent the application of any standard or requirement
3 under the Network Adequacy and Transparency Act to a plan that
4 is subject to both statutes, the Network Adequacy and
5 Transparency Act shall supersede this Act.

6 (b) Solicitation of enrollees by a managed care entity
7 granted a certificate of authority or its representatives
8 shall not be construed to violate any provision of law
9 relating to solicitation or advertising by health
10 professionals.

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

12 Section 15. The Network Adequacy and Transparency Act is
13 amended by changing Sections 3, 5, 10, and 25 as follows:

14 (215 ILCS 124/3)

15 Sec. 3. Applicability of Act. This Act applies to an
16 individual or group policy of health insurance coverage with a
17 network plan amended, delivered, issued, or renewed in this
18 State on or after January 1, 2019. This Act does not apply to
19 an individual or group policy for excepted benefits or
20 short-term, limited-duration health insurance coverage with a
21 network plan. This Act does not apply to stand-alone dental
22 plans. If federal law establishes network adequacy and
23 transparency standards for stand-alone dental plans, the
24 Department shall enforce those applicable federal requirements

1 ~~, except to the extent that federal law establishes network~~
2 ~~adequacy and transparency standards for stand-alone dental~~
3 ~~plans, which the Department shall enforce for plans amended,~~
4 ~~delivered, issued, or renewed on or after January 1, 2025.~~

5 (Source: P.A. 103-650, eff. 1-1-25; 103-777, eff. 1-1-25;
6 revised 11-26-24.)

7 (215 ILCS 124/5)

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

9 Sec. 5. Definitions. In this Act:

10 "Authorized representative" means a person to whom a
11 beneficiary has given express written consent to represent the
12 beneficiary; a person authorized by law to provide substituted
13 consent for a beneficiary; or the beneficiary's treating
14 provider only when the beneficiary or his or her family member
15 is unable to provide consent.

16 "Beneficiary" means an individual, an enrollee, an
17 insured, a participant, or any other person entitled to
18 reimbursement for covered expenses of or the discounting of
19 provider fees for health care services under a program in
20 which the beneficiary has an incentive to utilize the services
21 of a provider that has entered into an agreement or
22 arrangement with an issuer.

23 "Department" means the Department of Insurance.

24 "Director" means the Director of Insurance.

25 "Essential community provider" has the meaning given

1 ~~ascribed~~ to that term in 45 CFR 156.235.

2 "Excepted benefits" has the meaning given ~~ascribed~~ to that
3 term in 42 U.S.C. 300gg-91(c) and implementing regulations.
4 "Excepted benefits" includes individual, group, or blanket
5 coverage.

6 "Exchange" has the meaning given ~~ascribed~~ to that term in
7 45 CFR 155.20.

8 ~~"Director" means the Director of Insurance.~~

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

15 "Group health plan" has the meaning given ~~ascribed~~ to that
16 term in Section 5 of the Illinois Health Insurance Portability
17 and Accountability Act.

18 "Health insurance coverage" has the meaning given ~~ascribed~~
19 to that term in Section 5 of the Illinois Health Insurance
20 Portability and Accountability Act. "Health insurance
21 coverage" does not include any coverage or benefits under
22 Medicare or under the medical assistance program established
23 under Article V of the Illinois Public Aid Code.

24 "Issuer" means a "health insurance issuer" as defined in
25 Section 5 of the Illinois Health Insurance Portability and
26 Accountability Act.

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

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

13 "Network plan" means an individual or group policy of
14 health insurance coverage that either requires a covered
15 person to use or creates incentives, including financial
16 incentives, for a covered person to use providers managed,
17 owned, under contract with, or employed by the issuer or by a
18 third party contracted to arrange, contract for, or administer
19 such provider-related incentives for the issuer.

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 post-operative visits, or a serious and complex condition as
2 defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of
3 treatment for a health condition that a treating provider
4 attests that discontinuing care by that provider would worsen
5 the condition or interfere with anticipated outcomes; (4) the
6 third trimester of pregnancy through the post-partum period;
7 (5) undergoing a course of institutional or inpatient care
8 from the provider within the meaning of 42 U.S.C.
9 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective
10 surgery from the provider, including receipt of preoperative
11 or postoperative care from such provider with respect to such
12 a surgery; (7) being determined to be terminally ill, as
13 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
14 treatment for such illness from such provider; or (8) any
15 other treatment of a condition or disease that requires
16 repeated health care services pursuant to a plan of treatment
17 by a provider because of the potential for changes in the
18 therapeutic regimen or because of the potential for a
19 recurrence of symptoms.

20 "Preferred provider" means any provider who has entered,
21 either directly or indirectly, into an agreement with an
22 employer or risk-bearing entity relating to health care
23 services that may be rendered to beneficiaries under a network
24 plan.

25 "Providers" means physicians licensed to practice medicine
26 in all its branches, other health care professionals,

1 hospitals, or other health care institutions or facilities
2 that provide health care services.

3 ~~"Short term, limited duration insurance" means any type of~~
4 ~~accident and health insurance offered or provided within this~~
5 ~~State pursuant to a group or individual policy or individual~~
6 ~~certificate by a company, regardless of the situs state of the~~
7 ~~delivery of the policy, that has an expiration date specified~~
8 ~~in the contract that is fewer than 365 days after the original~~
9 ~~effective date. Regardless of the duration of coverage,~~
10 ~~"short term, limited duration insurance" does not include~~
11 ~~excepted benefits or any student health insurance coverage.~~

12 "Stand-alone dental plan" has the meaning given ~~ascribed~~
13 to that term in 45 CFR 156.400.

14 "Telehealth" has the meaning given to that term in Section
15 356z.22 of the Illinois Insurance Code.

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

18 "Tiered network" means a network that identifies and
19 groups some or all types of provider and facilities into
20 specific groups to which different provider reimbursement,
21 covered person cost-sharing or provider access requirements,
22 or any combination thereof, apply for the same services.

23 ~~"Woman's principal health care provider" means a physician~~
24 ~~licensed to practice medicine in all of its branches~~
25 ~~specializing in obstetrics, gynecology, or family practice.~~

26 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;

1 103-650, eff. 1-1-25.)

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

3 Sec. 5. Definitions. In this Act:

4 "Authorized representative" means a person to whom a
5 beneficiary has given express written consent to represent the
6 beneficiary; a person authorized by law to provide substituted
7 consent for a beneficiary; or the beneficiary's treating
8 provider only when the beneficiary or his or her family member
9 is unable to provide consent.

10 "Beneficiary" means an individual, an enrollee, an
11 insured, a participant, or any other person entitled to
12 reimbursement for covered expenses of or the discounting of
13 provider fees for health care services under a program in
14 which the beneficiary has an incentive to utilize the services
15 of a provider that has entered into an agreement or
16 arrangement with an issuer ~~insurer~~.

17 "Department" means the Department of Insurance.

18 "Director" means the Director of Insurance.

19 "Essential community provider" has the meaning given to
20 that term in 45 CFR 156.235.

21 "Excepted benefits" has the meaning given to that term in
22 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted
23 benefits" includes individual, group, or blanket coverage.

24 "Exchange" has the meaning given to that term in 45 CFR
25 155.20.

1 "Family caregiver" means a relative, partner, friend, or
2 neighbor who has a significant relationship with the patient
3 and administers or assists the patient with activities of
4 daily living, instrumental activities of daily living, or
5 other medical or nursing tasks for the quality and welfare of
6 that patient.

7 "Group health plan" has the meaning given to that term in
8 Section 5 of the Illinois Health Insurance Portability and
9 Accountability Act.

10 "Health insurance coverage" has the meaning given to that
11 term in Section 5 of the Illinois Health Insurance Portability
12 and Accountability Act. "Health insurance coverage" does not
13 include any coverage or benefits under Medicare or under the
14 medical assistance program established under Article V of the
15 Illinois Public Aid Code.

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

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

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

13 "Network plan" means an individual or group policy of
14 ~~accident and~~ health insurance coverage that either requires a
15 covered person to use or creates incentives, including
16 financial incentives, for a covered person to use providers
17 managed, owned, under contract with, or employed by the issuer
18 or by a third party contracted to arrange, contract for, or
19 administer such provider-related incentives for the issuer
20 insurer.

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

1 currently receiving, such as chemotherapy, radiation therapy,
2 ~~or~~ post-operative visits, or a serious and complex condition
3 as defined under 42 U.S.C. 300gg-113(b) (2); (3) a course of
4 treatment for a health condition that a treating provider
5 attests that discontinuing care by that provider would worsen
6 the condition or interfere with anticipated outcomes; ~~or~~ (4)
7 the third trimester of pregnancy through the post-partum
8 period; (5) undergoing a course of institutional or inpatient
9 care from the provider within the meaning of 42 U.S.C.
10 300gg-113(b) (1) (B); (6) being scheduled to undergo nonelective
11 surgery from the provider, including receipt of preoperative
12 or postoperative care from such provider with respect to such
13 a surgery; (7) being determined to be terminally ill, as
14 determined under 42 U.S.C. 1395x(dd) (3) (A), and receiving
15 treatment for such illness from such provider; or (8) any
16 other treatment of a condition or disease that requires
17 repeated health care services pursuant to a plan of treatment
18 by a provider because of the potential for changes in the
19 therapeutic regimen or because of the potential for a
20 recurrence of symptoms.

21 "Preferred provider" means any provider who has entered,
22 either directly or indirectly, into an agreement with an
23 employer or risk-bearing entity relating to health care
24 services that may be rendered to beneficiaries under a network
25 plan.

26 "Providers" means physicians licensed to practice medicine

1 in all its branches, other health care professionals,
2 hospitals, or other health care institutions or facilities
3 that provide health care services.

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

6 "Telehealth" has the meaning given to that term in Section
7 356z.22 of the Illinois Insurance Code.

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

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

15 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
16 103-718, eff. 7-19-24.)

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

18 Sec. 5. Definitions. In this Act:

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

25 "Beneficiary" means an individual, an enrollee, an

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

7 "Department" means the Department of Insurance.

8 "Director" means the Director of Insurance.

9 "Essential community provider" has the meaning given to
10 that term in 45 CFR 156.235.

11 "Excepted benefits" has the meaning given to that term in
12 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted
13 benefits" includes individual, group, or blanket coverage.

14 "Exchange" has the meaning given to that term in 45 CFR
15 155.20.

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

22 "Group health plan" has the meaning given to that term in
23 Section 5 of the Illinois Health Insurance Portability and
24 Accountability Act.

25 "Health insurance coverage" has the meaning given to that
26 term in Section 5 of the Illinois Health Insurance Portability

1 and Accountability Act. "Health insurance coverage" does not
2 include any coverage or benefits under Medicare or under the
3 medical assistance program established under Article V of the
4 Illinois Public Aid Code.

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

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

26 "Network" means the group or groups of preferred providers

1 providing services to a network plan.

2 "Network plan" means an individual or group policy of
3 ~~accident and~~ health insurance coverage that either requires a
4 covered person to use or creates incentives, including
5 financial incentives, for a covered person to use providers
6 managed, owned, under contract with, or employed by the issuer
7 or by a third party contracted to arrange, contract for, or
8 administer such provider-related incentives for the issuer
9 insurer.

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

1 or postoperative care from such provider with respect to such
2 a surgery; (7) being determined to be terminally ill, as
3 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
4 treatment for such illness from such provider; or (8) any
5 other treatment of a condition or disease that requires
6 repeated health care services pursuant to a plan of treatment
7 by a provider because of the potential for changes in the
8 therapeutic regimen or because of the potential for a
9 recurrence of symptoms.

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

15 "Providers" means physicians licensed to practice medicine
16 in all its branches, other health care professionals,
17 hospitals, or other health care institutions or facilities
18 that provide health care services.

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

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

24 "Telehealth" has the meaning given to that term in Section
25 356z.22 of the Illinois Insurance Code.

26 "Telemedicine" has the meaning given to that term in

1 Section 49.5 of the Medical Practice Act of 1987.

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

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

10 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22;
11 103-777, eff. 1-1-25.)

12 (215 ILCS 124/10)

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

14 Sec. 10. Network adequacy.

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

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

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

25 (3) The written policies and procedures on how the

1 network plan will provide 24-hour, 7-day per week access
2 to network-affiliated primary care, emergency services,
3 and obstetrical and gynecological health care
4 professionals ~~women's principal health care providers.~~

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

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

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

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

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

26 (4) An Internet website and toll-free telephone number

1 for beneficiaries and prospective beneficiaries to access
2 current and accurate lists of preferred providers in each
3 plan, additional information about the plan, as well as
4 any other information required by Department rule.

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

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

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

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

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

23 (6) A provision ensuring that whenever a beneficiary
24 has made a good faith effort, as evidenced by accessing
25 the provider directory, calling the network plan, and
26 calling the provider, to utilize preferred providers for a

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

26 (7) A provision that the beneficiary shall receive

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

12 (8) A limitation that complies with subsections (d)
13 and (e) of Section 55 of the Prior Authorization Reform
14 Act, if the plan provides that the beneficiary will incur
15 a penalty for failing to pre-certify inpatient hospital
16 treatment, the penalty may not exceed \$1,000 per
17 occurrence in addition to the plan cost sharing
18 provisions.

19 (9) For a network plan to be offered through the
20 Exchange in the individual or small group market, as well
21 as any off-Exchange mirror of such a network plan,
22 evidence that the network plan includes essential
23 community providers in accordance with rules established
24 by the Exchange that will operate in this State for the
25 applicable plan year.

26 (c) The issuer shall demonstrate to the Director a minimum

1 ratio of providers to plan beneficiaries as required by the
2 Department for each network plan.

3 (1) The minimum ratio of physicians or other providers
4 to plan beneficiaries shall be established by the
5 Department in consultation with the Department of Public
6 Health based upon the guidance from the federal Centers
7 for Medicare and Medicaid Services. The Department shall
8 not establish ratios for vision or dental providers who
9 provide services under dental-specific or vision-specific
10 benefits, except to the extent provided under federal law
11 for stand-alone dental plans. The Department shall
12 consider establishing ratios for the following physicians
13 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 shall
18 demonstrate to the Director that each in-network hospital
19 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 (3) Notwithstanding any other law or rule, the minimum
4 ratio for each provider type shall be no less than any such
5 ratio established for qualified health plans in
6 Federally-Facilitated Exchanges by federal law or by the
7 federal Centers for Medicare and Medicaid Services, even
8 if the network plan is issued in the large group market or
9 is otherwise not issued through an exchange. Federal
10 standards for stand-alone dental plans shall only apply to
11 such network plans. In the absence of an applicable
12 Department rule, the federal standards shall apply for the
13 time period specified in the federal law, regulation, or
14 guidance. If the Centers for Medicare and Medicaid
15 Services establish standards that are more stringent than
16 the standards in effect under any Department rule, the
17 Department may amend its rules to conform to the more
18 stringent federal standards.

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

25 (d) The network plan shall demonstrate to the Director
26 maximum travel and distance standards and appointment

1 wait-time ~~wait-time~~ standards for plan beneficiaries, which
2 shall be established by the Department in consultation with
3 the Department of Public Health based upon the guidance from
4 the federal Centers for Medicare and Medicaid Services. These
5 standards shall consist of the maximum minutes or miles to be
6 traveled by a plan beneficiary for each county type, such as
7 large counties, metro counties, or rural counties as defined
8 by Department rule.

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

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

16 Notwithstanding any other law or Department rule, the
17 maximum travel time and distance standards and appointment
18 wait-time ~~wait-time~~ standards shall be no greater than any
19 such standards established for qualified health plans in
20 Federally-Facilitated Exchanges by federal law or by the
21 federal Centers for Medicare and Medicaid Services, even if
22 the network plan is issued in the large group market or is
23 otherwise not issued through an exchange. Federal standards
24 for stand-alone dental plans shall only apply to such network
25 plans. In the absence of an applicable Department rule, the
26 federal standards shall apply for the time period specified in

1 the federal law, regulation, or guidance. If the Centers for
2 Medicare and Medicaid Services establish standards that are
3 more stringent than the standards in effect under any
4 Department rule, the Department may amend its rules to conform
5 to the more stringent federal standards.

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

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

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

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

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

3 (4) If the federal Centers for Medicare and Medicaid
4 Services establishes or law requires more stringent standards
5 for qualified health plans in the Federally-Facilitated
6 Exchanges, the federal standards shall control for all network
7 plans for the time period specified in the federal law,
8 regulation, or guidance, even if the network plan is issued in
9 the large group market, is issued through a different type of
10 Exchange, or is otherwise not issued through an Exchange.

11 (5) If the federal Centers for Medicare and Medicaid
12 Services establishes a more stringent standard in any county
13 than specified in paragraph (1) or (2) of this subsection
14 (d-5) for qualified health plans in the type of exchange in use
15 in this State for a given plan year, the federal standard shall
16 apply in lieu of the standard in paragraph (1) or (2) of this
17 subsection (d-5) for qualified health plans for that plan
18 year.

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

22 (f) The network plan may consider use of other health care
23 service delivery options, such as telemedicine or telehealth,
24 mobile clinics, and centers of excellence, or other ways of
25 delivering care to partially meet the requirements set under
26 this Section.

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

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

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

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

26 (h) Issuers are required to report to the Director any

1 material change to an approved network plan within 15 business
2 days after the change occurs and any change that would result
3 in failure to meet the requirements of this Act. The issuer
4 shall submit a revised version of the portions of the network
5 adequacy filing affected by the material change, as determined
6 by the Director by rule, and the issuer shall attach versions
7 with the changes indicated for each document that was revised
8 from the previous version of the filing. Upon notice from the
9 issuer, the Director shall reevaluate the network plan's
10 compliance with the network adequacy and transparency
11 standards of this Act. For every day past 15 business days that
12 the issuer fails to submit a revised network adequacy filing
13 to the Director, the Director may order a fine of \$5,000 per
14 day.

15 (i) If a network plan is inadequate under this Act with
16 respect to a provider type in a county, and if the network plan
17 does not have an approved exception for that provider type in
18 that county pursuant to subsection (g), an issuer shall cover
19 out-of-network claims for covered health care services
20 received from that provider type within that county at the
21 in-network benefit level and shall retroactively adjudicate
22 and reimburse beneficiaries to achieve that objective if their
23 claims were processed at the out-of-network level contrary to
24 this subsection. Nothing in this subsection shall be construed
25 to supersede Section 356z.3a of the Illinois Insurance Code.

26 (j) If the Director determines that a network is

1 inadequate in any county and no exception has been granted
2 under subsection (g) and the issuer does not have a process in
3 place to comply with subsection (d-5), the Director may
4 prohibit the network plan from being issued or renewed within
5 that county until the Director determines that the network is
6 adequate apart from processes and exceptions described in
7 subsections (d-5) and (g). Nothing in this subsection shall be
8 construed to terminate any beneficiary's health insurance
9 coverage under a network plan before the expiration of the
10 beneficiary's policy period if the Director makes a
11 determination under this subsection after the issuance or
12 renewal of the beneficiary's policy or certificate because of
13 a material change. Policies or certificates issued or renewed
14 in violation of this subsection may subject the issuer to a
15 civil penalty of \$5,000 per policy.

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

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

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

24 Sec. 10. Network adequacy.

25 (a) Before issuing, delivering, or renewing a network

1 plan, an issuer ~~An insurer~~ providing a network plan shall file
2 a description of all of the following with the Director:

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

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

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

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

23 (b) Before issuing, delivering, or renewing a network
24 plan, an issuer ~~Insurers~~ must file for review a description of
25 the services to be offered through a network plan. The
26 description shall include all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

22 (8) A limitation that complies with subsections (d)
23 and (e) of Section 55 of the Prior Authorization Reform
24 Act.

25 (9) For a network plan to be offered through the
26 Exchange in the individual or small group market, as well

1 as any off-Exchange mirror of such a network plan,
2 evidence that the network plan includes essential
3 community providers in accordance with rules established
4 by the Exchange that will operate in this State for the
5 applicable plan year.

6 (c) The issuer ~~network plan~~ shall demonstrate to the
7 Director a minimum ratio of providers to plan beneficiaries as
8 required by the Department for each network plan.

9 (1) The minimum ratio of physicians or other providers
10 to plan beneficiaries shall be established ~~annually~~ by the
11 Department in consultation with the Department of Public
12 Health based upon the guidance from the federal Centers
13 for Medicare and Medicaid Services. The Department shall
14 not establish ratios for vision or dental providers who
15 provide services under dental-specific or vision-specific
16 benefits, except to the extent provided under federal law
17 for stand-alone dental plans. The Department shall
18 consider establishing ratios for the following physicians
19 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 (1.5) Beginning January 1, 2026, every issuer shall
24 demonstrate to the Director that each in-network hospital
25 has at least one radiologist, pathologist,
26 anesthesiologist, and emergency room physician as a

1 preferred provider in a network plan. The Department may,
2 by rule, require additional types of hospital-based
3 medical specialists to be included as preferred providers
4 in each in-network hospital in a network plan.

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

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

25 (4) If the federal Centers for Medicare and Medicaid
26 Services establishes minimum provider ratios for

1 stand-alone dental plans in the type of exchange in use in
2 this State for a given plan year, the Department shall
3 enforce those standards for stand-alone dental plans for
4 that plan year.

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

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

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

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

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

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

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

1 type of exchange in use in this State for a given plan year,
2 the Department shall enforce those standards for stand-alone
3 dental plans for that plan year.

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

1 (A) For beneficiaries residing in the metropolitan
2 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
3 network adequacy standards for timely and proximate access
4 to treatment for mental, emotional, nervous, or substance
5 use disorders or conditions means a beneficiary shall not
6 have to travel longer than 30 minutes or 30 miles from the
7 beneficiary's residence to receive outpatient treatment
8 for mental, emotional, nervous, or substance use disorders
9 or conditions. Beneficiaries shall not be required to wait
10 longer than 10 business days between requesting an initial
11 appointment and being seen by the facility or provider of
12 mental, emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment or to wait longer than
14 20 business days between requesting a repeat or follow-up
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment; however, subject to
18 the protections of paragraph (3) of this subsection, a
19 network plan shall not be held responsible if the
20 beneficiary or provider voluntarily chooses to schedule an
21 appointment outside of these required time frames.

22 (B) For beneficiaries residing in Illinois counties
23 other than those counties listed in subparagraph (A) of
24 this paragraph, network adequacy standards for timely and
25 proximate access to treatment for mental, emotional,
26 nervous, or substance use disorders or conditions means a

1 beneficiary shall not have to travel longer than 60
2 minutes or 60 miles from the beneficiary's residence to
3 receive outpatient treatment for mental, emotional,
4 nervous, or substance use disorders or conditions.
5 Beneficiaries shall not be required to wait longer than 10
6 business days between requesting an initial appointment
7 and being seen by the facility or provider of mental,
8 emotional, nervous, or substance use disorders or
9 conditions for outpatient treatment or to wait longer than
10 20 business days between requesting a repeat or follow-up
11 appointment and being seen by the facility or provider of
12 mental, emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment; however, subject to
14 the protections of paragraph (3) of this subsection, a
15 network plan shall not be held responsible if the
16 beneficiary or provider voluntarily chooses to schedule an
17 appointment outside of these required time frames.

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

26 (3) If there is no in-network facility or provider

1 available for a beneficiary to receive timely and proximate
2 access to treatment for mental, emotional, nervous, or
3 substance use disorders or conditions in accordance with the
4 network adequacy standards outlined in this subsection, the
5 issuer ~~insurer~~ shall provide necessary exceptions to its
6 network to ensure admission and treatment with a provider or
7 at a treatment facility in accordance with the network
8 adequacy standards in this subsection.

9 (4) If the federal Centers for Medicare and Medicaid
10 Services establishes or law requires more stringent standards
11 for qualified health plans in the Federally-Facilitated
12 Exchanges, the federal standards shall control for all network
13 plans for the time period specified in the federal law,
14 regulation, or guidance, even if the network plan is issued in
15 the large group market, is issued through a different type of
16 Exchange, or is otherwise not issued through an Exchange.

17 (5) If the federal Centers for Medicare and Medicaid
18 Services establishes a more stringent standard in any county
19 than specified in paragraph (1) or (2) of this subsection
20 (d-5) for qualified health plans in the type of exchange in use
21 in this State for a given plan year, the federal standard shall
22 apply in lieu of the standard in paragraph (1) or (2) of this
23 subsection (d-5) for qualified health plans for that plan
24 year.

25 (e) Except for network plans solely offered as a group
26 health plan, these ratio and time and distance standards apply

1 to the lowest cost-sharing tier of any tiered network.

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

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

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

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

1 patterns, or local provider interviews, indicating where
2 the beneficiaries currently seek this type of care or
3 where the physicians currently refer beneficiaries, or
4 both; or

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

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

22 (i) If a network plan is inadequate under this Act with
23 respect to a provider type in a county, and if the network plan
24 does not have an approved exception for that provider type in
25 that county pursuant to subsection (g), an issuer shall cover
26 out-of-network claims for covered health care services

1 received from that provider type within that county at the
2 in-network benefit level and shall retroactively adjudicate
3 and reimburse beneficiaries to achieve that objective if their
4 claims were processed at the out-of-network level contrary to
5 this subsection. Nothing in this subsection shall be construed
6 to supersede Section 356z.3a of the Illinois Insurance Code.

7 (j) If the Director determines that a network is
8 inadequate in any county and no exception has been granted
9 under subsection (g) and the issuer does not have a process in
10 place to comply with subsection (d-5), the Director may
11 prohibit the network plan from being issued or renewed within
12 that county until the Director determines that the network is
13 adequate apart from processes and exceptions described in
14 subsections (d-5) and (g). Nothing in this subsection shall be
15 construed to terminate any beneficiary's health insurance
16 coverage under a network plan before the expiration of the
17 beneficiary's policy period if the Director makes a
18 determination under this subsection after the issuance or
19 renewal of the beneficiary's policy or certificate because of
20 a material change. Policies or certificates issued or renewed
21 in violation of this subsection may subject the issuer to a
22 civil penalty of \$5,000 per policy.

23 (k) For the Department to enforce any new or modified
24 federal standard before the Department adopts the standard by
25 rule, the Department must, no later than May 15 before the
26 start of the plan year, give public notice to the affected

1 health insurance issuers through a bulletin.

2 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
3 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

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

5 Sec. 10. Network adequacy.

6 (a) Before issuing, delivering, or renewing a network
7 plan, an issuer ~~An insurer~~ providing a network plan shall file
8 a description of all of the following with the Director:

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

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

16 (3) The written policies and procedures on how the
17 network plan will provide 24-hour, 7-day per week access
18 to network-affiliated primary care, emergency services,
19 and obstetrical and gynecological health care
20 professionals.

21 An issuer ~~insurer~~ shall not prohibit a preferred provider
22 from discussing any specific or all treatment options with
23 beneficiaries irrespective of the issuer's ~~insurer's~~ position
24 on those treatment options or from advocating on behalf of
25 beneficiaries within the utilization review, grievance, or

1 appeals processes established by the issuer ~~insurer~~ in
2 accordance with any rights or remedies available under
3 applicable State or federal law.

4 (b) Before issuing, delivering, or renewing a network
5 plan, an issuer ~~insurers~~ must file for review a description of
6 the services to be offered through a network plan. The
7 description shall include all of the following:

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

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

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

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

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

26 (A) the type of health care services to be

1 provided by the network plan;

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

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

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

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

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

17 (7) A provision that the beneficiary shall receive
18 emergency care coverage such that payment for this
19 coverage is not dependent upon whether the emergency
20 services are performed by a preferred or non-preferred
21 provider and the coverage shall be at the same benefit
22 level as if the service or treatment had been rendered by a
23 preferred provider. For purposes of this paragraph (7),
24 "the same benefit level" means that the beneficiary is
25 provided the covered service at no greater cost to the
26 beneficiary than if the service had been provided by a

1 preferred provider. This provision shall be consistent
2 with Section 356z.3a of the Illinois Insurance Code.

3 (8) A limitation that complies with subsections (d)
4 and (e) of Section 55 of the Prior Authorization Reform
5 Act, ~~if the plan provides that the beneficiary will incur~~
6 ~~a penalty for failing to pre certify inpatient hospital~~
7 ~~treatment, the penalty may not exceed \$1,000 per~~
8 ~~occurrence in addition to the plan cost sharing~~
9 ~~provisions.~~

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

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

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

1 benefits, except to the extent provided under federal law
2 for stand-alone dental plans. The Department shall
3 consider establishing ratios for the following physicians
4 or other providers:

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

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

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

- 1 (W) Pulmonary;
2 (X) Rheumatology;
3 (Y) Anesthesiology;
4 (Z) Pain Medicine;
5 (AA) Pediatric Specialty Services;
6 (BB) Outpatient Dialysis; and
7 (CC) HIV.

8 (1.5) Beginning January 1, 2026, every issuer shall
9 demonstrate to the Director that each in-network hospital
10 has at least one radiologist, pathologist,
11 anesthesiologist, and emergency room physician as a
12 preferred provider in a network plan. The Department may,
13 by rule, require additional types of hospital-based
14 medical specialists to be included as preferred providers
15 in each in-network hospital in a network plan.

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

20 (3) Notwithstanding any other law or rule, the minimum
21 ratio for each provider type shall be no less than any such
22 ratio established for qualified health plans in
23 Federally-Facilitated Exchanges by federal law or by the
24 federal Centers for Medicare and Medicaid Services, even
25 if the network plan is issued in the large group market or
26 is otherwise not issued through an exchange. Federal

1 standards for stand-alone dental plans shall only apply to
2 such network plans. In the absence of an applicable
3 Department rule, the federal standards shall apply for the
4 time period specified in the federal law, regulation, or
5 guidance. If the Centers for Medicare and Medicaid
6 Services establish standards that are more stringent than
7 the standards in effect under any Department rule, the
8 Department may amend its rules to conform to the more
9 stringent federal standards.

10 (4) If the federal Centers for Medicare and Medicaid
11 Services establishes minimum provider ratios for
12 stand-alone dental plans in the type of exchange in use in
13 this State for a given plan year, the Department shall
14 enforce those standards for stand-alone dental plans for
15 that plan year.

16 (d) The network plan shall demonstrate to the Director
17 maximum travel and distance standards and appointment
18 wait-time standards for plan beneficiaries, which shall be
19 established ~~annually~~ by the Department in consultation with
20 the Department of Public Health based upon the guidance from
21 the federal Centers for Medicare and Medicaid Services. These
22 standards shall consist of the maximum minutes or miles to be
23 traveled by a plan beneficiary for each county type, such as
24 large counties, metro counties, or rural counties as defined
25 by Department rule.

26 The maximum travel time and distance standards must

1 include standards for each physician and other provider
2 category listed for which ratios have been established.

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

7 Notwithstanding any other law or Department rule, the
8 maximum travel time and distance standards and appointment
9 wait-time standards shall be no greater than any such
10 standards established for qualified health plans in
11 Federally-Facilitated Exchanges by federal law or by the
12 federal Centers for Medicare and Medicaid Services, even if
13 the network plan is issued in the large group market or is
14 otherwise not issued through an exchange. Federal standards
15 for stand-alone dental plans shall only apply to such network
16 plans. In the absence of an applicable Department rule, the
17 federal standards shall apply for the time period specified in
18 the federal law, regulation, or guidance. If the Centers for
19 Medicare and Medicaid Services establish standards that are
20 more stringent than the standards in effect under any
21 Department rule, the Department may amend its rules to conform
22 to the more stringent federal standards.

23 If the federal area designations for the maximum time or
24 distance or appointment wait-time standards required are
25 changed by the most recent Letter to Issuers in the
26 Federally-facilitated Marketplaces, the Department shall post

1 on its website notice of such changes and may amend its rules
2 to conform to those designations if the Director deems
3 appropriate.

4 If the federal Centers for Medicare and Medicaid Services
5 establishes appointment wait-time standards for qualified
6 health plans, including stand-alone dental plans, in the type
7 of exchange in use in this State for a given plan year, the
8 Department shall enforce those standards for the same types of
9 qualified health plans for that plan year. If the federal
10 Centers for Medicare and Medicaid Services establishes time
11 and distance standards for stand-alone dental plans in the
12 type of exchange in use in this State for a given plan year,
13 the Department shall enforce those standards for stand-alone
14 dental plans for that plan year.

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

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

12 (A) For beneficiaries residing in the metropolitan
13 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
14 network adequacy standards for timely and proximate access
15 to treatment for mental, emotional, nervous, or substance
16 use disorders or conditions means a beneficiary shall not
17 have to travel longer than 30 minutes or 30 miles from the
18 beneficiary's residence to receive outpatient treatment
19 for mental, emotional, nervous, or substance use disorders
20 or conditions. Beneficiaries shall not be required to wait
21 longer than 10 business days between requesting an initial
22 appointment and being seen by the facility or provider of
23 mental, 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 (B) For beneficiaries residing in Illinois counties
8 other than those counties listed in subparagraph (A) of
9 this paragraph, network adequacy standards for timely and
10 proximate access to treatment for mental, emotional,
11 nervous, or substance use disorders or conditions means a
12 beneficiary shall not have to travel longer than 60
13 minutes or 60 miles from the beneficiary's residence to
14 receive outpatient treatment for mental, emotional,
15 nervous, or substance use disorders or conditions.
16 Beneficiaries shall not be required to wait longer than 10
17 business days between requesting an initial appointment
18 and being seen by the facility or provider of mental,
19 emotional, nervous, or substance use disorders or
20 conditions for outpatient treatment or to wait longer than
21 20 business days between requesting a repeat or follow-up
22 appointment and being seen by the facility or provider of
23 mental, emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment; however, subject to
25 the protections of paragraph (3) of this subsection, a
26 network plan shall not be held responsible if the

1 beneficiary or provider voluntarily chooses to schedule an
2 appointment outside of these required time frames.

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

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

20 (4) If the federal Centers for Medicare and Medicaid
21 Services establishes or law requires more stringent standards
22 for qualified health plans in the Federally-Facilitated
23 Exchanges, the federal standards shall control for all network
24 plans for the time period specified in the federal law,
25 regulation, or guidance, even if the network plan is issued in
26 the large group market, is issued through a different type of

1 Exchange, or is otherwise not issued through an Exchange.

2 (5) 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, ~~and~~ time and distance standards, ~~and~~
21 appointment wait-time standards established under this Act or
22 federal law ~~by the Department~~ may request an exception to
23 these requirements from the Department. The Department may
24 grant an exception in the 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 business days after the change occurs and any change
21 that would result in failure to meet the requirements of this
22 Act. The issuer shall submit a revised version of the portions
23 of the network adequacy filing affected by the material
24 change, as determined by the Director by rule, and the issuer
25 shall attach versions with the changes indicated for each
26 document that was revised from the previous version of the

1 filing. Upon notice from the issuer insurer, the Director
2 shall reevaluate the network plan's compliance with the
3 network adequacy and transparency standards of this Act. For
4 every day past 15 business days that the issuer fails to submit
5 a revised network adequacy filing to the Director, the
6 Director may order a fine of \$5,000 per day.

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

18 (j) If the Director determines that a network is
19 inadequate in any county and no exception has been granted
20 under subsection (g) and the issuer does not have a process in
21 place to comply with subsection (d-5), the Director may
22 prohibit the network plan from being issued or renewed within
23 that county until the Director determines that the network is
24 adequate apart from processes and exceptions described in
25 subsections (d-5) and (g). Nothing in this subsection shall be
26 construed to terminate any beneficiary's health insurance

1 coverage under a network plan before the expiration of the
2 beneficiary's policy period if the Director makes a
3 determination under this subsection after the issuance or
4 renewal of the beneficiary's policy or certificate because of
5 a material change. Policies or certificates issued or renewed
6 in violation of this subsection may subject the issuer to a
7 civil penalty of \$5,000 per policy.

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

13 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
14 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

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

16 Sec. 10. Network adequacy.

17 (a) Before issuing, delivering, or renewing a network
18 plan, an issuer ~~An insurer~~ providing a network plan shall file
19 a description of all of the following with the Director:

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

25 (2) The written policies and procedures for making

1 referrals within and outside the network.

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

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

15 (b) Before issuing, delivering, or renewing a network
16 plan, an issuer ~~Insurers~~ must file for review a description of
17 the services to be offered through a network plan. The
18 description shall include all of the following:

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

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

26 (3) The number of beneficiaries anticipated to be

1 covered by the network plan.

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

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

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

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

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

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

25 (6) A provision ensuring that whenever a beneficiary
26 has made a good faith effort, as evidenced by accessing

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

1 described in paragraph (2) of subsection (b-5).

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

14 (8) A limitation that complies with subsections (d)
15 and (e) of Section 55 of the Prior Authorization Reform
16 Act, ~~if the plan provides that the beneficiary will incur~~
17 ~~a penalty for failing to pre-certify inpatient hospital~~
18 ~~treatment, the penalty may not exceed \$1,000 per~~
19 ~~occurrence in addition to the plan cost sharing~~
20 ~~provisions.~~

21 (9) For a network plan to be offered through the
22 Exchange in the individual or small group market, as well
23 as any off-Exchange mirror of such a network plan,
24 evidence that the network plan includes essential
25 community providers in accordance with rules established
26 by the Exchange that will operate in this State for the

1 applicable plan year.

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

5 (1) The minimum ratio of physicians or other providers
6 to plan 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, except to the extent provided under federal law
13 for stand-alone dental plans. The Department shall
14 consider establishing ratios for the following physicians
15 or other providers:

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

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

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

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

5 (3) Notwithstanding any other law or rule, the minimum
6 ratio for each provider type shall be no less than any such
7 ratio established for qualified health plans in
8 Federally-Facilitated Exchanges by federal law or by the
9 federal Centers for Medicare and Medicaid Services, even
10 if the network plan is issued in the large group market or
11 is otherwise not issued through an exchange. Federal
12 standards for stand-alone dental plans shall only apply to
13 such network plans. In the absence of an applicable
14 Department rule, the federal standards shall apply for the
15 time period specified in the federal law, regulation, or
16 guidance. If the Centers for Medicare and Medicaid
17 Services establish standards that are more stringent than
18 the standards in effect under any Department rule, the
19 Department may amend its rules to conform to the more
20 stringent federal standards.

21 (4) ~~(3)~~ If the federal Centers for Medicare and
22 Medicaid Services establishes minimum provider ratios for
23 stand-alone dental plans in the type of exchange in use in
24 this State for a given plan year, the Department shall
25 enforce those standards for stand-alone dental plans for
26 that plan year.

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

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

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

18 Notwithstanding any other law or Department rule, the
19 maximum travel time and distance standards and appointment
20 wait-time standards shall be no greater than any such
21 standards established for qualified health plans in
22 Federally-Facilitated Exchanges by federal law or by the
23 federal Centers for Medicare and Medicaid Services, even if
24 the network plan is issued in the large group market or is
25 otherwise not issued through an exchange. Federal standards
26 for stand-alone dental plans shall only apply to such network

1 plans. In the absence of an applicable Department rule, the
2 federal standards shall apply for the time period specified in
3 the federal law, regulation, or guidance. If the Centers for
4 Medicare and Medicaid Services establish standards that are
5 more stringent than the standards in effect under any
6 Department rule, the Department may amend its rules to conform
7 to the more stringent federal standards.

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

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

26 (d-5) (1) Every issuer ~~insurer~~ shall ensure that

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

23 (A) For beneficiaries residing in the metropolitan
24 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
25 network adequacy standards for timely and proximate access
26 to treatment for mental, emotional, nervous, or substance

1 use disorders or conditions means a beneficiary shall not
2 have to travel longer than 30 minutes or 30 miles from the
3 beneficiary's residence to receive outpatient treatment
4 for mental, emotional, nervous, or substance use disorders
5 or conditions. Beneficiaries shall not be required to wait
6 longer than 10 business days between requesting an initial
7 appointment and being seen by the facility or provider of
8 mental, emotional, nervous, or substance use disorders or
9 conditions for outpatient treatment or to wait longer than
10 20 business days between requesting a repeat or follow-up
11 appointment and being seen by the facility or provider of
12 mental, emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment; however, subject to
14 the protections of paragraph (3) of this subsection, a
15 network plan shall not be held responsible if the
16 beneficiary or provider voluntarily chooses to schedule an
17 appointment outside of these required time frames.

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

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

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

22 (3) If there is no in-network facility or provider
23 available for a beneficiary to receive timely and proximate
24 access to treatment for mental, emotional, nervous, or
25 substance use disorders or conditions in accordance with the
26 network adequacy standards outlined in this subsection, the

1 issuer ~~insurer~~ shall provide necessary exceptions to its
2 network to ensure admission and treatment with a provider or
3 at a treatment facility in accordance with the network
4 adequacy standards in this subsection.

5 (4) If the federal Centers for Medicare and Medicaid
6 Services establishes or law requires more stringent standards
7 for qualified health plans in the Federally-Facilitated
8 Exchanges, the federal standards shall control for all network
9 plans for the time period specified in the federal law,
10 regulation, or guidance, even if the network plan is issued in
11 the large group market, is issued through a different type of
12 Exchange, or is otherwise not issued through an Exchange.

13 (5) ~~(4)~~ If the federal Centers for Medicare and Medicaid
14 Services establishes a more stringent standard in any county
15 than specified in paragraph (1) or (2) of this subsection
16 (d-5) for qualified health plans in the type of exchange in use
17 in this State for a given plan year, the federal standard shall
18 apply in lieu of the standard in paragraph (1) or (2) of this
19 subsection (d-5) for qualified health plans for that plan
20 year.

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

24 (f) The network plan may consider use of other health care
25 service delivery options, such as telemedicine or telehealth,
26 mobile clinics, and centers of excellence, or other ways of

1 delivering care to partially meet the requirements set under
2 this Section.

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

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

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

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

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

18 (i) If a network plan is inadequate under this Act with
19 respect to a provider type in a county, and if the network plan
20 does not have an approved exception for that provider type in
21 that county pursuant to subsection (g), an issuer shall cover
22 out-of-network claims for covered health care services
23 received from that provider type within that county at the
24 in-network benefit level and shall retroactively adjudicate
25 and reimburse beneficiaries to achieve that objective if their
26 claims were processed at the out-of-network level contrary to

1 this subsection. Nothing in this subsection shall be construed
2 to supersede Section 356z.3a of the Illinois Insurance Code.

3 (j) If the Director determines that a network is
4 inadequate in any county and no exception has been granted
5 under subsection (g) and the issuer does not have a process in
6 place to comply with subsection (d-5), the Director may
7 prohibit the network plan from being issued or renewed within
8 that county until the Director determines that the network is
9 adequate apart from processes and exceptions described in
10 subsections (d-5) and (g). Nothing in this subsection shall be
11 construed to terminate any beneficiary's health insurance
12 coverage under a network plan before the expiration of the
13 beneficiary's policy period if the Director makes a
14 determination under this subsection after the issuance or
15 renewal of the beneficiary's policy or certificate because of
16 a material change. Policies or certificates issued or renewed
17 in violation of this subsection may subject the issuer to a
18 civil penalty of \$5,000 per policy.

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

24 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
25 102-1117, 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) Before issuing, delivering, or renewing a network
4 plan, an issuer ~~An insurer~~ providing a network plan shall file
5 a description of all of the following with the Director:

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

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

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

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

26 (b) Before issuing, delivering, or renewing a network

1 plan, an issuer ~~Insurers~~ must file for review a description of
2 the services to be offered through a network plan. The
3 description shall include all of the following:

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

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

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

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

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

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

24 (B) the ratio of physicians and other providers to
25 beneficiaries, by specialty and including primary care
26 physicians and facility-based physicians when

1 applicable under the contract, necessary to meet the
2 health care needs and service demands of the currently
3 enrolled population;

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

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

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

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

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

25 (8) A limitation that complies with subsections (d)
26 and (e) of Section 55 of the Prior Authorization Reform

1 ~~Act, if the plan provides that the beneficiary will incur~~
2 ~~a penalty for failing to pre-certify inpatient hospital~~
3 ~~treatment, the penalty may not exceed \$1,000 per~~
4 ~~occurrence in addition to the plan cost sharing~~
5 ~~provisions.~~

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

13 (c) The issuer ~~network plan~~ shall demonstrate to the
14 Director a minimum ratio of providers to plan beneficiaries as
15 required by the Department for each network plan.

16 (1) The minimum ratio of physicians or other providers
17 to plan beneficiaries shall be established ~~annually~~ by the
18 Department in consultation with the Department of Public
19 Health based upon the guidance from the federal Centers
20 for Medicare and Medicaid Services. The Department shall
21 not establish ratios for vision or dental providers who
22 provide services under dental-specific or vision-specific
23 benefits, except to the extent provided under federal law
24 for stand-alone dental plans. The Department shall
25 consider establishing ratios for the following physicians
26 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 (1.5) Beginning January 1, 2026, every issuer ~~insurer~~
5 shall demonstrate to the Director that each in-network
6 hospital has at least one radiologist, pathologist,
7 anesthesiologist, and emergency room physician as a
8 preferred provider in a network plan. The Department may,
9 by rule, require additional types of hospital-based
10 medical specialists to be included as preferred providers
11 in each in-network hospital in a network plan.

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

1 guidance. If the Centers for Medicare and Medicaid
2 Services establish standards that are more stringent than
3 the standards in effect under any Department rule, the
4 Department may amend its rules to conform to the more
5 stringent federal standards.

6 (4) If the federal Centers for Medicare and Medicaid
7 Services establishes minimum provider ratios for
8 stand-alone dental plans in the type of exchange in use in
9 this State for a given plan year, the Department shall
10 enforce those standards for stand-alone dental plans for
11 that plan year.

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

22 The maximum travel time and distance standards must
23 include standards for each physician and other provider
24 category listed for which ratios have been established.

25 The Director shall establish a process for the review of
26 the adequacy of these standards along with an assessment of

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

3 Notwithstanding any other law or Department rule, the
4 maximum travel time and distance standards and appointment
5 wait-time standards shall be no greater than any such
6 standards established for qualified health plans in
7 Federally-Facilitated Exchanges by federal law or by the
8 federal Centers for Medicare and Medicaid Services, even if
9 the network plan is issued in the large group market or is
10 otherwise not issued through an exchange. Federal standards
11 for stand-alone dental plans shall only apply to such network
12 plans. In the absence of an applicable Department rule, the
13 federal standards shall apply for the time period specified in
14 the federal law, regulation, or guidance. If the Centers for
15 Medicare and Medicaid Services establish standards that are
16 more stringent than the standards in effect under any
17 Department rule, the Department may amend its rules to conform
18 to the more stringent federal standards.

19 If the federal area designations for the maximum time or
20 distance or appointment wait-time standards required are
21 changed by the most recent Letter to Issuers in the
22 Federally-facilitated Marketplaces, the Department shall post
23 on its website notice of such changes and may amend its rules
24 to conform to those designations if the Director deems
25 appropriate.

26 If the federal Centers for Medicare and Medicaid Services

1 establishes appointment wait-time standards for qualified
2 health plans, including stand-alone dental plans, in the type
3 of exchange in use in this State for a given plan year, the
4 Department shall enforce those standards for the same types of
5 qualified health plans for that plan year. If the federal
6 Centers for Medicare and Medicaid Services establishes time
7 and distance standards for stand-alone dental plans in the
8 type of exchange in use in this State for a given plan year,
9 the Department shall enforce those standards for stand-alone
10 dental plans for that plan year.

11 (d-5) (1) Every issuer ~~insurer~~ shall ensure that
12 beneficiaries have timely and proximate access to treatment
13 for mental, emotional, nervous, or substance use disorders or
14 conditions in accordance with the provisions of paragraph (4)
15 of subsection (a) of Section 370c of the Illinois Insurance
16 Code. Issuers ~~Insurers~~ shall use a comparable process,
17 strategy, evidentiary standard, and other factors in the
18 development and application of the network adequacy standards
19 for timely and proximate access to treatment for mental,
20 emotional, nervous, or substance use disorders or conditions
21 and those for the access to treatment for medical and surgical
22 conditions. As such, the network adequacy standards for timely
23 and proximate access shall equally be applied to treatment
24 facilities and providers for mental, emotional, nervous, or
25 substance use disorders or conditions and specialists
26 providing medical or surgical benefits pursuant to the parity

1 requirements of Section 370c.1 of the Illinois Insurance Code
2 and the federal Paul Wellstone and Pete Domenici Mental Health
3 Parity and Addiction Equity Act of 2008. Notwithstanding the
4 foregoing, the network adequacy standards for timely and
5 proximate access to treatment for mental, emotional, nervous,
6 or substance use disorders or conditions shall, at a minimum,
7 satisfy the following requirements:

8 (A) For beneficiaries residing in the metropolitan
9 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
10 network adequacy standards for timely and proximate access
11 to treatment for mental, emotional, nervous, or substance
12 use disorders or conditions means a beneficiary shall not
13 have to travel longer than 30 minutes or 30 miles from the
14 beneficiary's residence to receive outpatient treatment
15 for mental, emotional, nervous, or substance use disorders
16 or conditions. Beneficiaries shall not be required to wait
17 longer than 10 business days between requesting an initial
18 appointment and being seen by the facility or provider of
19 mental, emotional, nervous, or substance use disorders or
20 conditions for outpatient treatment or to wait longer than
21 20 business days between requesting a repeat or follow-up
22 appointment and being seen by the facility or provider of
23 mental, emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment; however, subject to
25 the protections of paragraph (3) of this subsection, a
26 network plan shall not be held responsible if the

1 beneficiary or provider voluntarily chooses to schedule an
2 appointment outside of these required time frames.

3 (B) For beneficiaries residing in Illinois counties
4 other than those counties listed in subparagraph (A) of
5 this paragraph, network adequacy standards for timely and
6 proximate access to treatment for mental, emotional,
7 nervous, or substance use disorders or conditions means a
8 beneficiary shall not have to travel longer than 60
9 minutes or 60 miles from the beneficiary's residence to
10 receive outpatient treatment for mental, emotional,
11 nervous, or substance use disorders or conditions.
12 Beneficiaries shall not be required to wait longer than 10
13 business days between requesting an initial appointment
14 and being seen by the facility or provider of mental,
15 emotional, nervous, or substance use disorders or
16 conditions for outpatient treatment or to wait longer than
17 20 business days between requesting a repeat or follow-up
18 appointment and being seen by the facility or provider of
19 mental, emotional, nervous, or substance use disorders or
20 conditions for outpatient treatment; however, subject to
21 the protections of paragraph (3) of this subsection, a
22 network plan shall not be held responsible if the
23 beneficiary or provider voluntarily chooses to schedule an
24 appointment outside of these required time frames.

25 (2) For beneficiaries residing in all Illinois counties,
26 network adequacy standards for timely and proximate access to

1 treatment for mental, emotional, nervous, or substance use
2 disorders or conditions means a beneficiary shall not have to
3 travel longer than 60 minutes or 60 miles from the
4 beneficiary's residence to receive inpatient or residential
5 treatment for mental, emotional, nervous, or substance use
6 disorders or conditions.

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

16 (4) If the federal Centers for Medicare and Medicaid
17 Services establishes or law requires more stringent standards
18 for qualified health plans in the Federally-Facilitated
19 Exchanges, the federal standards shall control for all network
20 plans for the time period specified in the federal law,
21 regulation, or guidance, even if the network plan is issued in
22 the large group market, is issued through a different type of
23 Exchange, or is otherwise not issued through an Exchange.

24 (5) If the federal Centers for Medicare and Medicaid
25 Services establishes a more stringent standard in any county
26 than specified in paragraph (1) or (2) of this subsection

1 (d-5) for qualified health plans in the type of exchange in use
2 in this State for a given plan year, the federal standard shall
3 apply in lieu of the standard in paragraph (1) or (2) of this
4 subsection (d-5) for qualified health plans for that plan
5 year.

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

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

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

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

1 area and (ii) provides contact information, including
2 names, addresses, and phone numbers for the next closest
3 contracted provider or facility;

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

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

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

1 a revised network adequacy filing to the Director, the
2 Director may order a fine of \$5,000 per day.

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

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

1 a material change. Policies or certificates issued or renewed
2 in violation of this subsection may subject the issuer to a
3 civil penalty of \$5,000 per policy.

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

9 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
10 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

11 (215 ILCS 124/25)

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

13 Sec. 25. Network transparency.

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

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

24 (2) An issuer's failure to update a network plan's
25 directory shall subject the issuer to a civil penalty of

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

19 (3) At least once every 90 days, the issuer shall
20 self-audit each network plan's ~~The network plan shall~~
21 ~~audit periodically at least 25% of its~~ provider
22 directories for accuracy, make any corrections necessary,
23 and retain documentation of the audit. The issuer shall
24 submit the self-audit and a summary to the Department, and
25 the Department shall make the summary of each self-audit
26 publicly available. The Department shall specify the

1 requirements of the summary, which shall be statistical in
2 nature except for a high-level narrative evaluating the
3 impact of internal and external factors on the accuracy of
4 the directory and the timeliness of updates. ~~The network~~
5 ~~plan shall submit the audit to the Director upon request.~~
6 As part of these self-audits ~~audits~~, the network plan
7 shall contact any provider in its network that has not
8 submitted a claim to the plan or otherwise communicated
9 his or her intent to continue participation in the plan's
10 network. The self-audits shall comply with 42 U.S.C.
11 300gg-115(a)(2), except that "provider directory
12 information" shall include all information required to be
13 included in a provider directory pursuant to this Act.

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

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

1 (A) in plain language, a description of the
2 criteria the plan has used to build its provider
3 network;

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

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

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

18 (E) a telephone number and email address for a
19 customer service representative to whom directory
20 inaccuracies may be reported; and

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

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

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

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

20 (1) for health care professionals:

21 (A) name;

22 (B) gender;

23 (C) participating office locations;

24 (D) patient population served (such as pediatric,
25 adult, elderly, or women) and specialty or
26 subspecialty, if applicable;

- 1 (E) medical group affiliations, if applicable;
- 2 (F) facility affiliations, if applicable;
- 3 (G) participating facility affiliations, if
4 applicable;
- 5 (H) languages spoken other than English, if
6 applicable;
- 7 (I) whether accepting new patients;
- 8 (J) board certifications, if applicable; ~~and~~
- 9 (K) use of telehealth or telemedicine, including,
10 but not limited to:
- 11 (i) whether the provider offers the use of
12 telehealth or telemedicine to deliver services to
13 patients for whom it would be clinically
14 appropriate;
- 15 (ii) what modalities are used and what types
16 of services may be provided via telehealth or
17 telemedicine; and
- 18 (iii) whether the provider has the ability and
19 willingness to include in a telehealth or
20 telemedicine encounter a family caregiver who is
21 in a separate location than the patient if the
22 patient wishes and provides his or her consent;
- 23 (L) whether the health care professional
24 accepts appointment requests from patients; and
- 25 (M) the anticipated date the provider will
26 leave the network, if applicable, which shall be

1 included no more than 10 days after the issuer
2 confirms that the provider is scheduled to leave
3 the network;

4 (2) for hospitals:

5 (A) hospital name;

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

8 (C) participating hospital location; ~~and~~

9 (D) hospital accreditation status; and

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

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

15 (A) facility name;

16 (B) facility type;

17 (C) types of services performed; ~~and~~

18 (D) participating facility location or locations;

19 and

20 (E) the anticipated date the facility will leave
21 the network, if applicable, which shall be included no
22 more than 10 days after the issuer confirms the
23 facility is scheduled to leave the network.

24 (c) For the electronic provider directories, for each
25 network plan, a network plan shall make available all of the
26 following information in addition to the searchable

1 information required in this Section:

2 (1) for health care professionals:

3 (A) contact information, including both a
4 telephone number and digital contact information if
5 the provider has supplied digital contact information;
6 and

7 (B) languages spoken other than English by
8 clinical staff, if applicable;

9 (2) for hospitals, telephone number and digital
10 contact information; and

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

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

16 (1) for health care professionals:

17 (A) name;

18 (B) contact information, including a telephone
19 number and digital contact information if the provider
20 has supplied digital contact information;

21 (C) participating office location or locations;

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

25 (E) languages spoken other than English, if
26 applicable;

- 1 (F) whether accepting new patients; ~~and~~
2 (G) use of telehealth or telemedicine, including,
3 but not limited to:
- 4 (i) whether the provider offers the use of
5 telehealth or telemedicine to deliver services to
6 patients for whom it would be clinically
7 appropriate;
- 8 (ii) what modalities are used and what types
9 of services may be provided via telehealth or
10 telemedicine; and
- 11 (iii) whether the provider has the ability and
12 willingness to include in a telehealth or
13 telemedicine encounter a family caregiver who is
14 in a separate location than the patient if the
15 patient wishes and provides his or her consent;
16 and
- 17 (H) whether the health care professional accepts
18 appointment requests from patients;
- 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 digital contact information; and
- 25 (3) for facilities, other than hospitals, by type:
- 26 (A) facility name;

1 (B) facility type;

2 (C) patient population (such as pediatric, adult,
3 elderly, or women) served, if applicable, and types of
4 services performed; and

5 (D) participating facility location or locations,
6 ~~and~~ telephone numbers, and digital contact information
7 for each location.

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

24 (f) The Director may conduct periodic audits of the
25 accuracy of provider directories. A network plan shall not be
26 subject to any fines or penalties for information required in

1 this Section that a provider submits that is inaccurate or
2 incomplete.

3 (g) To the extent not otherwise provided in this Act, an
4 issuer shall comply with the requirements of 42 U.S.C.
5 300gg-115, except that "provider directory information" shall
6 include all information required to be included in a provider
7 directory pursuant to this Section.

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

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

24 (j) This Section applies to network plans not otherwise
25 exempt under Section 3.

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

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

2 Sec. 25. Network transparency.

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

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

13 (2) An issuer's failure to update a network plan's
14 directory shall subject the issuer to a civil penalty of
15 \$5,000 per month. Providers shall notify the network plan
16 electronically or in writing within 10 business days of
17 any changes to their information as listed in the provider
18 directory, including the information required in
19 subsections (b), (c), and (d). With regard to subparagraph
20 (I) of paragraph (1) of subsection (b), the provider must
21 give notice to the issuer within 20 business days of
22 deciding to cease accepting new patients covered by the
23 plan if the new patient limitation is expected to last 40
24 business days or longer. The network plan shall update its
25 online provider directory in a manner consistent with the

1 information provided by the provider within 2 business
2 days after being notified of the change by the provider.
3 Nothing in this paragraph (2) shall void any contractual
4 relationship between the provider and the plan.

5 (3) At least once every 90 days, the issuer shall
6 self-audit each network plan's provider directories for
7 accuracy, make any corrections necessary, and retain
8 documentation of the audit. The issuer shall submit the
9 self-audit and a summary to the Department, and the
10 Department shall make the summary of each self-audit
11 publicly available. The Department shall specify the
12 requirements of the summary, which shall be statistical in
13 nature except for a high-level narrative evaluating the
14 impact of internal and external factors on the accuracy of
15 the directory and the timeliness of updates. As part of
16 these self-audits, the network plan shall contact any
17 provider in its network that has not submitted a claim to
18 the plan or otherwise communicated his or her intent to
19 continue participation in the plan's network. The
20 self-audits shall comply with 42 U.S.C. 300gg-115(a)(2),
21 except that "provider directory information" shall include
22 all information required to be included in a provider
23 directory pursuant to this Act.

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

1 beneficiary or a prospective beneficiary. Except when an
2 issuer's printed ~~print~~ copies use the same provider
3 information as the electronic provider directory on each
4 printed ~~print~~ copy's date of printing, printed ~~print~~
5 copies must be updated at least every 90 days and errata
6 that reflects changes in the provider network must be
7 included in each update.

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

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

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

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

26 (D) if applicable, a notation that authorization

1 or referral may be required to access some providers;

2 (E) a telephone number and email address for a
3 customer service representative to whom directory
4 inaccuracies may be reported; and

5 (F) a detailed description of the process to
6 dispute charges for out-of-network providers,
7 hospitals, or facilities that were incorrectly listed
8 as in-network prior to the provision of care and a
9 telephone number and email address to dispute such
10 charges.

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

22 (7) A provider directory, whether in electronic or
23 print format, shall accommodate the communication needs of
24 individuals with disabilities, and include a link to or
25 information regarding available assistance for persons
26 with limited English proficiency.

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

4 (1) for health care professionals:

5 (A) name;

6 (B) gender;

7 (C) participating office locations;

8 (D) patient population served (such as pediatric,
9 adult, elderly, or women) and specialty or
10 subspecialty, if applicable;

11 (E) medical group affiliations, if applicable;

12 (F) facility affiliations, if applicable;

13 (G) participating facility affiliations, if
14 applicable;

15 (H) languages spoken other than English, if
16 applicable;

17 (I) whether accepting new patients;

18 (J) board certifications, if applicable;

19 (K) use of telehealth or telemedicine, including,
20 but not limited to:

21 (i) whether the provider offers the use of
22 telehealth or telemedicine to deliver services to
23 patients for whom it would be clinically
24 appropriate;

25 (ii) what modalities are used and what types
26 of services may be provided via telehealth or

1 telemedicine; and

2 (iii) whether the provider has the ability and
3 willingness to include in a telehealth or
4 telemedicine encounter a family caregiver who is
5 in a separate location than the patient if the
6 patient wishes and provides his or her consent;

7 (L) whether the health care professional accepts
8 appointment requests from patients; and

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

13 (2) for hospitals:

14 (A) hospital name;

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

17 (C) participating hospital location;

18 (D) hospital accreditation status; and

19 (E) the anticipated date the hospital will leave
20 the network, if applicable, which shall be included no
21 more than 10 days after the issuer confirms the
22 hospital is scheduled to leave the network; and

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

24 (A) facility name;

25 (B) facility type;

26 (C) types of services performed;

1 (D) participating facility location or locations;
2 and

3 (E) the anticipated date the facility will leave
4 the network, if applicable, which shall be included no
5 more than 10 days after the issuer confirms the
6 facility is scheduled to leave the network.

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

11 (1) for health care professionals:

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

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

18 (2) for hospitals, telephone number and digital
19 contact information; and

20 (3) for facilities other than hospitals, telephone
21 number.

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

25 (1) for health care professionals:

26 (A) name;

1 (B) contact information, including a telephone
2 number and digital contact information if the provider
3 has supplied digital contact information;

4 (C) participating office location or locations;

5 (D) patient population (such as pediatric, adult,
6 elderly, or women) and specialty or subspecialty, if
7 applicable;

8 (E) languages spoken other than English, if
9 applicable;

10 (F) whether accepting new patients;

11 (G) use of telehealth or telemedicine, including,
12 but not limited to:

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

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

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

26 (H) whether the health care professional accepts

1 appointment requests from patients;~~;~~

2 (2) for hospitals:

3 (A) hospital name;

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

6 (C) participating hospital location, telephone
7 number, and digital contact information; and

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

9 (A) facility name;

10 (B) facility type;

11 (C) patient population (such as pediatric, adult,
12 elderly, or women) served, if applicable, and types of
13 services performed; and

14 (D) participating facility location or locations,
15 telephone numbers, and digital contact information for
16 each location.

17 (e) The network plan shall include a disclosure in the
18 print format provider directory that the information included
19 in the directory is accurate as of the date of printing and
20 that beneficiaries or prospective beneficiaries should consult
21 the issuer's electronic provider directory on its website and
22 contact the provider. The network plan shall also include a
23 telephone number and email address in the print format
24 provider directory for a customer service representative where
25 the beneficiary can obtain current provider directory
26 information or report provider directory inaccuracies. The

1 printed provider directory shall include a detailed
2 description of the process to dispute charges for
3 out-of-network providers, hospitals, or facilities that were
4 incorrectly listed as in-network prior to the provision of
5 care and a telephone number and email address to dispute those
6 charges.

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

12 (g) To the extent not otherwise provided in this Act, an
13 issuer shall comply with the requirements of 42 U.S.C.
14 300gg-115, except that "provider directory information" shall
15 include all information required to be included in a provider
16 directory pursuant to this Section.

17 (h) If the issuer or the Department identifies a provider
18 incorrectly listed in the provider directory, the issuer shall
19 check each of the issuer's network plan provider directories
20 for the provider within 2 business days to ascertain whether
21 the provider is a preferred provider in that network plan and,
22 if the provider is incorrectly listed in the provider
23 directory, remove the provider from the provider directory
24 without delay.

25 (i) If the Director determines that an issuer violated
26 this Section, the Director may assess a fine up to \$5,000 per

1 violation, except for inaccurate information given by a
2 provider to the issuer. If an issuer, or any entity or person
3 acting on the issuer's behalf, knew or reasonably should have
4 known that a provider was incorrectly included in a provider
5 directory, the Director may assess a fine of up to \$25,000 per
6 violation against the issuer.

7 (j) This Section applies to network plans not otherwise
8 exempt under Section 3, ~~including stand alone dental plans.~~

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

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

11 Sec. 25. Network transparency.

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

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

22 (2) An issuer's failure to update a network plan's
23 directory shall subject the issuer to a civil penalty of
24 \$5,000 per month. ~~The network plan shall update the online~~
25 ~~provider directory at least monthly.~~ Providers shall

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

17 (3) At least once every 90 days, the issuer shall
18 self-audit each network plan's ~~The network plan shall~~
19 ~~audit periodically at least 25% of its~~ provider
20 directories for accuracy, make any corrections necessary,
21 and retain documentation of the audit. The issuer shall
22 submit the self-audit and a summary to the Department, and
23 the 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. ~~The network~~
3 ~~plan shall submit the audit to the Director upon request.~~
4 As part of these self-audits ~~audits~~, the network plan
5 shall contact any provider in its network that has not
6 submitted a claim to the plan or otherwise communicated
7 his or her intent to continue participation in the plan's
8 network. The self-audits shall comply with 42 U.S.C.
9 300gg-115(a)(2), except that "provider directory
10 information" shall include all information required to be
11 included in a provider directory pursuant to this Act.

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

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

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

1 network;

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

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

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

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

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

25 (6) A network plan shall make it clear for both its
26 electronic and print directories what provider directory

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

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

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

18 (1) for health care professionals:

19 (A) name;

20 (B) gender;

21 (C) participating office locations;

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

25 (E) medical group affiliations, if applicable;

26 (F) facility affiliations, if applicable;

1 (G) participating facility affiliations, if
2 applicable;

3 (H) languages spoken other than English, if
4 applicable;

5 (I) whether accepting new patients;

6 (J) board certifications, if applicable; ~~and~~

7 (K) use of telehealth or telemedicine, including,
8 but not limited to:

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

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

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

21 (L) whether the health care professional
22 accepts appointment requests from patients; and

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

1 the network;

2 (2) for hospitals:

3 (A) hospital name;

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

6 (C) participating hospital location; ~~and~~

7 (D) hospital accreditation status; and

8 (E) the anticipated date the hospital will leave

9 the network, if applicable, which shall be included no

10 more than 10 days after the issuer confirms the

11 hospital is scheduled to leave the network; and

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

13 (A) facility name;

14 (B) facility type;

15 (C) types of services performed; ~~and~~

16 (D) participating facility location or locations;

17 and-

18 (E) the anticipated date the facility will leave

19 the network, if applicable, which shall be included no

20 more than 10 days after the issuer confirms the

21 facility is scheduled to leave the network.

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

26 (1) for health care professionals:

1 (A) contact information, including both a
2 telephone number and digital contact information if
3 the provider has supplied digital contact information;
4 and

5 (B) languages spoken other than English by
6 clinical staff, if applicable;

7 (2) for hospitals, telephone number and digital
8 contact information; and

9 (3) for facilities other than hospitals, telephone
10 number.

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

14 (1) for health care professionals:

15 (A) name;

16 (B) contact information, including a telephone
17 number and digital contact information if the provider
18 has supplied digital contact information;

19 (C) participating office location or locations;

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

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

25 (F) whether accepting new patients; ~~and~~

26 (G) use of telehealth or telemedicine, including,

1 but not limited to:

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

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

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

15 (H) whether the health care professional accepts
16 appointment requests from patients;

17 (2) for hospitals:

18 (A) hospital name;

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

21 (C) participating hospital location, ~~and~~ telephone
22 number, and digital contact information; and

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

24 (A) facility name;

25 (B) facility type;

26 (C) patient population (such as pediatric, adult,

1 elderly, or women) served, if applicable, and types of
2 services performed; and

3 (D) participating facility location or locations,
4 ~~and~~ telephone numbers, and digital contact information
5 for each location.

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

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

1 (g) To the extent not otherwise provided in this Act, an
2 issuer shall comply with the requirements of 42 U.S.C.
3 300gg-115, except that "provider directory information" shall
4 include all information required to be included in a provider
5 directory pursuant to this Section.

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

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

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

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

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

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

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

5 Sec. 5-3. Insurance Code provisions.

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

1 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
2 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
3 Illinois Insurance Code.

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

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

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

12 (3) a corporation organized under the laws of another
13 state, 30% or more of the enrollees of which are residents
14 of this State, except a corporation subject to
15 substantially the same requirements in its state of
16 organization as is a "domestic company" under Article VIII
17 1/2 of the Illinois Insurance Code.

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

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

26 (2) (i) the criteria specified in subsection (1) (b) of

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

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

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

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

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

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

25 (d) The provisions of Article VIII 1/2 of the Illinois
26 Insurance Code and this Section 5-3 shall apply to the sale by

1 any health maintenance organization of greater than 10% of its
2 enrollee population (including, without limitation, the health
3 maintenance organization's right, title, and interest in and
4 to its health care certificates).

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

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

22 (i) the amount of, and other terms and conditions with
23 respect to, the refund or additional premium are set forth
24 in the group or enrollment unit contract agreed in advance
25 of the period for which a refund is to be paid or
26 additional premium is to be charged (which period shall

1 not be less than one year); and

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

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

1 the resulting additional premium to be paid by the group or
2 enrollment unit.

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

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

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

1 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

2 (Text of Section after 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,
9 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
10 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
11 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
12 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
13 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
14 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
15 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
16 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
17 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
18 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
19 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
20 356z.76, 356z.77, 356z.78, 364, 364.01, 364.3, 367.2, 367.2-5,
21 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1,
22 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
23 paragraph (c) of subsection (2) of Section 367, and Articles
24 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
25 XXXIIB of the 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; 103-808, eff. 1-1-26; 103-914, eff.
24 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
25 11-26-24.)

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

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

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

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

24 (2) a corporation organized under the laws of another
25 state, 30% or more of the enrollees of which are residents

1 of this State, except a corporation subject to
2 substantially the same requirements in its state of
3 organization as is a domestic company under Article VIII
4 1/2 of the Illinois Insurance Code.

5 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
6 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
7 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
8 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
9 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
10 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
11 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;
12 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.
13 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,
14 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

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

17 (720 ILCS 5/17-0.5)

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

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

24 "Cardholder" means the person or organization named on the

1 face of a credit card or debit card to whom or for whose
2 benefit the credit card or debit card is issued by an issuer.

3 "Computer" means a device that accepts, processes, stores,
4 retrieves, or outputs data and includes, but is not limited
5 to, auxiliary storage, including cloud-based networks of
6 remote services hosted on the Internet, and telecommunications
7 devices connected to computers.

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

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

16 "Computer services" means computer time or services,
17 including data processing services, Internet services,
18 electronic mail services, electronic message services, or
19 information or data stored in connection therewith.

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

23 "Credit card" means any instrument or device, whether
24 known as a credit card, credit plate, charge plate or any other
25 name, issued with or without fee by an issuer for the use of
26 the cardholder in obtaining money, goods, services or anything

1 else of value on credit or in consideration or an undertaking
2 or guaranty by the issuer of the payment of a check drawn by
3 the cardholder.

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

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

21 "Document" includes, but is not limited to, any document,
22 representation, or image produced manually, electronically, or
23 by computer.

24 "Electronic fund transfer terminal" means any machine or
25 device that, when properly activated, will perform any of the
26 following services:

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

3 (2) Print the cardholder's account balances on a
4 statement; or

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

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

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

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

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

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

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

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

25 "Expired credit card or debit card" means a credit card or
26 debit card which is no longer valid because the term on it has

1 elapsed.

2 "False academic degree" means a certificate, diploma,
3 transcript, or other document purporting to be issued by an
4 institution of higher learning or purporting to indicate that
5 a person has completed an organized academic program of study
6 at an institution of higher learning when the person has not
7 completed the organized academic program of study indicated on
8 the certificate, diploma, transcript, or other document.

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

17 (1) Contains any false, incomplete, or misleading
18 information concerning any fact or thing material to the
19 claim.

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

25 "Financial institution" means any bank, savings and loan
26 association, credit union, or other depository of money or

1 medium of savings and collective investment.

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

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

21 "Institution of higher learning" means a public or private
22 college, university, or community college located in the State
23 of Illinois that is authorized by the Board of Higher
24 Education or the Illinois Community College Board to issue
25 post-secondary degrees, or a public or private college,
26 university, or community college located anywhere in the

1 United States that is or has been legally constituted to offer
2 degrees and instruction in its state of origin or
3 incorporation.

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

15 "Issuer" means the business organization or financial
16 institution which issues a credit card or debit card, or its
17 duly authorized agent.

18 "Merchant" has the meaning ascribed to it in Section
19 16-0.1 of this Code.

20 "Person" means any individual, corporation, government,
21 governmental subdivision or agency, business trust, estate,
22 trust, partnership or association or any other entity.

23 "Receives" or "receiving" means acquiring possession or
24 control.

25 "Record of charge form" means any document submitted or
26 intended to be submitted to an issuer as evidence of a credit

1 transaction for which the issuer has agreed to reimburse
2 persons providing money, goods, property, services or other
3 things of value.

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

7 "Sale" means any delivery for value.

8 "Scheme or artifice to defraud" includes a scheme or
9 artifice to deprive another of the intangible right to honest
10 services.

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

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

1 some visitors to the profile web page and may also include a
2 form of electronic mail for members of the social networking
3 website.

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

13 "Universal Price Code Label" means a unique symbol that
14 consists of a machine-readable code and human-readable
15 numbers.

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

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

25 Section 95. No acceleration or delay. Where this Act makes

1 changes in a statute that is represented in this Act by text
2 that is not yet or no longer in effect (for example, a Section
3 represented by multiple versions), the use of that text does
4 not accelerate or delay the taking effect of (i) the changes
5 made by this Act or (ii) provisions derived from any other
6 Public Act.

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