



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB4330

Introduced 1/14/2026, by Rep. Martha Deuter

#### SYNOPSIS AS INTRODUCED:

215 ILCS 5/363

Amends the Illinois Insurance Code. Provides that an issuer of a Medicare supplement policy shall not deny coverage to an applicant who voluntarily switches from a Medicare Advantage plan to a Medicare plan under Parts A, B, or D, or any combination of those plans, so long as the application for a Medicare supplement policy is submitted within 30 calendar days after the first effective day of the new plan. Provides that when such an application for a Medicare supplement policy is submitted, the issuer of the Medicare supplement policy may not charge a higher cost than what is normally offered to applicants who have become newly eligible for Medicare, nor raise costs or deny coverage for a preexisting condition.

LRB104 16228 BAB 29612 b

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 Section 363 as follows:

6 (215 ILCS 5/363)

7 (Text of Section before amendment by P.A. 103-747)

8 Sec. 363. Medicare supplement policies; minimum standards.

9 (1) Except as otherwise specifically provided therein,  
10 this Section and Section 363a of this Code shall apply to:

11 (a) all Medicare supplement policies and subscriber  
12 contracts delivered or issued for delivery in this State  
13 on and after January 1, 1989; and

14 (b) all certificates issued under group Medicare  
15 supplement policies or subscriber contracts, which  
16 certificates are issued or issued for delivery in this  
17 State on and after January 1, 1989.

18 This Section shall not apply to "Accident Only" or  
19 "Specified Disease" types of policies. The provisions of this  
20 Section are not intended to prohibit or apply to policies or  
21 health care benefit plans, including group conversion  
22 policies, provided to Medicare eligible persons, which  
23 policies or plans are not marketed or purported or held to be

1 Medicare supplement policies or benefit plans.

2 (2) For the purposes of this Section and Section 363a, the  
3 following terms have the following meanings:

4 (a) "Applicant" means:

5 (i) in the case of individual Medicare supplement  
6 policy, the person who seeks to contract for insurance  
7 benefits, and

8 (ii) in the case of a group Medicare policy or  
9 subscriber contract, the proposed certificate holder.

10 (b) "Certificate" means any certificate delivered or  
11 issued for delivery in this State under a group Medicare  
12 supplement policy.

13 (c) "Medicare supplement policy" means an individual  
14 policy of accident and health insurance, as defined in  
15 paragraph (a) of subsection (2) of Section 355a of this  
16 Code, or a group policy or certificate delivered or issued  
17 for delivery in this State by an insurer, fraternal  
18 benefit society, voluntary health service plan, or health  
19 maintenance organization, other than a policy issued  
20 pursuant to a contract under Section 1876 of the federal  
21 Social Security Act (42 U.S.C. Section 1395 et seq.) or a  
22 policy issued under a demonstration project specified in  
23 42 U.S.C. Section 1395ss(g)(1), or any similar  
24 organization, that is advertised, marketed, or designed  
25 primarily as a supplement to reimbursements under Medicare  
26 for the hospital, medical, or surgical expenses of persons

1 eligible for Medicare.

2 (d) "Issuer" includes insurance companies, fraternal  
3 benefit societies, voluntary health service plans, health  
4 maintenance organizations, or any other entity providing  
5 Medicare supplement insurance, unless the context clearly  
6 indicates otherwise.

7 (e) "Medicare" means the Health Insurance for the Aged  
8 Act, Title XVIII of the Social Security Amendments of  
9 1965.

10 (3) No Medicare supplement insurance policy, contract, or  
11 certificate, that provides benefits that duplicate benefits  
12 provided by Medicare, shall be issued or issued for delivery  
13 in this State after December 31, 1988. No such policy,  
14 contract, or certificate shall provide lesser benefits than  
15 those required under this Section or the existing Medicare  
16 Supplement Minimum Standards Regulation, except where  
17 duplication of Medicare benefits would result.

18 (4) Medicare supplement policies or certificates shall  
19 have a notice prominently printed on the first page of the  
20 policy or attached thereto stating in substance that the  
21 policyholder or certificate holder shall have the right to  
22 return the policy or certificate within 30 days of its  
23 delivery and to have the premium refunded directly to him or  
24 her in a timely manner if, after examination of the policy or  
25 certificate, the insured person is not satisfied for any  
26 reason.

1           (5) A Medicare supplement policy or certificate may not  
2 deny a claim for losses incurred more than 6 months from the  
3 effective date of coverage for a preexisting condition. The  
4 policy may not define a preexisting condition more  
5 restrictively than a condition for which medical advice was  
6 given or treatment was recommended by or received from a  
7 physician within 6 months before the effective date of  
8 coverage.

9           (6) An issuer of a Medicare supplement policy shall:

10           (a) not deny coverage to an applicant under 65 years  
11 of age who meets any of the following criteria:

12                   (i) becomes eligible for Medicare by reason of  
13 disability if the person makes application for a  
14 Medicare supplement policy within 6 months of the  
15 first day on which the person enrolls for benefits  
16 under Medicare Part B; for a person who is  
17 retroactively enrolled in Medicare Part B due to a  
18 retroactive eligibility decision made by the Social  
19 Security Administration, the application must be  
20 submitted within a 6-month period beginning with the  
21 month in which the person received notice of  
22 retroactive eligibility to enroll;

23                   (ii) has Medicare and an employer group health  
24 plan (either primary or secondary to Medicare) that  
25 terminates or ceases to provide all such supplemental  
26 health benefits;

1 (iii) is insured by a Medicare Advantage plan that  
2 includes a Health Maintenance Organization, a  
3 Preferred Provider Organization, and a Private  
4 Fee-For-Service or Medicare Select plan and the  
5 applicant moves out of the plan's service area; the  
6 insurer goes out of business, withdraws from the  
7 market, or has its Medicare contract terminated; or  
8 the plan violates its contract provisions or is  
9 misrepresented in its marketing; or

10 (iv) is insured by a Medicare supplement policy  
11 and the insurer goes out of business, withdraws from  
12 the market, or the insurance company or agents  
13 misrepresent the plan and the applicant is without  
14 coverage;

15 (a-5) not deny coverage if the applicant voluntarily  
16 switches from a Medicare Advantage plan to a Medicare plan  
17 under Part A, B, or D, or any combination of those plans,  
18 so long as the application for a Medicare supplement  
19 policy is submitted within 30 calendar days after the  
20 first effective day of the new plan. When such an  
21 application for a Medicare supplement policy is submitted,  
22 the issuer of the Medicare supplement policy may not  
23 charge a higher cost than what is normally offered to  
24 applicants who have become newly eligible for Medicare,  
25 nor raise costs or deny coverage for a preexisting  
26 condition. As used in this paragraph (a-5), "preexisting

1 condition" has the meaning given to that term in Section  
2 351A-5 of this Code;

3 (b) make available to persons eligible for Medicare by  
4 reason of disability each type of Medicare supplement  
5 policy the issuer makes available to persons eligible for  
6 Medicare by reason of age;

7 (c) not charge individuals who become eligible for  
8 Medicare by reason of disability and who are under the age  
9 of 65 premium rates for any medical supplemental insurance  
10 benefit plan offered by the issuer that exceed the  
11 issuer's highest rate on the current rate schedule filed  
12 with the Department of Insurance for that plan to  
13 individuals who are age 65 or older; and

14 (d) provide the rights granted by items (a) through  
15 (d), for 6 months after June 1, 2008 (the effective date of  
16 Public Act 95-436), to any person who had enrolled for  
17 benefits under Medicare Part B prior to Public Act 95-436  
18 and who otherwise would have been eligible for coverage  
19 under item (a).

20 (7) The Director shall issue reasonable rules and  
21 regulations for the following purposes:

22 (a) To establish specific standards for policy  
23 provisions of Medicare policies and certificates. The  
24 standards shall be in accordance with the requirements of  
25 this Code. No requirement of this Code relating to minimum  
26 required policy benefits, other than the minimum standards

1 contained in this Section and Section 363a, shall apply to  
2 Medicare supplement policies and certificates. The  
3 standards may cover, but are not limited to the following:

4 (A) Terms of renewability.

5 (B) Initial and subsequent terms of eligibility.

6 (C) Non-duplication of coverage.

7 (D) Probationary and elimination periods.

8 (E) Benefit limitations, exceptions and  
9 reductions.

10 (F) Requirements for replacement.

11 (G) Recurrent conditions.

12 (H) Definition of terms.

13 (I) Requirements for issuing rebates or credits to  
14 policyholders if the policy's loss ratio does not  
15 comply with subsection (7) of Section 363a.

16 (J) Uniform methodology for the calculating and  
17 reporting of loss ratio information.

18 (K) Assuring public access to loss ratio  
19 information of an issuer of Medicare supplement  
20 insurance.

21 (L) Establishing a process for approving or  
22 disapproving proposed premium increases.

23 (M) Establishing a policy for holding public  
24 hearings prior to approval of premium increases.

25 (N) Establishing standards for Medicare Select  
26 policies.

1           (0) Prohibited policy provisions not otherwise  
2 specifically authorized by statute that, in the  
3 opinion of the Director, are unjust, unfair, or  
4 unfairly discriminatory to any person insured or  
5 proposed for coverage under a Medicare supplement  
6 policy or certificate.

7           (b) To establish minimum standards for benefits and  
8 claims payments, marketing practices, compensation  
9 arrangements, and reporting practices for Medicare  
10 supplement policies.

11           (c) To implement transitional requirements of Medicare  
12 supplement insurance benefits and premiums of Medicare  
13 supplement policies and certificates to conform to  
14 Medicare program revisions.

15           (8) If an individual is at least 65 years of age but no  
16 more than 75 years of age and has an existing Medicare  
17 supplement policy, the individual is entitled to an annual  
18 open enrollment period lasting 45 days, commencing with the  
19 individual's birthday, and the individual may purchase any  
20 Medicare supplement policy with the same issuer that offers  
21 benefits equal to or lesser than those provided by the  
22 previous coverage. During this open enrollment period, an  
23 issuer of a Medicare supplement policy shall not deny or  
24 condition the issuance or effectiveness of Medicare  
25 supplemental coverage, nor discriminate in the pricing of  
26 coverage, because of health status, claims experience, receipt

1 of health care, or a medical condition of the individual. An  
2 issuer shall provide notice of this annual open enrollment  
3 period for eligible Medicare supplement policyholders at the  
4 time that the application is made for a Medicare supplement  
5 policy or certificate. The notice shall be in a form that may  
6 be prescribed by the Department.

7 (9) Without limiting an individual's eligibility under  
8 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for  
9 at least 63 days after the later of the applicant's loss of  
10 benefits or the notice of termination of benefits, including a  
11 notice of claim denial due to termination of benefits, under  
12 the State's medical assistance program under Article V of the  
13 Illinois Public Aid Code, an issuer shall not deny or  
14 condition the issuance or effectiveness of any Medicare  
15 supplement policy or certificate that is offered and is  
16 available for issuance to new enrollees by the issuer; shall  
17 not discriminate in the pricing of such a Medicare supplement  
18 policy because of health status, claims experience, receipt of  
19 health care, or medical condition; and shall not include a  
20 policy provision that imposes an exclusion of benefits based  
21 on a preexisting condition under such a Medicare supplement  
22 policy if the individual:

23 (a) is enrolled for Medicare Part B;

24 (b) was enrolled in the State's medical assistance  
25 program during the COVID-19 Public Health Emergency  
26 described in Section 5-1.5 of the Illinois Public Aid

1 Code;

2 (c) was terminated or disenrolled from the State's  
3 medical assistance program after the COVID-19 Public  
4 Health Emergency and the later of the date of termination  
5 of benefits or the date of the notice of termination,  
6 including a notice of a claim denial due to termination,  
7 occurred on, after, or no more than 63 days before the end  
8 of either, as applicable:

9 (A) the individual's Medicare supplement open  
10 enrollment period described in Department rules  
11 implementing 42 U.S.C. 1395ss(s) (2) (A); or

12 (B) the 6-month period described in Section  
13 363(6) (a) (i) of this Code; and

14 (d) submits evidence of the date of termination of  
15 benefits or notice of termination under the State's  
16 medical assistance program with the application for a  
17 Medicare supplement policy or certificate.

18 (10) Each Medicare supplement policy and certificate  
19 available from an insurer on and after June 16, 2023 (the  
20 effective date of Public Act 103-102) shall be made available  
21 to all applicants who qualify under subparagraph (i) of  
22 paragraph (a) of subsection (6) or Department rules  
23 implementing 42 U.S.C. 1395ss(s) (2) (A) without regard to age  
24 or applicability of a Medicare Part B late enrollment penalty.  
25 (Source: P.A. 102-142, eff. 1-1-22; 103-102, eff. 6-16-23;  
26 104-417, eff. 8-15-25.)

1 (Text of Section after amendment by P.A. 103-747)

2 Sec. 363. Medicare supplement policies; minimum standards.

3 (1) Except as otherwise specifically provided therein,  
4 this Section and Section 363a of this Code shall apply to:

5 (a) all Medicare supplement policies and subscriber  
6 contracts delivered or issued for delivery in this State  
7 on and after January 1, 1989; and

8 (b) all certificates issued under group Medicare  
9 supplement policies or subscriber contracts, which  
10 certificates are issued or issued for delivery in this  
11 State on and after January 1, 1989.

12 This Section shall not apply to "Accident Only" or  
13 "Specified Disease" types of policies. The provisions of this  
14 Section are not intended to prohibit or apply to policies or  
15 health care benefit plans, including group conversion  
16 policies, provided to Medicare eligible persons, which  
17 policies or plans are not marketed or purported or held to be  
18 Medicare supplement policies or benefit plans.

19 (2) For the purposes of this Section and Section 363a, the  
20 following terms have the following meanings:

21 (a) "Applicant" means:

22 (i) in the case of individual Medicare supplement  
23 policy, the person who seeks to contract for insurance  
24 benefits, and

25 (ii) in the case of a group Medicare policy or

1 subscriber contract, the proposed certificate holder.

2 (b) "Certificate" means any certificate delivered or  
3 issued for delivery in this State under a group Medicare  
4 supplement policy.

5 (c) "Medicare supplement policy" means an individual  
6 policy of accident and health insurance, as defined in  
7 paragraph (a) of subsection (2) of Section 355a of this  
8 Code, or a group policy or certificate delivered or issued  
9 for delivery in this State by an insurer, fraternal  
10 benefit society, voluntary health service plan, or health  
11 maintenance organization, other than a policy issued  
12 pursuant to a contract under Section 1876 of the federal  
13 Social Security Act (42 U.S.C. Section 1395 et seq.) or a  
14 policy issued under a demonstration project specified in  
15 42 U.S.C. Section 1395ss(g)(1), or any similar  
16 organization, that is advertised, marketed, or designed  
17 primarily as a supplement to reimbursements under Medicare  
18 for the hospital, medical, or surgical expenses of persons  
19 eligible for Medicare.

20 (d) "Issuer" includes insurance companies, fraternal  
21 benefit societies, voluntary health service plans, health  
22 maintenance organizations, or any other entity providing  
23 Medicare supplement insurance, unless the context clearly  
24 indicates otherwise.

25 (e) "Medicare" means the Health Insurance for the Aged  
26 Act, Title XVIII of the Social Security Amendments of

1 1965.

2 (3) No Medicare supplement insurance policy, contract, or  
3 certificate, that provides benefits that duplicate benefits  
4 provided by Medicare, shall be issued or issued for delivery  
5 in this State after December 31, 1988. No such policy,  
6 contract, or certificate shall provide lesser benefits than  
7 those required under this Section or the existing Medicare  
8 Supplement Minimum Standards Regulation, except where  
9 duplication of Medicare benefits would result.

10 (4) Medicare supplement policies or certificates shall  
11 have a notice prominently printed on the first page of the  
12 policy or attached thereto stating in substance that the  
13 policyholder or certificate holder shall have the right to  
14 return the policy or certificate within 30 days of its  
15 delivery and to have the premium refunded directly to him or  
16 her in a timely manner if, after examination of the policy or  
17 certificate, the insured person is not satisfied for any  
18 reason.

19 (5) A Medicare supplement policy or certificate may not  
20 deny a claim for losses incurred more than 6 months from the  
21 effective date of coverage for a preexisting condition. The  
22 policy may not define a preexisting condition more  
23 restrictively than a condition for which medical advice was  
24 given or treatment was recommended by or received from a  
25 physician within 6 months before the effective date of  
26 coverage.

1 (6) An issuer of a Medicare supplement policy shall:

2 (a) not deny coverage to an applicant under 65 years  
3 of age who meets any of the following criteria:

4 (i) becomes eligible for Medicare by reason of  
5 disability if the person makes application for a  
6 Medicare supplement policy within 6 months of the  
7 first day on which the person enrolls for benefits  
8 under Medicare Part B; for a person who is  
9 retroactively enrolled in Medicare Part B due to a  
10 retroactive eligibility decision made by the Social  
11 Security Administration, the application must be  
12 submitted within a 6-month period beginning with the  
13 month in which the person received notice of  
14 retroactive eligibility to enroll;

15 (ii) has Medicare and an employer group health  
16 plan (either primary or secondary to Medicare) that  
17 terminates or ceases to provide all such supplemental  
18 health benefits;

19 (iii) is insured by a Medicare Advantage plan that  
20 includes a Health Maintenance Organization, a  
21 Preferred Provider Organization, and a Private  
22 Fee-For-Service or Medicare Select plan and the  
23 applicant moves out of the plan's service area; the  
24 insurer goes out of business, withdraws from the  
25 market, or has its Medicare contract terminated; or  
26 the plan violates its contract provisions or is

1 misrepresented in its marketing; or

2 (iv) is insured by a Medicare supplement policy  
3 and the insurer goes out of business, withdraws from  
4 the market, or the insurance company or agents  
5 misrepresent the plan and the applicant is without  
6 coverage;

7 (a-5) not deny coverage if the applicant voluntarily  
8 switches from a Medicare Advantage plan to a Medicare plan  
9 under Part A, B, or D, or any combination of those plans,  
10 so long as the application for a Medicare supplement  
11 policy is submitted within 30 calendar days after the  
12 first effective day of the new plan. When such an  
13 application for a Medicare supplement policy is submitted,  
14 the issuer of the Medicare supplement policy may not  
15 charge a higher cost than what is normally offered to  
16 applicants who have become newly eligible for Medicare,  
17 nor raise costs or deny coverage for a preexisting  
18 condition. As used in this paragraph (a-5), "preexisting  
19 condition" has the meaning given to that term in Section  
20 351A-5 of this Code;

21 (b) make available to persons eligible for Medicare by  
22 reason of disability each type of Medicare supplement  
23 policy the issuer makes available to persons eligible for  
24 Medicare by reason of age;

25 (c) not charge individuals who become eligible for  
26 Medicare by reason of disability and who are under the age

1 of 65 premium rates for any medical supplemental insurance  
2 benefit plan offered by the issuer that exceed the  
3 issuer's highest rate on the current rate schedule filed  
4 with the Department of Insurance for that plan to  
5 individuals who are age 65 or older; and

6 (d) provide the rights granted by items (a) through  
7 (d), for 6 months after June 1, 2008 (the effective date of  
8 Public Act 95-436), to any person who had enrolled for  
9 benefits under Medicare Part B prior to Public Act 95-436  
10 and who otherwise would have been eligible for coverage  
11 under item (a).

12 (7) The Director shall issue reasonable rules and  
13 regulations for the following purposes:

14 (a) To establish specific standards for policy  
15 provisions of Medicare policies and certificates. The  
16 standards shall be in accordance with the requirements of  
17 this Code. No requirement of this Code relating to minimum  
18 required policy benefits, other than the minimum standards  
19 contained in this Section and Section 363a, shall apply to  
20 Medicare supplement policies and certificates. The  
21 standards may cover, but are not limited to the following:

22 (A) Terms of renewability.

23 (B) Initial and subsequent terms of eligibility.

24 (C) Non-duplication of coverage.

25 (D) Probationary and elimination periods.

26 (E) Benefit limitations, exceptions and

1 reductions.

2 (F) Requirements for replacement.

3 (G) Recurrent conditions.

4 (H) Definition of terms.

5 (I) Requirements for issuing rebates or credits to  
6 policyholders if the policy's loss ratio does not  
7 comply with subsection (7) of Section 363a.

8 (J) Uniform methodology for the calculating and  
9 reporting of loss ratio information.

10 (K) Assuring public access to loss ratio  
11 information of an issuer of Medicare supplement  
12 insurance.

13 (L) Establishing a process for approving or  
14 disapproving proposed premium increases.

15 (M) Establishing a policy for holding public  
16 hearings prior to approval of premium increases.

17 (N) Establishing standards for Medicare Select  
18 policies.

19 (O) Prohibited policy provisions not otherwise  
20 specifically authorized by statute that, in the  
21 opinion of the Director, are unjust, unfair, or  
22 unfairly discriminatory to any person insured or  
23 proposed for coverage under a Medicare supplement  
24 policy or certificate.

25 (b) To establish minimum standards for benefits and  
26 claims payments, marketing practices, compensation

1 arrangements, and reporting practices for Medicare  
2 supplement policies.

3 (c) To implement transitional requirements of Medicare  
4 supplement insurance benefits and premiums of Medicare  
5 supplement policies and certificates to conform to  
6 Medicare program revisions.

7 (8) If an individual is at least 65 years of age but no  
8 more than 75 years of age and has an existing Medicare  
9 supplement policy, the individual is entitled to an annual  
10 open enrollment period lasting 45 days, commencing with the  
11 individual's birthday, and the individual may purchase any  
12 Medicare supplement policy with the same issuer or any  
13 affiliate authorized to transact business in this State that  
14 offers benefits equal to or lesser than those provided by the  
15 previous coverage. During this open enrollment period, an  
16 issuer of a Medicare supplement policy shall not deny or  
17 condition the issuance or effectiveness of Medicare  
18 supplemental coverage, nor discriminate in the pricing of  
19 coverage, because of health status, claims experience, receipt  
20 of health care, or a medical condition of the individual. An  
21 issuer shall provide notice of this annual open enrollment  
22 period for eligible Medicare supplement policyholders at the  
23 time that the application is made for a Medicare supplement  
24 policy or certificate. The notice shall be in a form that may  
25 be prescribed by the Department.

26 (9) Without limiting an individual's eligibility under

1 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for  
2 at least 63 days after the later of the applicant's loss of  
3 benefits or the notice of termination of benefits, including a  
4 notice of claim denial due to termination of benefits, under  
5 the State's medical assistance program under Article V of the  
6 Illinois Public Aid Code, an issuer shall not deny or  
7 condition the issuance or effectiveness of any Medicare  
8 supplement policy or certificate that is offered and is  
9 available for issuance to new enrollees by the issuer; shall  
10 not discriminate in the pricing of such a Medicare supplement  
11 policy because of health status, claims experience, receipt of  
12 health care, or medical condition; and shall not include a  
13 policy provision that imposes an exclusion of benefits based  
14 on a preexisting condition under such a Medicare supplement  
15 policy if the individual:

16 (a) is enrolled for Medicare Part B;

17 (b) was enrolled in the State's medical assistance  
18 program during the COVID-19 Public Health Emergency  
19 described in Section 5-1.5 of the Illinois Public Aid  
20 Code;

21 (c) was terminated or disenrolled from the State's  
22 medical assistance program after the COVID-19 Public  
23 Health Emergency and the later of the date of termination  
24 of benefits or the date of the notice of termination,  
25 including a notice of a claim denial due to termination,  
26 occurred on, after, or no more than 63 days before the end

1 of either, as applicable:

2 (A) the individual's Medicare supplement open  
3 enrollment period described in Department rules  
4 implementing 42 U.S.C. 1395ss(s) (2) (A); or

5 (B) the 6-month period described in Section  
6 363(6) (a) (i) of this Code; and

7 (d) submits evidence of the date of termination of  
8 benefits or notice of termination under the State's  
9 medical assistance program with the application for a  
10 Medicare supplement policy or certificate.

11 (10) Each Medicare supplement policy and certificate  
12 available from an insurer on and after June 16, 2023 (the  
13 effective date of Public Act 103-102) shall be made available  
14 to all applicants who qualify under subparagraph (i) of  
15 paragraph (a) of subsection (6) or Department rules  
16 implementing 42 U.S.C. 1395ss(s) (2) (A) without regard to age  
17 or applicability of a Medicare Part B late enrollment penalty.  
18 (Source: P.A. 103-102, eff. 6-16-23; 103-747, eff. 1-1-26;  
19 104-417, eff. 8-15-25.)

20 Section 95. No acceleration or delay. Where this Act makes  
21 changes in a statute that is represented in this Act by text  
22 that is not yet or no longer in effect (for example, a Section  
23 represented by multiple versions), the use of that text does  
24 not accelerate or delay the taking effect of (i) the changes  
25 made by this Act or (ii) provisions derived from any other

1 Public Act.