



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5393

Introduced 2/10/2026, by Rep. Ann M. Williams

SYNOPSIS AS INTRODUCED:

215 ILCS 130/1002
215 ILCS 130/3009

from Ch. 73, par. 1501-2
from Ch. 73, par. 1503-9

Amends the Limited Health Service Organization Act. Makes changes to defined terms. In provisions concerning the offering of a point-of-sale contract by a limited health service organization (LHSO), removes a provision requiring the LHSO to include an annual maximum benefit allowance not to exceed \$2,500 per year that is separate from any limits or allowances applied to in-plan services. Provides that, if an LHSO expends in any calendar quarter more than 20% of its total limited health services expenditures for all its members for out-of-plan covered services, then specified limitations shall not apply subject to the LHSO minimum capital and surplus requirements applicable to a life, accident, and health insurance company. Makes other changes.

LRB104 18114 BAB 31553 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 Limited Health Service Organization Act is
5 amended by changing Sections 1002 and 3009 as follows:

6 (215 ILCS 130/1002) (from Ch. 73, par. 1501-2)

7 Sec. 1002. Definitions. As used in this Act, unless the
8 context otherwise requires, the following terms shall have the
9 meanings ascribed to them:

10 "Advertisement" means any printed or published material,
11 audiovisual material and descriptive literature of the limited
12 health care plan used in direct mail, newspapers, magazines,
13 radio scripts, television scripts, billboards and similar
14 displays; and any descriptive literature or sales aids of all
15 kinds disseminated by a representative of the limited health
16 care plan for presentation to the public including, but not
17 limited to, circulars, leaflets, booklets, depictions,
18 illustrations, form letters and prepared sales presentations.

19 "Copayment" means the amount that an enrollee must pay in
20 order to receive a specific service that is not fully prepaid.

21 "Director" means the Director of Insurance.

22 "Enrollee" means an individual, including a dependent, who
23 is entitled to limited health services pursuant to a contract

1 with an entity authorized to provide or arrange for those
2 services under this Act ~~who has been enrolled in a limited~~
3 ~~health care plan.~~

4 "Evidence of coverage" means any certificate, agreement or
5 contract issued to an enrollee setting out the coverage to
6 which that enrollee is entitled ~~in exchange for a per capita~~
7 ~~prepaid sum.~~

8 "Group contract" means a contract for limited health
9 services which by its terms limits eligibility to members of a
10 specified group.

11 "In-plan covered services" means covered limited health
12 services obtained from providers who are employed by, under
13 contract with, referred by, or otherwise affiliated with the
14 LHSO and emergency services.

15 "Limited health care plan" means any arrangement whereby
16 an organization undertakes to provide or arrange for and, pay
17 for or reimburse the cost of any limited health services from
18 providers selected by the limited health service organization
19 and such arrangement consists of arranging for or the
20 provision of such limited health services on a per capita or
21 fixed prepaid basis, as distinguished from mere
22 indemnification against the cost of such limited services on a
23 per capita prepaid basis through insurance except as otherwise
24 provided under Section 3009.

25 "Limited health service" means dental care services,
26 vision care services, mental health services, services for

1 substance use disorders, pharmaceutical services, podiatric
2 care services, and such other services as may be determined by
3 the Director to be limited health services. "Limited health
4 service" does not include hospital, medical, surgical, or
5 emergency services, except as these services are provided
6 incident to the limited health services set forth in this
7 definition ~~ambulance care services, dental care services,~~
8 ~~vision care services, pharmaceutical services, clinical~~
9 ~~laboratory services, and podiatric care services. Limited~~
10 ~~health service shall not include hospital, medical, surgical~~
11 ~~or emergency services except when those services are essential~~
12 ~~to the delivery of the limited health service. Essential~~
13 ~~hospital, medical, surgical, or emergency services shall be~~
14 ~~covered unless specifically excluded.~~

15 "Limited health service organization" (LHSO) means any
16 organization formed under the laws of this or another state to
17 provide or arrange for one or more limited health care plans
18 under a system which causes any part of the risk of limited
19 health care delivery to be borne by the organization or its
20 providers.

21 "Net worth" means admitted assets, as defined in Section
22 1003 of this Act, minus liabilities.

23 "Organization" means any insurance company or other
24 corporation organized under the laws of this or another state
25 for the purpose of operating one or more limited health care
26 plans and doing no business other than that of a health

1 maintenance organization or a limited health service
2 organization or an insurance company. Organization does not
3 include (1) any entity otherwise authorized on the effective
4 date of this Act pursuant to the laws of this State either to
5 provide any limited health service on a prepayment basis or to
6 indemnity for any limited health service; nor does it include
7 (2) any provider or other entity when providing or arranging
8 for the provision of limited health services pursuant to a
9 contract with a limited health service organization or with
10 any entity described in (1) of this definition.

11 "Out-of-plan covered services" means non-emergency,
12 self-referred covered limited health services obtained from
13 providers who are not otherwise employed by, under contract
14 with, or otherwise affiliated with the LHSO or services
15 obtained without a referral from providers who have contracted
16 to provide limited health services to the enrollee on behalf
17 of the limited health care plan.

18 "Point-of-service product" (POS) means a group contract
19 that includes both in-plan covered services and out-of-plan
20 covered services as well as a POS contract in which the risk
21 for out-of-plan covered services is borne through reinsurance.
22 This term does not apply to indemnity benefits offered through
23 an LHSO that are underwritten in whole by a licensed insurance
24 carrier and offered in conjunction with the LHSO benefit
25 package.

26 "Provider" means any physician, dentist, health facility,

1 or other person or institution which is duly licensed or
2 otherwise authorized to deliver or furnish limited health
3 services and also includes any other entity that arranges for
4 the delivery or furnishing of limited health service.

5 "Per capita prepaid" means a basis of payment by which a
6 fixed amount of money is prepaid per individual or any other
7 enrollment unit to the limited health service organization or
8 for limited health services which are provided during a
9 definite time period regardless of the frequency or extent of
10 the services rendered, except for copayments of a fixed amount
11 by the limited health service organization.

12 "Subscriber" means the person whose employment or other
13 status, except for family dependency, is the basis for
14 entitlement to limited health services pursuant to a contract
15 with an organization authorized to provide or arrange for such
16 services under this Act.

17 "Uncovered expense" means the cost of limited health
18 services that are the obligation of a limited health service
19 organization for which an enrollee may be liable in the event
20 of the insolvency of the organization. Costs incurred by a
21 provider who has agreed in writing not to bill enrollees,
22 except for permissible supplemental charges, shall be
23 considered covered expenses.

24 (Source: P.A. 87-1079; 88-568, eff. 8-5-94; 88-667, eff.
25 9-16-94.)

1 (215 ILCS 130/3009) (from Ch. 73, par. 1503-9)
2 Sec. 3009. Point-of-service limited health service
3 contracts.

4 (a) An LHSO that offers a POS contract:

5 (1) shall include as in-plan covered services all
6 services required by law to be provided by an LHSO;

7 (2) shall provide incentives, which shall include
8 financial incentives, for enrollees to use in-plan covered
9 services;

10 (3) shall not offer services out-of-plan without
11 providing those services on an in-plan basis;

12 (4) may limit or exclude specific types of services
13 from coverage when obtained out-of-plan;

14 (5) may include annual out-of-pocket limits and
15 lifetime maximum benefits allowances for out-of-plan
16 services that are separate from any limits or allowances
17 applied to in-plan services;

18 ~~(6) shall include an annual maximum benefit allowance~~
19 ~~not to exceed \$2,500 per year that is separate from any~~
20 ~~limits or allowances applied to in-plan services;~~

21 (6) ~~(7)~~ may limit the groups to which a POS product is
22 offered, however, if a POS product is offered to a group,
23 then it must be offered to all eligible members of that
24 group, when an LHSO provider is available;

25 (7) ~~(8)~~ shall not consider emergency services,
26 authorized referral services, or non-routine services

1 obtained out of the service area to be POS services; and

2 (8) ~~(9)~~ may treat as out-of-plan services those
3 services that an enrollee obtains from a participating
4 provider, but for which the proper authorization was not
5 given by the LHSO.

6 (b) An LHSO offering a POS contract shall be subject to the
7 following limitations:

8 (1) The LHSO shall not expend in any calendar quarter
9 more than 20% of its total limited health services
10 expenditures for all its members for out-of-plan covered
11 services, unless otherwise allowed under this subsection.

12 (2) If the amount specified in paragraph (1) is
13 exceeded by 2% in a quarter, the LHSO shall effect
14 compliance with paragraph (1) by the end of the following
15 quarter.

16 (3) If compliance with the amount specified in
17 paragraph (1) is not demonstrated in the LHSO's next
18 quarterly report, the LHSO may not offer the POS contract
19 to new groups or include the POS option in the renewal of
20 an existing group until compliance with the amount
21 specified in paragraph (1) is demonstrated ~~or otherwise~~
22 ~~allowed by the Director.~~

23 (4) Any LHSO failing, without just cause, to comply
24 with the provisions of this subsection shall be required,
25 after notice and hearing, to pay a penalty of \$250 for each
26 day out of compliance, to be recovered by the Director of

1 Insurance. Any penalty recovered shall be paid into the
2 General Revenue Fund. The Director may reduce the penalty
3 if the LHSO demonstrates to the Director that the
4 imposition of the penalty would constitute a financial
5 hardship to the LHSO.

6 If an LHSO expends in any calendar quarter more than 20% of
7 its total limited health services expenditures for all its
8 members for out-of-plan covered services, then paragraphs (2),
9 (3), and (4) shall not apply subject to the LHSO minimum
10 capital and surplus requirements applicable to a life,
11 accident, and health insurance company as outlined in Section
12 13 of the Illinois Insurance Code.

13 (c) Any LHSO that offers a POS product shall:

14 (1) File a quarterly financial statement detailing
15 compliance with the requirements of subsection (b).

16 (2) Track out-of-plan POS utilization separately from
17 in-plan or non-POS out-of-plan emergency care, referral
18 care, and urgent care out of the service area utilization.

19 (3) Record out-of-plan utilization in a manner that
20 will permit such utilization and cost reporting as the
21 Director may, by regulation, require.

22 (4) Demonstrate to the Director's satisfaction that
23 the LHSO has the fiscal, administrative, and marketing
24 capacity to control its POS enrollment, utilization, and
25 costs so as not to jeopardize the financial security of
26 the LHSO.

1 (5) Maintain the deposit required by subsection (b) of
2 Section 2006 in addition to any other deposit required
3 under this Act.

4 (d) An LHSO shall not issue a POS contract until it has
5 filed and had approved by the Director a plan to comply with
6 the provisions of this Section. The compliance plan shall at a
7 minimum include provisions demonstrating that the LHSO will do
8 all of the following:

9 (1) Design the benefit levels and conditions of
10 coverage for in-plan covered services and out-of-plan
11 covered services as required by this Article.

12 (2) Provide or arrange for the provision of adequate
13 systems to:

14 (A) process and pay claims for all out-of-plan
15 covered services;

16 (B) meet the requirements for a POS contract set
17 forth in this Section and any additional requirements
18 that may be set forth by the Director; and

19 (C) generate accurate data and financial and
20 regulatory reports on a timely basis so that the
21 Department can evaluate the LHSO's experience with the
22 POS contract and monitor compliance with POS contract
23 provisions.

24 (3) Comply initially and on an ongoing basis with the
25 requirements of subsections (b) and (c).

26 (e) A limited health service organization that offers a

1 POS contract must comply with Sections 356w and 356x of the
2 Illinois Insurance Code.

3 (Source: P.A. 90-741, eff. 1-1-99.)