



Sen. Ram Villivalam

Filed: 5/9/2025

10400SB2405sam002

LRB104 10637 BAB 25960 a

1 AMENDMENT TO SENATE BILL 2405

2 AMENDMENT NO. _____. Amend Senate Bill 2405 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The State Employees Group Insurance Act of
5 1971 is amended by changing Section 6.11 as follows:

6 (5 ILCS 375/6.11)

7 Sec. 6.11. Required health benefits; Illinois Insurance
8 Code requirements. The program of health benefits shall
9 provide the post-mastectomy care benefits required to be
10 covered by a policy of accident and health insurance under
11 Section 356t of the Illinois Insurance Code. The program of
12 health benefits shall provide the coverage required under
13 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10,
14 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8,
15 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
16 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,

1 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
2 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59,
3 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~
4 356z.70, ~~and~~ 356z.71, 356z.74, 356z.76, 356z.77, and 356z.80

5 of the Illinois Insurance Code. The program of health benefits
6 must comply with Sections 155.22a, 155.37, 355b, 356z.19,
7 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance
8 Code. The program of health benefits shall provide the
9 coverage required under Section 356m of the Illinois Insurance
10 Code and, for the employees of the State Employee Group
11 Insurance Program only, the coverage as also provided in
12 Section 6.11B of this Act. The Department of Insurance shall
13 enforce the requirements of this Section with respect to
14 Sections 370c and 370c.1 of the Illinois Insurance Code; all
15 other requirements of this Section shall be enforced by the
16 Department of Central Management Services.

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.
25 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768,
26 eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;

1 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.
2 1-1-23; 102-1117, eff. 1-13-23; 103-8, eff. 1-1-24; 103-84,
3 eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24;
4 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff.
5 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751,
6 eff. 8-2-24; 103-870, eff. 1-1-25; 103-914, eff. 1-1-25;
7 103-918, eff. 1-1-25; 103-951, eff. 1-1-25; 103-1024, eff.
8 1-1-25; revised 11-26-24.)

9 Section 10. The Counties Code is amended by changing
10 Section 5-1069.3 as follows:

11 (55 ILCS 5/5-1069.3)

12 Sec. 5-1069.3. Required health benefits. If a county,
13 including a home rule county, is a self-insurer for purposes
14 of providing health insurance coverage for its employees, the
15 coverage shall include coverage for the post-mastectomy care
16 benefits required to be covered by a policy of accident and
17 health insurance under Section 356t and the coverage required
18 under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u,
19 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9,
20 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
21 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36,
22 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,
23 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61,
24 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, and

1 356z.74, 356z.77, and 356z.80 of the Illinois Insurance Code.
2 The coverage shall comply with Sections 155.22a, 355b,
3 356z.19, and 370c of the Illinois Insurance Code. The
4 Department of Insurance shall enforce the requirements of this
5 Section. The requirement that health benefits be covered as
6 provided in this Section is an exclusive power and function of
7 the State and is a denial and limitation under Article VII,
8 Section 6, subsection (h) of the Illinois Constitution. A home
9 rule county to which this Section applies must comply with
10 every provision of this Section.

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

17 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
18 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
19 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,
20 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;
21 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.
22 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
23 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
24 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.
25 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914,
26 eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25;

1 revised 11-26-24.)

2 Section 15. The Illinois Municipal Code is amended by
3 changing Section 10-4-2.3 as follows:

4 (65 ILCS 5/10-4-2.3)

5 Sec. 10-4-2.3. Required health benefits. If a
6 municipality, including a home rule municipality, is a
7 self-insurer for purposes of providing health insurance
8 coverage for its employees, the coverage shall include
9 coverage for the post-mastectomy care benefits required to be
10 covered by a policy of accident and health insurance under
11 Section 356t and the coverage required under Sections 356g,
12 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x,
13 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,
14 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,
15 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,
16 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,
17 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64,
18 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, 356z.77,
19 and 356z.80 of the Illinois Insurance Code. The coverage shall
20 comply with Sections 155.22a, 355b, 356z.19, and 370c of the
21 Illinois Insurance Code. The Department of Insurance shall
22 enforce the requirements of this Section. The requirement that
23 health benefits be covered as provided in this is an exclusive
24 power and function of the State and is a denial and limitation

1 under Article VII, Section 6, subsection (h) of the Illinois
2 Constitution. A home rule municipality to which this Section
3 applies must comply with every provision of this Section.

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

10 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
11 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
12 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,
13 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;
14 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.
15 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
16 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
17 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.
18 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914,
19 eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25;
20 revised 11-26-24.)

21 Section 20. The School Code is amended by changing Section
22 10-22.3f as follows:

23 (105 ILCS 5/10-22.3f)

24 Sec. 10-22.3f. Required health benefits. Insurance

1 protection and benefits for employees shall provide the
2 post-mastectomy care benefits required to be covered by a
3 policy of accident and health insurance under Section 356t and
4 the coverage required under Sections 356g, 356g.5, 356g.5-1,
5 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a,
6 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14,
7 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,
8 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
9 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,
10 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~
11 356z.71, 356z.74, 356z.77, and 356z.80 of the Illinois
12 Insurance Code. Insurance policies shall comply with Section
13 356z.19 of the Illinois Insurance Code. The coverage shall
14 comply with Sections 155.22a, 355b, and 370c of the Illinois
15 Insurance Code. The Department of Insurance shall enforce the
16 requirements of this Section.

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.
25 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804,
26 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;

1 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff.
2 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420,
3 eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23;
4 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff.
5 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918,
6 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

7 Section 25. The Illinois Insurance Code is amended by
8 changing Section 356z.3a and by adding Section 356z.80 as
9 follows:

10 (215 ILCS 5/356z.3a)

11 Sec. 356z.3a. Billing; emergency services;
12 nonparticipating providers.

13 (a) As used in this Section:

14 "Ancillary services" means:

15 (1) items and services related to emergency medicine,
16 anesthesiology, pathology, radiology, and neonatology that
17 are provided by any health care provider;

18 (2) items and services provided by assistant surgeons,
19 hospitalists, and intensivists;

20 (3) diagnostic services, including radiology and
21 laboratory services, except for advanced diagnostic
22 laboratory tests identified on the most current list
23 published by the United States Secretary of Health and
24 Human Services under 42 U.S.C. 300gg-132(b) (3);

1 (4) items and services provided by other specialty
2 practitioners as the United States Secretary of Health and
3 Human Services specifies through rulemaking under 42
4 U.S.C. 300gg-132(b)(3);

5 (5) items and services provided by a nonparticipating
6 provider if there is no participating provider who can
7 furnish the item or service at the facility; and

8 (6) items and services provided by a nonparticipating
9 provider if there is no participating provider who will
10 furnish the item or service because a participating
11 provider has asserted the participating provider's rights
12 under the Health Care Right of Conscience Act.

13 "Cost sharing" means the amount an insured, beneficiary,
14 or enrollee is responsible for paying for a covered item or
15 service under the terms of the policy or certificate. "Cost
16 sharing" includes copayments, coinsurance, and amounts paid
17 toward deductibles, but does not include amounts paid towards
18 premiums, balance billing by out-of-network providers, or the
19 cost of items or services that are not covered under the policy
20 or certificate.

21 "Emergency department of a hospital" means any hospital
22 department that provides emergency services, including a
23 hospital outpatient department.

24 "Emergency medical condition" has the meaning ascribed to
25 that term in Section 10 of the Managed Care Reform and Patient
26 Rights Act.

1 "Emergency medical screening examination" has the meaning
2 ascribed to that term in Section 10 of the Managed Care Reform
3 and Patient Rights Act.

4 "Emergency services" means, with respect to an emergency
5 medical condition:

6 (1) in general, an emergency medical screening
7 examination, including ancillary services routinely
8 available to the emergency department to evaluate such
9 emergency medical condition, and such further medical
10 examination and treatment as would be required to
11 stabilize the patient regardless of the department of the
12 hospital or other facility in which such further
13 examination or treatment is furnished; or

14 (2) additional items and services for which benefits
15 are provided or covered under the coverage and that are
16 furnished by a nonparticipating provider or
17 nonparticipating emergency facility regardless of the
18 department of the hospital or other facility in which such
19 items are furnished after the insured, beneficiary, or
20 enrollee is stabilized and as part of outpatient
21 observation or an inpatient or outpatient stay with
22 respect to the visit in which the services described in
23 paragraph (1) are furnished. Services after stabilization
24 cease to be emergency services only when all the
25 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and
26 regulations thereunder are met.

1 "Emergency service" includes ground ambulance service
2 provided by ground ambulance service providers if the service
3 was provided pursuant to a request to 9-1-1 or an equivalent
4 telephone number, texting system, or other method of summoning
5 emergency service or if the service provided was provided when
6 a patient's condition, at the time of service, was considered
7 to be an emergency medical condition as defined by this Act or
8 as determined by a physician licensed pursuant to the Medical
9 Practice Act of 1987.

10 "Evaluation" means, with respect to ground ambulance
11 service, the provision of a medical screening examination to
12 determine whether an emergency medical condition exists.

13 "Freestanding Emergency Center" means a facility licensed
14 under Section 32.5 of the Emergency Medical Services (EMS)
15 Systems Act.

16 "Ground ambulance service" means both medical
17 transportation service that is described as ground ambulance
18 service by the Centers for Medicare and Medicaid Services and
19 medical nontransportation service, such as evaluation without
20 transport, treatment without transport, or paramedic
21 intercept, and that is, in either case, provided in a vehicle
22 that is licensed as an ambulance under the Emergency Medical
23 Services (EMS) Systems Act or by EMS Personnel assigned to a
24 vehicle that is licensed as an ambulance under the Emergency
25 Medical Services (EMS) Systems Act. "Ground ambulance service"
26 may include any combination of the following: emergency ground

1 ambulance service in a ground ambulance, urgent ground
2 ambulance service, evaluation without treatment, treatment
3 without transport, and paramedic intercept.

4 "Ground ambulance service provider" means a vehicle
5 service provider under the Emergency Medical Services (EMS)
6 Systems Act that operates licensed ground ambulances. "Ground
7 ambulance service provider" includes both ambulance providers
8 and ambulance suppliers as described by the Centers for
9 Medicare and Medicaid Services.

10 "Health care facility" means, in the context of
11 non-emergency services, any of the following:

- 12 (1) a hospital as defined in 42 U.S.C. 1395x(e);
13 (2) a hospital outpatient department;
14 (3) a critical access hospital certified under 42
15 U.S.C. 1395i-4(e);
16 (4) an ambulatory surgical treatment center as defined
17 in the Ambulatory Surgical Treatment Center Act; or
18 (5) any recipient of a license under the Hospital
19 Licensing Act that is not otherwise described in this
20 definition.

21 "Health care provider" means a provider as defined in
22 subsection (d) of Section 370g. "Health care provider" does
23 not include a provider of air ambulance or ground ambulance
24 services.

25 "Health care services" has the meaning ascribed to that
26 term in subsection (a) of Section 370g.

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

4 "Nonparticipating emergency facility" means, with respect
5 to the furnishing of an item or service under a policy of group
6 or individual health insurance coverage, any of the following
7 facilities that does not have a contractual relationship
8 directly or indirectly with a health insurance issuer in
9 relation to the coverage:

10 (1) an emergency department of a hospital;

11 (2) a Freestanding Emergency Center;

12 (3) an ambulatory surgical treatment center as defined
13 in the Ambulatory Surgical Treatment Center Act; or

14 (4) with respect to emergency services described in
15 paragraph (2) of the definition of "emergency services", a
16 hospital.

17 "Nonparticipating ground ambulance service provider"
18 means, with respect to the furnishing of an item or services
19 under a policy of group or individual health insurance
20 coverage, any ground ambulance service provider that does not
21 have a contractual relationship directly or indirectly with a
22 health insurance issuer in relation to the coverage.

23 "Nonparticipating provider" means, with respect to the
24 furnishing of an item or service under a policy of group or
25 individual health insurance coverage, any health care provider
26 who does not have a contractual relationship directly or

1 indirectly with a health insurance issuer in relation to the
2 coverage.

3 "Paramedic intercept" means a service in which a ground
4 ambulance staffed by licensed paramedics rendezvouses with a
5 ground ambulance staffed with nonparamedics to provide
6 advanced life support care. In this definition, "advanced life
7 support care" means life support care that is warranted when a
8 patient's condition and need for treatment exceed the basic
9 life support or intermediate life support level of care.

10 "Participating emergency facility" means any of the
11 following facilities that has a contractual relationship
12 directly or indirectly with a health insurance issuer offering
13 group or individual health insurance coverage setting forth
14 the terms and conditions on which a relevant health care
15 service is provided to an insured, beneficiary, or enrollee
16 under the coverage:

17 (1) an emergency department of a hospital;

18 (2) a Freestanding Emergency Center;

19 (3) an ambulatory surgical treatment center as defined
20 in the Ambulatory Surgical Treatment Center Act; or

21 (4) with respect to emergency services described in
22 paragraph (2) of the definition of "emergency services", a
23 hospital.

24 For purposes of this definition, a single case agreement
25 between an emergency facility and an issuer that is used to
26 address unique situations in which an insured, beneficiary, or

1 enrollee requires services that typically occur out-of-network
2 constitutes a contractual relationship and is limited to the
3 parties to the agreement.

4 "Participating health care facility" means any health care
5 facility that has a contractual relationship directly or
6 indirectly with a health insurance issuer offering group or
7 individual health insurance coverage setting forth the terms
8 and conditions on which a relevant health care service is
9 provided to an insured, beneficiary, or enrollee under the
10 coverage. A single case agreement between an emergency
11 facility and an issuer that is used to address unique
12 situations in which an insured, beneficiary, or enrollee
13 requires services that typically occur out-of-network
14 constitutes a contractual relationship for purposes of this
15 definition and is limited to the parties to the agreement.

16 "Participating provider" means any health care provider
17 that has a contractual relationship directly or indirectly
18 with a health insurance issuer offering group or individual
19 health insurance coverage setting forth the terms and
20 conditions on which a relevant health care service is provided
21 to an insured, beneficiary, or enrollee under the coverage.

22 "Qualifying payment amount" has the meaning given to that
23 term in 42 U.S.C. 300gg-111(a)(3)(E) and the regulations
24 promulgated thereunder.

25 "Recognized amount" means, except as otherwise provided in
26 this Section, the lesser of the amount initially billed by the

1 provider or the qualifying payment amount.

2 "Stabilize" means "stabilization" as defined in Section 10
3 of the Managed Care Reform and Patient Rights Act.

4 "Treating provider" means a health care provider who has
5 evaluated the individual.

6 "Treatment" means, with respect to the provision of ground
7 ambulance service, the provision of (i) an assessment and (ii)
8 either a therapy or therapeutic agent used to treat a medical
9 condition or a procedure used to treat a medical condition.

10 "Urgent ground ambulance service" means ground ambulance
11 service that is deemed medically necessary by a health care
12 professional and is required within 12 hours after the
13 certification of the need for the service.

14 "Visit" means, with respect to health care services
15 furnished to an individual at a health care facility, health
16 care services furnished by a provider at the facility, as well
17 as equipment, devices, telehealth services, imaging services,
18 laboratory services, and preoperative and postoperative
19 services regardless of whether the provider furnishing such
20 services is at the facility.

21 (b) Emergency services. When a beneficiary, insured, or
22 enrollee receives emergency services from a nonparticipating
23 provider or a nonparticipating emergency facility, the health
24 insurance issuer shall ensure that the beneficiary, insured,
25 or enrollee shall incur no greater out-of-pocket costs than
26 the beneficiary, insured, or enrollee would have incurred with

1 a participating provider or a participating emergency
2 facility. Any cost-sharing requirements shall be applied as
3 though the emergency services had been received from a
4 participating provider or a participating facility. Cost
5 sharing shall be calculated based on the recognized amount for
6 the emergency services. If the cost sharing for the same item
7 or service furnished by a participating provider would have
8 been a flat-dollar copayment, that amount shall be the
9 cost-sharing amount unless the provider has billed a lesser
10 total amount. In no event shall the beneficiary, insured,
11 enrollee, or any group policyholder or plan sponsor be liable
12 to or billed by the health insurance issuer, the
13 nonparticipating provider, or the nonparticipating emergency
14 facility for any amount beyond the cost sharing calculated in
15 accordance with this subsection with respect to the emergency
16 services delivered. Administrative requirements or limitations
17 shall be no greater than those applicable to emergency
18 services received from a participating provider or a
19 participating emergency facility.

20 (b-5) Non-emergency services at participating health care
21 facilities.

22 (1) When a beneficiary, insured, or enrollee utilizes
23 a participating health care facility and, due to any
24 reason, covered ancillary services are provided by a
25 nonparticipating provider during or resulting from the
26 visit, the health insurance issuer shall ensure that the

beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider for the ancillary services. Any cost-sharing requirements shall be applied as though the ancillary services had been received from a participating provider. Cost sharing shall be calculated based on the recognized amount for the ancillary services. If the cost sharing for the same item or service furnished by a participating provider would have been a flat-dollar copayment, that amount shall be the cost-sharing amount unless the provider has billed a lesser total amount. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the ancillary services delivered. In addition to ancillary services, the requirements of this paragraph shall also apply with respect to covered items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria under paragraph (2) of this subsection.

(2) When a beneficiary, insured, or enrollee utilizes

1 a participating health care facility and receives
2 non-emergency covered health care services other than
3 those described in paragraph (1) of this subsection from a
4 nonparticipating provider during or resulting from the
5 visit, the health insurance issuer shall ensure that the
6 beneficiary, insured, or enrollee incurs no greater
7 out-of-pocket costs than the beneficiary, insured, or
8 enrollee would have incurred with a participating provider
9 unless the nonparticipating provider or the participating
10 health care facility on behalf of the nonparticipating
11 provider satisfies the notice and consent criteria
12 provided in 42 U.S.C. 300gg-132 and regulations
13 promulgated thereunder. If the notice and consent criteria
14 are not satisfied, then:

15 (A) any cost-sharing requirements shall be applied
16 as though the health care services had been received
17 from a participating provider;

18 (B) cost sharing shall be calculated based on the
19 recognized amount for the health care services; and

20 (C) in no event shall the beneficiary, insured,
21 enrollee, or any group policyholder or plan sponsor be
22 liable to or billed by the health insurance issuer,
23 the nonparticipating provider, or the participating
24 health care facility for any amount beyond the cost
25 sharing calculated in accordance with this subsection
26 with respect to the health care services delivered.

1 (b-10) Payments to nonparticipating ground ambulance
2 service providers for dates of service on or after January 1,
3 2026.

4 (1) As used in this subsection, "occurrence" means a
5 base charge and, if applicable, a loaded mileage charge.

6 (2) Notwithstanding any other provision of this
7 Section, when a beneficiary, insured, or enrollee receives
8 ground ambulance services from a nonparticipating ground
9 ambulance service provider, the health insurance issuer
10 shall ensure that the beneficiary, insured, or enrollee
11 shall incur no greater out-of-pocket costs than the
12 beneficiary, insured, or enrollee would have incurred with
13 a participating ground ambulance service provider. Any
14 cost-sharing requirements shall be applied as though the
15 services provided by the nonparticipating ground ambulance
16 service provider had been provided by a participating
17 ground ambulance service provider.

18 (3) Health insurance issuers shall approve charges for
19 nonparticipating ground ambulance service providers at a
20 recognized amount that shall be calculated as the lesser
21 of: (i) the nonparticipating ground ambulance service
22 provider's billed charge; (ii) the negotiated rate between
23 the nonparticipating ground ambulance service provider and
24 the health insurance insurer; or (iii) the rate the ground
25 ambulance service provider has filed for the date of
26 service in question with the Department of Insurance as

1 specified in (b-15).

2 (4) Payment for ground ambulance services shall be
3 made on a per occurrence basis and shall be paid directly
4 to the nonparticipating ground ambulance service provider.

5 (5) Except as otherwise provided by State or federal
6 law, the cost-sharing amount for any occurrence of a
7 ground ambulance service provided to a beneficiary,
8 insured, or enrollee shall not exceed the lesser of the
9 plan's emergency room visit copay or 10% of the recognized
10 amount for the occurrence.

11 (6) If a health insurance issuer has calculated the
12 allowable amount for services provided by a ground
13 ambulance service provider in compliance with this
14 subsection, by accepting payment from the health insurance
15 issuer, the nonparticipating ground ambulance service
16 provider shall not seek any payment from the beneficiary,
17 insured, or enrollee for any amount which exceeds the
18 deductible, coinsurance, or copay for services provided to
19 the beneficiary, insured, or enrollee.

20 (b-15) Rates for services provided by nonparticipating
21 ground ambulance service providers. By no later than October
22 1, 2025, each ground ambulance service provider in Illinois
23 shall file with the Department of Insurance, in the form and
24 manner prescribed by the Department of Insurance, its rates
25 for the provision of ground ambulance services provided on
26 January 1, 2025 and its rates for ground ambulance services to

1 be provided during the calendar year beginning January 1,
2 2026. For calendar year 2026, the proposed rates may not
3 exceed the rates in place on January 1, 2025 by more than the
4 annual unadjusted percentage increase in the consumer price
5 index-u for the 12 months ending with the immediately
6 preceding June plus 10%. As used in this subsection (b-15),
7 "consumer price index-u" means the index published by the
8 Bureau of Labor Statistics of the United States Department of
9 Labor that measures the average change in prices of goods and
10 services purchased by all urban consumers, United States city
11 average, all items, 1982-84 = 100. The filing required under
12 this subsection (b-15) shall include rates for each of the
13 following ground ambulance services, as applicable:

14 (1) basic life support, emergency base;

15 (2) basic life support, non-emergency base;

16 (3) advanced life support, non-emergency, level 1
17 base;

18 (4) advanced life support, emergency, level 1 base;

19 (5) advanced life support, level 2 base;

20 (6) specialty care transport base;

21 (7) evaluation without transport;

22 (8) treatment without transport;

23 (9) paramedic intercept; and

24 (10) ground mileage, per loaded mile.

25 If a ground ambulance service provider does not have a
26 rate in place for the provision of ground ambulance service

1 provided on January 1, 2025, for evaluation without transport,
2 treatment without transport, or paramedic intercept, the
3 ground ambulance service provider may stipulate a rate as
4 follows: (i) for evaluation without transport, 25% of the
5 ground ambulance service provider's basic life support,
6 emergency base; (ii) for treatment without transport, 50% of
7 the ground ambulance service provider's advanced life support,
8 emergency, level 1 base; (iii) for paramedic intercept, 75% of
9 the ground ambulance service provider's advanced life support,
10 level 1 base. If a ground ambulance service provider does not
11 have a rate in place for any other base rate or for ground
12 mileage, per loaded mile, the ground ambulance service
13 provider may request that the Department of Insurance
14 calculate such a rate. Upon receiving a request from a ground
15 ambulance service provider to calculate a rate, the Department
16 of Insurance shall calculate a rate using the unweighted
17 average of the applicable rates provided by all of the ground
18 ambulance service providers within the Medicare locality of
19 the ground ambulance service provider's registered office. If
20 a ground ambulance service provider begins providing ground
21 ambulance services after January 1, 2025, the Department of
22 Insurance shall calculate applicable rates for the ground
23 ambulance service provider, when requested by a ground
24 ambulance service provider, using the same methodology as for
25 calculating any other rate for a ground ambulance service
26 provider described in this subsection. Where a ground

1 ambulance service provider participates in the Ground
2 Emergency Transportation (GEMT) program administered by the
3 Department of Healthcare and Family Services, it may
4 substitute its basic life support, emergency base and advanced
5 life support, level 1 base, as calculated by the Department of
6 Healthcare and Family Services, for the calendar year in which
7 the rates were calculated, for its respective reported rate,
8 for January 1, 2026 or any subsequent year without regard to
9 any provision of this subsection that restricts the percentage
10 by which rates may increase on a year-over-year basis.

11 By October 1, 2026, and by October 1 of each year
12 thereafter, each ground ambulance service provider in Illinois
13 shall file with the Department of Insurance, in the form and
14 manner prescribed by the Department of Insurance, its rates
15 for the provision of ground ambulance services for the
16 following calendar year. For calendar year 2027 and each year
17 thereafter, the proposed rates may not exceed the rates in
18 place on January 1 of the immediately preceding year by more
19 than the annual unadjusted percentage increase in the consumer
20 price index-u for the 12 months ending with the immediately
21 preceding June plus 10%. As used in this subsection (b-15),
22 "consumer price index-u" means the index published by the
23 Bureau of Labor Statistics of the United States Department of
24 Labor that measures the average change in prices of goods and
25 services purchased by all urban consumers, United States city
26 average, all items, 1982-84 = 100.

1 (c) Notwithstanding any other provision of this Code,
2 except when the notice and consent criteria are satisfied for
3 the situation in paragraph (2) of subsection (b-5), any
4 benefits a beneficiary, insured, or enrollee receives for
5 services under the situations in subsection (b), ~~or (b-5)~~,
6 (b-10), or (b-15) are assigned to the nonparticipating
7 providers, nonparticipating ground ambulance service provider,
8 or the facility acting on their behalf. Upon receipt of the
9 provider's bill or facility's bill, the health insurance
10 issuer shall provide the nonparticipating provider,
11 nonparticipating ground ambulance service provider, or the
12 facility with a written explanation of benefits that specifies
13 the proposed reimbursement and the applicable deductible,
14 copayment, or coinsurance amounts owed by the insured,
15 beneficiary, or enrollee. The health insurance issuer shall
16 pay any reimbursement subject to this Section directly to the
17 nonparticipating provider, nonparticipating ground ambulance
18 service provider, or the facility.

19 (d) For bills assigned under subsection (c), the
20 nonparticipating provider or the facility may bill the health
21 insurance issuer for the services rendered, and the health
22 insurance issuer may pay the billed amount or attempt to
23 negotiate reimbursement with the nonparticipating provider or
24 the facility. Within 30 calendar days after the provider or
25 facility transmits the bill to the health insurance issuer,
26 the issuer shall send an initial payment or notice of denial of

1 payment with the written explanation of benefits to the
2 provider or facility. If attempts to negotiate reimbursement
3 for services provided by a nonparticipating provider do not
4 result in a resolution of the payment dispute within 30 days
5 after receipt of written explanation of benefits by the health
6 insurance issuer, then the health insurance issuer or
7 nonparticipating provider or the facility may initiate binding
8 arbitration to determine payment for services provided on a
9 per-bill or batched-bill basis, in accordance with Section
10 300gg-111 of the Public Health Service Act and the regulations
11 promulgated thereunder. The party requesting arbitration shall
12 notify the other party arbitration has been initiated and
13 state its final offer before arbitration. In response to this
14 notice, the nonrequesting party shall inform the requesting
15 party of its final offer before the arbitration occurs.
16 Arbitration shall be initiated by filing a request with the
17 Department of Insurance.

18 (e) The Department of Insurance shall publish a list of
19 approved arbitrators or entities that shall provide binding
20 arbitration. These arbitrators shall be American Arbitration
21 Association or American Health Lawyers Association trained
22 arbitrators. Both parties must agree on an arbitrator from the
23 Department of Insurance's or its approved entity's list of
24 arbitrators. If no agreement can be reached, then a list of 5
25 arbitrators shall be provided by the Department of Insurance
26 or the approved entity. From the list of 5 arbitrators, the

1 health insurance issuer can veto 2 arbitrators and the
2 provider or facility can veto 2 arbitrators. The remaining
3 arbitrator shall be the chosen arbitrator. This arbitration
4 shall consist of a review of the written submissions by both
5 parties. The arbitrator shall not establish a rebuttable
6 presumption that the qualifying payment amount should be the
7 total amount owed to the provider or facility by the
8 combination of the issuer and the insured, beneficiary, or
9 enrollee. Binding arbitration shall provide for a written
10 decision within 45 days after the request is filed with the
11 Department of Insurance. Both parties shall be bound by the
12 arbitrator's decision. The arbitrator's expenses and fees,
13 together with other expenses, not including attorney's fees,
14 incurred in the conduct of the arbitration, shall be paid as
15 provided in the decision.

16 (f) (Blank).

17 (g) Section 368a of this Act shall not apply during the
18 pendency of a decision under subsection (d). Upon the issuance
19 of the arbitrator's decision, Section 368a applies with
20 respect to the amount, if any, by which the arbitrator's
21 determination exceeds the issuer's initial payment under
22 subsection (c), or the entire amount of the arbitrator's
23 determination if initial payment was denied. Any interest
24 required to be paid to a provider under Section 368a shall not
25 accrue until after 30 days of an arbitrator's decision as
26 provided in subsection (d), but in no circumstances longer

1 than 150 days from the date the nonparticipating
2 facility-based provider billed for services rendered.

3 (h) Nothing in this Section shall be interpreted to change
4 the prudent layperson provisions with respect to emergency
5 services under the Managed Care Reform and Patient Rights Act.

6 (i) Nothing in this Section shall preclude a health care
7 provider from billing a beneficiary, insured, or enrollee for
8 reasonable administrative fees, such as service fees for
9 checks returned for nonsufficient funds and missed
10 appointments.

11 (j) Nothing in this Section shall preclude a beneficiary,
12 insured, or enrollee from assigning benefits to a
13 nonparticipating provider when the notice and consent criteria
14 are satisfied under paragraph (2) of subsection (b-5) or in
15 any other situation not described in subsection (b) or (b-5).

16 (k) Except when the notice and consent criteria are
17 satisfied under paragraph (2) of subsection (b-5), if an
18 individual receives health care services under the situations
19 described in subsection (b) or (b-5), no referral requirement
20 or any other provision contained in the policy or certificate
21 of coverage shall deny coverage, reduce benefits, or otherwise
22 defeat the requirements of this Section for services that
23 would have been covered with a participating provider.
24 However, this subsection shall not be construed to preclude a
25 provider contract with a health insurance issuer, or with an
26 administrator or similar entity acting on the issuer's behalf,

1 from imposing requirements on the participating provider,
2 participating emergency facility, or participating health care
3 facility relating to the referral of covered individuals to
4 nonparticipating providers.

5 (l) Except if the notice and consent criteria are
6 satisfied under paragraph (2) of subsection (b-5),
7 cost-sharing amounts calculated in conformity with this
8 Section shall count toward any deductible or out-of-pocket
9 maximum applicable to in-network coverage.

10 (m) The Department has the authority to enforce the
11 requirements of this Section in the situations described in
12 subsections (b) and (b-5), and in any other situation for
13 which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and
14 regulations promulgated thereunder would prohibit an
15 individual from being billed or liable for emergency services
16 furnished by a nonparticipating provider or nonparticipating
17 emergency facility or for non-emergency health care services
18 furnished by a nonparticipating provider at a participating
19 health care facility.

20 (n) This Section does not apply with respect to air
21 ambulance ~~or ground ambulance services~~. This Section does not
22 apply to any policy of excepted benefits or to short-term,
23 limited-duration health insurance coverage.

24 (o) A home rule unit may not regulate payments for ground
25 ambulance service in a manner inconsistent with this Section.
26 This subsection is a limitation under subsection (i) of

1 Section 6 of Article VII of the Illinois Constitution on the
2 concurrent exercise by home rule units of powers and functions
3 exercised by the State.

4 (Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23;
5 103-440, eff. 1-1-24.)

6 (215 ILCS 5/356z.80 new)

7 Sec. 356z.80. Coverage for ground ambulance services. Any
8 group or individual policy of accident and health insurance or
9 managed care plan amended, delivered, issued, or renewed on or
10 after January 1, 2027 shall provide coverage for ground
11 ambulance service.

12 Section 30. The Health Maintenance Organization Act is
13 amended by changing Sections 4-15 and 5-3 as follows:

14 (215 ILCS 125/4-15) (from Ch. 111 1/2, par. 1409.8)

15 Sec. 4-15. (a) No contract or evidence of coverage for
16 basic health care services delivered, issued for delivery,
17 renewed or amended by a Health Maintenance Organization shall
18 exclude coverage for ground ambulance service as defined in
19 Section 356z.3a of the Illinois Insurance Code ~~emergency~~
20 ~~transportation by ambulance. For the purposes of this Section,~~
21 ~~the term "emergency" means a need for immediate medical~~
22 ~~attention resulting from a life threatening condition or~~
23 ~~situation or a need for immediate medical attention as~~

1 ~~otherwise reasonably determined by a physician, public safety~~
2 ~~official or other emergency medical personnel.~~

3 (b) Payments to nonparticipating ground ambulance service
4 providers shall be as described in subsections (b-10) and
5 (b-15) of Section 356z.3a of the Illinois Insurance Code ~~Upon~~
6 ~~reasonable demand by a provider of emergency transportation by~~
7 ~~ambulance, a Health Maintenance Organization shall promptly~~
8 ~~pay to the provider, subject to coverage limitations stated in~~
9 ~~the contract or evidence of coverage, the charges for~~
10 ~~emergency transportation by ambulance provided to an enrollee~~
11 ~~in a health care plan arranged for by the Health Maintenance~~
12 ~~Organization. By accepting any such payment from the Health~~
13 ~~Maintenance Organization, the provider of emergency~~
14 ~~transportation by ambulance agrees not to seek any payment~~
15 ~~from the enrollee for services provided to the enrollee.~~

16 (Source: P.A. 86-833; 86-1028.)

17 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

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

19 Sec. 5-3. Insurance Code provisions.

20 (a) Health Maintenance Organizations shall be subject to
21 the provisions of Sections 133, 134, 136, 137, 139, 140,
22 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
23 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
24 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1,
25 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a,

1 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
2 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,
3 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25,
4 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33,
5 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40,
6 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47,
7 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55,
8 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62,
9 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69,
10 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.77,
11 356z.80, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,
12 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,
13 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
14 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
15 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
16 Illinois Insurance Code.

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

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

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

25 (3) a corporation organized under the laws of another
26 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 (c) In considering the merger, consolidation, or other
6 acquisition of control of a Health Maintenance Organization
7 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

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

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

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

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

25 (B) pro forma financial statements reflecting the
26 combined balance sheets of the acquiring company and

1 the Health Maintenance Organization sought to be
2 acquired as of the end of the preceding year and as of
3 a date 90 days prior to the acquisition, as well as pro
4 forma financial statements reflecting projected
5 combined operation for a period of 2 years;

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

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

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

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

1 agreement on competition.

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

9 (i) the amount of, and other terms and conditions with
10 respect to, the refund or additional premium are set forth
11 in the group or enrollment unit contract agreed in advance
12 of the period for which a refund is to be paid or
13 additional premium is to be charged (which period shall
14 not be less than one year); and

15 (ii) the amount of the refund or additional premium
16 shall not exceed 20% of the Health Maintenance
17 Organization's profitable or unprofitable experience with
18 respect to the group or other enrollment unit for the
19 period (and, for purposes of a refund or additional
20 premium, the profitable or unprofitable experience shall
21 be calculated taking into account a pro rata share of the
22 Health Maintenance Organization's administrative and
23 marketing expenses, but shall not include any refund to be
24 made or additional premium to be paid pursuant to this
25 subsection (f)). The Health Maintenance Organization and
26 the group or enrollment unit may agree that the profitable

1 or unprofitable experience may be calculated taking into
2 account the refund period and the immediately preceding 2
3 plan years.

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

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

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

26 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;

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

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

16 Sec. 5-3. Insurance Code provisions.

17 (a) Health Maintenance Organizations shall be subject to
18 the provisions of Sections 133, 134, 136, 137, 139, 140,
19 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
20 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
21 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g,
22 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
23 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
24 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
25 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,

1 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
2 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
3 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
4 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
5 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
6 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
7 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
8 356z.77, 356z.80, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
9 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
10 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
11 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
12 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
13 Illinois Insurance Code.

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

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

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

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

1 1/2 of the Illinois Insurance Code.

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

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

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

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

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

22 (B) pro forma financial statements reflecting the
23 combined balance sheets of the acquiring company and
24 the Health Maintenance Organization sought to be
25 acquired as of the end of the preceding year and as of
26 a date 90 days prior to the acquisition, as well as pro

1 forma financial statements reflecting projected
2 combined operation for a period of 2 years;

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

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

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

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

25 (f) Except for small employer groups as defined in the
26 Small Employer Rating, Renewability and Portability Health

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a
3 Health Maintenance Organization may by contract agree with a
4 group or other enrollment unit to effect refunds or charge
5 additional premiums under the following terms and conditions:

6 (i) the amount of, and other terms and conditions with
7 respect to, the refund or additional premium are set forth
8 in the group or enrollment unit contract agreed in advance
9 of the period for which a refund is to be paid or
10 additional premium is to be charged (which period shall
11 not be less than one year); and

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

1 The Health Maintenance Organization shall include a
2 statement in the evidence of coverage issued to each enrollee
3 describing the possibility of a refund or additional premium,
4 and upon request of any group or enrollment unit, provide to
5 the group or enrollment unit a description of the method used
6 to calculate (1) the Health Maintenance Organization's
7 profitable experience with respect to the group or enrollment
8 unit and the resulting refund to the group or enrollment unit
9 or (2) the Health Maintenance Organization's unprofitable
10 experience with respect to the group or enrollment unit and
11 the resulting additional premium to be paid by the group or
12 enrollment unit.

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

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
25 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
26 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;

1 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
2 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
3 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
4 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
5 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
6 eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24;
7 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff.
8 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,
9 eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25;
10 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff.
11 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised
12 11-26-24.)

13 Section 35. The Limited Health Service Organization Act is
14 amended by changing Section 4003 as follows:

15 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

16 Sec. 4003. Illinois Insurance Code provisions. Limited
17 health service organizations shall be subject to the
18 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
19 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153,
20 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 352c,
21 355.2, 355.3, 355b, 355d, 356m, 356q, 356v, 356z.4, 356z.4a,
22 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.32,
23 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54,
24 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 356z.71,

1 356z.73, 356z.74, 356z.75, 356z.80, 364.3, 368a, 401, 401.1,
2 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and
3 Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and
4 XXVI of the Illinois Insurance Code. Nothing in this Section
5 shall require a limited health care plan to cover any service
6 that is not a limited health service. For purposes of the
7 Illinois Insurance Code, except for Sections 444 and 444.1 and
8 Articles XIII and XIII 1/2, limited health service
9 organizations in the following categories are deemed to be
10 domestic companies:

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

12 (2) 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 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
19 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.
20 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,
21 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
22 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
23 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
24 eff. 1-1-24; 103-605, eff. 7-1-24; 103-649, eff. 1-1-25;
25 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff.
26 7-19-24; 103-751, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832,

1 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

2 Section 40. The Voluntary Health Services Plans Act is
3 amended by changing Section 10 as follows:

4 (215 ILCS 165/10) (from Ch. 32, par. 604)

5 Sec. 10. Application of Insurance Code provisions. Health
6 services plan corporations and all persons interested therein
7 or dealing therewith shall be subject to the provisions of
8 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
9 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3,
10 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r, 356t,
11 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 356z.2,
12 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
13 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18,
14 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
15 356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46,
16 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59,
17 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71,
18 356z.72, 356z.74, 356z.75, 356z.77, 356z.80, 364.01, 364.3,
19 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
20 and paragraphs (7) and (15) of Section 367 of the Illinois
21 Insurance Code.

22 Rulemaking authority to implement Public Act 95-1045, if
23 any, is conditioned on the rules being adopted in accordance
24 with all provisions of the Illinois Administrative Procedure

1 Act and all rules and procedures of the Joint Committee on
2 Administrative Rules; any purported rule not so adopted, for
3 whatever reason, is unauthorized.

4 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;
5 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.
6 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,
7 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;
8 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.
9 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,
10 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
11 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, eff.
12 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753,
13 eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25;
14 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff.
15 1-1-25; revised 11-26-24.)

16 Section 45. The Illinois Public Aid Code is amended by
17 changing Section 5-16.8 as follows:

18 (305 ILCS 5/5-16.8)

19 Sec. 5-16.8. Required health benefits. The medical
20 assistance program shall (i) provide the post-mastectomy care
21 benefits required to be covered by a policy of accident and
22 health insurance under Section 356t and the coverage required
23 under Sections 356g.5, 356q, 356u, 356w, 356x, 356z.6,
24 356z.26, 356z.29, 356z.32, 356z.33, 356z.34, 356z.35, 356z.46,

1 356z.47, 356z.51, 356z.53, 356z.59, 356z.60, 356z.61, 356z.64,
2 ~~and 356z.67, and 356z.71~~, 356z.75, and 356z.80 of the Illinois
3 Insurance Code, (ii) be subject to the provisions of Sections
4 356z.19, 356z.44, 356z.49, 364.01, 370c, and 370c.1 of the
5 Illinois Insurance Code, and (iii) be subject to the
6 provisions of subsection (d-5) of Section 10 of the Network
7 Adequacy and Transparency Act.

8 The Department, by rule, shall adopt a model similar to
9 the requirements of Section 356z.39 of the Illinois Insurance
10 Code.

11 On and after July 1, 2012, the Department shall reduce any
12 rate of reimbursement for services or other payments or alter
13 any methodologies authorized by this Code to reduce any rate
14 of reimbursement for services or other payments in accordance
15 with Section 5-5e.

16 To ensure full access to the benefits set forth in this
17 Section, on and after January 1, 2016, the Department shall
18 ensure that provider and hospital reimbursement for
19 post-mastectomy care benefits required under this Section are
20 no lower than the Medicare reimbursement rate.

21 (Source: P.A. 102-30, eff. 1-1-22; 102-144, eff. 1-1-22;
22 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-530, eff.
23 1-1-22; 102-642, eff. 1-1-22; 102-804, eff. 1-1-23; 102-813,
24 eff. 5-13-22; 102-816, eff. 1-1-23; 102-1093, eff. 1-1-23;
25 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.
26 1-1-24; 103-420, eff. 1-1-24; 103-605, eff. 7-1-24; 103-703,

1 eff. 1-1-25; 103-758, eff. 1-1-25; 103-1024, eff. 1-1-25;
2 revised 11-26-24.)

3 Section 95. No acceleration or delay. Where this Act makes
4 changes in a statute that is represented in this Act by text
5 that is not yet or no longer in effect (for example, a Section
6 represented by multiple versions), the use of that text does
7 not accelerate or delay the taking effect of (i) the changes
8 made by this Act or (ii) provisions derived from any other
9 Public Act.

10 Section 99. Effective date. This Act takes effect upon
11 becoming law.".