Sen. Ram Villivalam

Filed: 5/9/2025

AMENDMENT TO SENATE BILL 2405

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

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

(5 ILCS 375/6.11)

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

356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, 356z.76, 356z.77, and 356z.80 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Section 356m of the Illinois Insurance Code and, for the employees of the State Employee Group Insurance Program only, the coverage as also provided in Section 6.11B of this Act. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

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

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

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

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

(55 ILCS 5/5-1069.3)

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

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

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

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

revised 11-26-24.)

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

(65 ILCS 5/10-4-2.3)

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

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

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

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

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

(105 ILCS 5/10-22.3f)

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

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

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

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

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

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

(215 ILCS 5/356z.3a)

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

(a) As used in this Section:

"Ancillary services" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) a hospital as defined in 42 U.S.C. 1395x(e);

(2) a hospital outpatient department;

(3) a critical access hospital certified under 42 U.S.C. 1395i-4(e);

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

(5) any recipient of a license under the Hospital Licensing Act that is not otherwise described in this definition.

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

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

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

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

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

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

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

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

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

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

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

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

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

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

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

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

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

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

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

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

"Recognized amount" means<u>, except as otherwise provided in this Section,</u> the lesser of the amount initially billed by the

provider or the qualifying payment amount.

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

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

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

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

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

(b) Emergency services. When a beneficiary, insured, or enrollee receives emergency services from a nonparticipating provider or a nonparticipating emergency facility, 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 or a participating emergency facility. Any cost-sharing requirements shall be applied as though the emergency services had been received from a participating provider or a participating facility. Cost sharing shall be calculated based on the recognized amount for the emergency 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 nonparticipating emergency facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the emergency services delivered. Administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or a participating emergency facility.

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

(1) When a beneficiary, insured, or enrollee utilizes a participating health care facility and, due to any reason, covered ancillary services are provided by a nonparticipating provider during or resulting from the 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

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

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

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

(C) 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 health care services delivered.

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

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

(2) Notwithstanding any other provision of this Section, when a beneficiary, insured, or enrollee receives ground ambulance services from a nonparticipating ground ambulance service provider, 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 ground ambulance service provider. Any cost-sharing requirements shall be applied as though the services provided by the nonparticipating ground ambulance service provider had been provided by a participating ground ambulance service provider.

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

specified in (b-15).

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

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

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

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

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

(1) basic life support, emergency base;

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

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

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

(5) advanced life support, level 2 base;

(6) specialty care transport base;

(7) evaluation without transport;

(8) treatment without transport;

(9) paramedic intercept; and

(10) ground mileage, per loaded mile.

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

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

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

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

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

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

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

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

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

(f) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

(215 ILCS 5/356z.80 new)

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

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

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

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

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

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

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

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

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

Sec. 5-3. Insurance Code provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

agreement on competition.

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

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

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

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

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

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

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

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

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

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

Sec. 5-3. Insurance Code provisions.

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

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

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

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

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

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

1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5-16.8)

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

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

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

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

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

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

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

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

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