

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Sections 356z.3 and 356z.3a as follows:

6 (215 ILCS 5/356z.3)

7 Sec. 356z.3. Disclosure of limited benefit. An insurer
8 that issues, delivers, amends, or renews an individual or
9 group policy of accident and health insurance in this State
10 after the effective date of this amendatory Act of the 92nd
11 General Assembly and arranges, contracts with, or administers
12 contracts with a provider whereby beneficiaries are provided
13 an incentive to use the services of such provider must include
14 the following disclosure on its contracts and evidences of
15 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN
16 NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that
17 when you elect to utilize the services of a non-participating
18 provider for a covered service in non-emergency situations,
19 benefit payments to such non-participating provider are not
20 based upon the amount billed. The basis of your benefit
21 payment will be determined according to your policy's fee
22 schedule, usual and customary charge (which is determined by
23 comparing charges for similar services adjusted to the

1 geographical area where the services are performed), or other
2 method as defined by the policy. YOU CAN EXPECT TO PAY MORE
3 THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE
4 PLAN HAS PAID ITS REQUIRED PORTION. Non-participating
5 providers may bill members for any amount up to the billed
6 charge after the plan has paid its portion of the bill, except
7 as provided in Section 356z.3a of the Illinois Insurance Code
8 for covered services received at a participating health care
9 facility from a nonparticipating provider that are: (a)
10 ancillary services, (b) items or services furnished as a
11 result of unforeseen, urgent medical needs that arise at the
12 time the item or service is furnished, or (c) items or services
13 received when the facility or the non-participating provider
14 fails to satisfy the notice and consent criteria specified
15 under Section 356z.3a. Participating providers have agreed to
16 accept discounted payments for services with no additional
17 billing to the member other than co-insurance and deductible
18 amounts. You may obtain further information about the
19 participating status of professional providers and information
20 on out-of-pocket expenses by calling the toll free telephone
21 number on your identification card."

22 (Source: P.A. 96-1523, eff. 6-1-11; 97-813, eff. 7-13-12.)

23 (215 ILCS 5/356z.3a)

24 Sec. 356z.3a. Billing; emergency services;
25 nonparticipating providers ~~Nonparticipating facility based~~

1 ~~physicians and providers.~~

2 (a) ~~As used in this Section: For purposes of this Section,~~
3 ~~"facility-based provider" means a physician or other provider~~
4 ~~who provide radiology, anesthesiology, pathology, neonatology,~~
5 ~~or emergency department services to insureds, beneficiaries,~~
6 ~~or enrollees in a participating hospital or participating~~
7 ~~ambulatory surgical treatment center.~~

8 "Ancillary services" means:

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

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

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

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

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

26 "Cost sharing" means the amount an insured, beneficiary,

1 or enrollee is responsible for paying for a covered item or
2 service under the terms of the policy or certificate. "Cost
3 sharing" includes copayments, coinsurance, and amounts paid
4 toward deductibles, but does not include amounts paid towards
5 premiums, balance billing by out-of-network providers, or the
6 cost of items or services that are not covered under the policy
7 or certificate.

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

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

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

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

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

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

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

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

- 19 (1) a hospital as defined in 42 U.S.C. 1395x(e);
20 (2) a hospital outpatient department;
21 (3) a critical access hospital certified under 42
22 U.S.C. 1395i-4(e);
23 (4) an ambulatory surgical treatment center as defined
24 in the Ambulatory Surgical Treatment Center Act; or
25 (5) any recipient of a license under the Hospital
26 Licensing Act that is not otherwise described in this

1 definition.

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

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

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

11 "Nonparticipating emergency facility" means, with respect
12 to the furnishing of an item or service under a policy of group
13 or individual health insurance coverage, any of the following
14 facilities that does not have a contractual relationship
15 directly or indirectly with a health insurance issuer in
16 relation to 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 "Nonparticipating provider" means, with respect to the
25 furnishing of an item or service under a policy of group or
26 individual health insurance coverage, any health care provider

1 who does not have a contractual relationship directly or
2 indirectly with a health insurance issuer in relation to the
3 coverage.

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

11 (1) an emergency department of a hospital;

12 (2) a Freestanding Emergency Center;

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

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

18 For purposes of this definition, a single case agreement
19 between an emergency facility and an issuer that is used to
20 address unique situations in which an insured, beneficiary, or
21 enrollee requires services that typically occur out-of-network
22 constitutes a contractual relationship and is limited to the
23 parties to the agreement.

24 "Participating health care facility" means any health care
25 facility that has a contractual relationship directly or
26 indirectly with a health insurance issuer offering group or

1 individual health insurance coverage setting forth the terms
2 and conditions on which a relevant health care service is
3 provided to an insured, beneficiary, or enrollee under the
4 coverage. A single case agreement between an emergency
5 facility and an issuer that is used to address unique
6 situations in which an insured, beneficiary, or enrollee
7 requires services that typically occur out-of-network
8 constitutes a contractual relationship for purposes of this
9 definition and is limited to the parties to the agreement.

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

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

19 "Recognized amount" means the lesser of the amount
20 initially billed by the provider or the qualifying payment
21 amount.

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

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

26 "Visit" means, with respect to health care services

1 furnished to an individual at a health care facility, health
2 care services furnished by a provider at the facility, as well
3 as equipment, devices, telehealth services, imaging services,
4 laboratory services, and preoperative and postoperative
5 services regardless of whether the provider furnishing such
6 services is at the facility.

7 (b) Emergency services. When a beneficiary, insured, or
8 enrollee receives emergency services from a nonparticipating
9 provider or a nonparticipating emergency facility, the health
10 insurance issuer shall ensure that the beneficiary, insured,
11 or enrollee shall incur no greater out-of-pocket costs than
12 the beneficiary, insured, or enrollee would have incurred with
13 a participating provider or a participating emergency
14 facility. Any cost-sharing requirements shall be applied as
15 though the emergency services had been received from a
16 participating provider or a participating facility. Cost
17 sharing shall be calculated based on the recognized amount for
18 the emergency services. If the cost sharing for the same item
19 or service furnished by a participating provider would have
20 been a flat-dollar copayment, that amount shall be the
21 cost-sharing amount unless the provider has billed a lesser
22 total amount. In no event shall the beneficiary, insured,
23 enrollee, or any group policyholder or plan sponsor be liable
24 to or billed by the health insurance issuer, the
25 nonparticipating provider, or the nonparticipating emergency
26 facility for any amount beyond the cost sharing calculated in

1 accordance with this subsection with respect to the emergency
2 services delivered. Administrative requirements or limitations
3 shall be no greater than those applicable to emergency
4 services received from a participating provider or a
5 participating emergency facility.

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

8 (1) When a beneficiary, insured, or enrollee utilizes
9 a participating health care facility ~~network hospital or a~~
10 ~~participating network ambulatory surgery center~~ and, due
11 to any reason, covered ancillary services ~~in network~~
12 ~~services for radiology, anesthesiology, pathology,~~
13 ~~emergency physician, or neonatology are unavailable and~~
14 are provided by a nonparticipating ~~facility-based~~
15 ~~physician or~~ provider during or resulting from the visit,
16 the health insurance issuer ~~insurer or health plan~~ shall
17 ensure that the beneficiary, insured, or enrollee shall
18 incur no greater out-of-pocket costs than the beneficiary,
19 insured, or enrollee would have incurred with a
20 participating ~~physician or~~ provider for the ancillary
21 ~~covered~~ services. Any cost-sharing requirements shall be
22 applied as though the ancillary services had been received
23 from a participating provider. Cost sharing shall be
24 calculated based on the recognized amount for the
25 ancillary services. If the cost sharing for the same item
26 or service furnished by a participating provider would

1 have been a flat-dollar copayment, that amount shall be
2 the cost-sharing amount unless the provider has billed a
3 lesser total amount. In no event shall the beneficiary,
4 insured, enrollee, or any group policyholder or plan
5 sponsor be liable to or billed by the health insurance
6 issuer, the nonparticipating provider, or the
7 participating health care facility for any amount beyond
8 the cost sharing calculated in accordance with this
9 subsection with respect to the ancillary services
10 delivered. In addition to ancillary services, the
11 requirements of this paragraph shall also apply with
12 respect to covered items or services furnished as a result
13 of unforeseen, urgent medical needs that arise at the time
14 an item or service is furnished, regardless of whether the
15 nonparticipating provider satisfied the notice and consent
16 criteria under paragraph (2) of this subsection.

17 (2) When a beneficiary, insured, or enrollee utilizes
18 a participating health care facility and receives
19 non-emergency covered health care services other than
20 those described in paragraph (1) of this subsection from a
21 nonparticipating provider during or resulting from the
22 visit, the health insurance issuer shall ensure that the
23 beneficiary, insured, or enrollee incurs no greater
24 out-of-pocket costs than the beneficiary, insured, or
25 enrollee would have incurred with a participating provider
26 unless the nonparticipating provider, or the participating

1 health care facility on behalf of the nonparticipating
2 provider, satisfies the notice and consent criteria
3 provided in 42 U.S.C. 300gg-132 and regulations
4 promulgated thereunder. If the notice and consent criteria
5 are not satisfied, then:

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

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

11 (C) in no event shall the beneficiary, insured,
12 enrollee, or any group policyholder or plan sponsor be
13 liable to or billed by the health insurance issuer,
14 the nonparticipating provider, or the participating
15 health care facility for any amount beyond the cost
16 sharing calculated in accordance with this subsection
17 with respect to the health care services delivered.

18 (c) Notwithstanding ~~If a beneficiary, insured, or enrollee~~
19 ~~agrees in writing, notwithstanding~~ any other provision of this
20 Code, except when the notice and consent criteria are
21 satisfied for the situation in paragraph (2) of subsection
22 (b-5), any benefits a beneficiary, insured, or enrollee
23 receives for services under the situations ~~situation~~ in
24 subsections ~~subsection~~ (b) or (b-5) are assigned to the
25 nonparticipating ~~facility-based~~ providers or the facility
26 acting on their behalf. Upon receipt of the provider's bill or

1 facility's bill, the health insurance issuer ~~The insurer or~~
2 ~~health plan~~ shall provide the nonparticipating provider or the
3 facility with a written explanation of benefits that specifies
4 the proposed reimbursement and the applicable deductible,
5 copayment or coinsurance amounts owed by the insured,
6 beneficiary or enrollee. The health insurance issuer ~~insurer~~
7 ~~or health plan~~ shall pay any reimbursement subject to this
8 Section directly to the nonparticipating ~~facility based~~
9 provider or the facility. ~~The nonparticipating facility based~~
10 ~~physician or provider shall not bill the beneficiary, insured,~~
11 ~~or enrollee, except for applicable deductible, copayment, or~~
12 ~~coinsurance amounts that would apply if the beneficiary,~~
13 ~~insured, or enrollee utilized a participating physician or~~
14 ~~provider for covered services. If a beneficiary, insured, or~~
15 ~~enrollee specifically rejects assignment under this Section in~~
16 ~~writing to the nonparticipating facility based provider, then~~
17 ~~the nonparticipating facility based provider may bill the~~
18 ~~beneficiary, insured, or enrollee for the services rendered.~~

19 (d) For bills assigned under subsection (c), the
20 nonparticipating ~~facility based~~ provider or the facility may
21 bill the health insurance issuer ~~insurer or health plan~~ for
22 the services rendered, and the health insurance issuer ~~insurer~~
23 ~~or health plan~~ may pay the billed amount or attempt to
24 negotiate reimbursement with the nonparticipating
25 ~~facility based~~ provider or the facility. Within 30 calendar
26 days after the provider or facility transmits the bill to the

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

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

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

17 (f) (Blank). ~~This Section 356z.3a does not apply to a~~
18 ~~beneficiary, insured, or enrollee who willfully chooses to~~
19 ~~access a nonparticipating facility based physician or provider~~
20 ~~for health care services available through the insurer's or~~
21 ~~plan's network of participating physicians and providers. In~~
22 ~~these circumstances, the contractual requirements for~~
23 ~~nonparticipating facility based provider reimbursements will~~
24 ~~apply.~~

25 (g) Section 368a of this Act shall not apply during the
26 pendency of a decision under subsection (d). Upon the issuance

1 of the arbitrator's decision, Section 368a applies with
2 respect to the amount, if any, by which the arbitrator's
3 determination exceeds the issuer's initial payment under
4 subsection (c), or the entire amount of the arbitrator's
5 determination if initial payment was denied. Any ~~any~~ interest
6 required to be paid a provider under Section 368a shall not
7 accrue until after 30 days of an arbitrator's decision as
8 provided in subsection (d), but in no circumstances longer
9 than 150 days from date the nonparticipating facility-based
10 provider billed for services rendered.

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

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

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

24 (k) Except when the notice and consent criteria are
25 satisfied under paragraph (2) of subsection (b-5), if an
26 individual receives health care services under the situations

1 described in subsections (b) or (b-5), no referral requirement
2 or any other provision contained in the policy or certificate
3 of coverage shall deny coverage, reduce benefits, or otherwise
4 defeat the requirements of this Section for services that
5 would have been covered with a participating provider.
6 However, this subsection shall not be construed to preclude a
7 provider contract with a health insurance issuer, or with an
8 administrator or similar entity acting on the issuer's behalf,
9 from imposing requirements on the participating provider,
10 participating emergency facility, or participating health care
11 facility relating to the referral of covered individuals to
12 nonparticipating providers.

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

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

1 health care facility.

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

6 (Source: P.A. 98-154, eff. 8-2-13.)

7 Section 10. The Network Adequacy and Transparency Act is
8 amended by changing Section 10 as follows:

9 (215 ILCS 124/10)

10 Sec. 10. Network adequacy.

11 (a) An insurer providing a network plan shall file a
12 description of all of the following with the Director:

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

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

20 (3) The written policies and procedures on how the
21 network plan will provide 24-hour, 7-day per week access
22 to network-affiliated primary care, emergency services,
23 and woman's principal health care providers.

24 An insurer shall not prohibit a preferred provider from

1 discussing any specific or all treatment options with
2 beneficiaries irrespective of the insurer's position on those
3 treatment options or from advocating on behalf of
4 beneficiaries within the utilization review, grievance, or
5 appeals processes established by the insurer in accordance
6 with any rights or remedies available under applicable State
7 or federal law.

8 (b) Insurers must file for review a description of the
9 services to be offered through a network plan. The description
10 shall include all of the following:

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

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

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

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

25 (5) A description of how health care services to be
26 rendered under the network plan are reasonably accessible

1 and available to beneficiaries. The description shall
2 address all of the following:

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

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

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

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

17 (6) A provision ensuring that whenever a beneficiary
18 has made a good faith effort, as evidenced by accessing
19 the provider directory, calling the network plan, and
20 calling the provider, to utilize preferred providers for a
21 covered service and it is determined the insurer does not
22 have the appropriate preferred providers due to
23 insufficient number, type, or unreasonable travel distance
24 or delay, the insurer shall ensure, directly or
25 indirectly, by terms contained in the payer contract, that
26 the beneficiary will be provided the covered service at no

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

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

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

3 (8) A limitation that, if the plan provides that the
4 beneficiary will incur a penalty for failing to
5 pre-certify inpatient hospital treatment, the penalty may
6 not exceed \$1,000 per occurrence in addition to the plan
7 cost sharing provisions.

8 (c) The network plan shall demonstrate to the Director a
9 minimum ratio of providers to plan beneficiaries as required
10 by the Department.

11 (1) The ratio of physicians or other providers to plan
12 beneficiaries shall be established annually by the
13 Department in consultation with the Department of Public
14 Health based upon the guidance from the federal Centers
15 for Medicare and Medicaid Services. The Department shall
16 not establish ratios for vision or dental providers who
17 provide services under dental-specific or vision-specific
18 benefits. The Department shall consider establishing
19 ratios for the following physicians or other providers:

20 (A) Primary Care;

21 (B) Pediatrics;

22 (C) Cardiology;

23 (D) Gastroenterology;

24 (E) General Surgery;

25 (F) Neurology;

26 (G) OB/GYN;

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

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

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

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

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

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

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

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

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

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

1 the protections of paragraph (3) of this subsection, a
2 network plan shall not be held responsible if the
3 beneficiary or provider voluntarily chooses to schedule an
4 appointment outside of these required time frames.

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

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

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

25 (f) The network plan may consider use of other health care
26 service delivery options, such as telemedicine or telehealth,

1 mobile clinics, and centers of excellence, or other ways of
2 delivering care to partially meet the requirements set under
3 this Section.

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

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

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

26 (3) other circumstances deemed appropriate by the

1 Department consistent with the requirements of this Act.

2 (h) Insurers are required to report to the Director any
3 material change to an approved network plan within 15 days
4 after the change occurs and any change that would result in
5 failure to meet the requirements of this Act. Upon notice from
6 the insurer, the Director shall reevaluate the network plan's
7 compliance with the network adequacy and transparency
8 standards of this Act.

9 (Source: P.A. 102-144, eff. 1-1-22.)

10 Section 15. The Health Maintenance Organization Act is
11 amended by changing Sections 4.5-1 and 5-3 as follows:

12 (215 ILCS 125/4.5-1)

13 Sec. 4.5-1. Point-of-service health service contracts.

14 (a) A health maintenance organization that offers a
15 point-of-service contract:

16 (1) must include as in-plan covered services all
17 services required by law to be provided by a health
18 maintenance organization;

19 (2) must provide incentives, which shall include
20 financial incentives, for enrollees to use in-plan covered
21 services;

22 (3) may not offer services out-of-plan without
23 providing those services on an in-plan basis;

24 (4) may include annual out-of-pocket limits and

1 lifetime maximum benefits allowances for out-of-plan
2 services that are separate from any limits or allowances
3 applied to in-plan services;

4 (5) may not consider emergency services, authorized
5 referral services, or non-routine services obtained out of
6 the service area to be point-of-service services;

7 (6) may treat as out-of-plan services those services
8 that an enrollee obtains from a participating provider,
9 but for which the proper authorization was not given by
10 the health maintenance organization; and

11 (7) after the effective date of this amendatory Act of
12 the 92nd General Assembly, must include the following
13 disclosure on its point-of-service contracts and evidences
14 of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN
15 NON-PARTICIPATING PROVIDERS ARE USED. You should be aware
16 that when you elect to utilize the services of a
17 non-participating provider for a covered service in
18 non-emergency situations, benefit payments to such
19 non-participating provider are not based upon the amount
20 billed. The basis of your benefit payment will be
21 determined according to your policy's fee schedule, usual
22 and customary charge (which is determined by comparing
23 charges for similar services adjusted to the geographical
24 area where the services are performed), or other method as
25 defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE
26 COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN

1 HAS PAID ITS REQUIRED PORTION. Non-participating providers
2 may bill members for any amount up to the billed charge
3 after the plan has paid its portion of the bill, except as
4 provided in Section 356z.3a of the Illinois Insurance Code
5 for covered services received at a participating health
6 care facility from a non-participating provider that are:
7 (a) ancillary services, (b) items or services furnished as
8 a result of unforeseen, urgent medical needs that arise at
9 the time the item or service is furnished, or (c) items or
10 services received when the facility or the
11 non-participating provider fails to satisfy the notice and
12 consent criteria specified under Section 356z.3a.
13 Participating providers have agreed to accept discounted
14 payments for services with no additional billing to the
15 member other than co-insurance and deductible amounts. You
16 may obtain further information about the participating
17 status of professional providers and information on
18 out-of-pocket expenses by calling the toll free telephone
19 number on your identification card."

20 (b) A health maintenance organization offering a
21 point-of-service contract is subject to all of the following
22 limitations:

23 (1) The health maintenance organization may not expend
24 in any calendar quarter more than 20% of its total
25 expenditures for all its members for out-of-plan covered
26 services.

1 (2) If the amount specified in item (1) of this
2 subsection is exceeded by 2% in a quarter, the health
3 maintenance organization must effect compliance with item
4 (1) of this subsection by the end of the following
5 quarter.

6 (3) If compliance with the amount specified in item
7 (1) of this subsection is not demonstrated in the health
8 maintenance organization's next quarterly report, the
9 health maintenance organization may not offer the
10 point-of-service contract to new groups or include the
11 point-of-service option in the renewal of an existing
12 group until compliance with the amount specified in item
13 (1) of this subsection is demonstrated or until otherwise
14 allowed by the Director.

15 (4) A health maintenance organization failing, without
16 just cause, to comply with the provisions of this
17 subsection shall be required, after notice and hearing, to
18 pay a penalty of \$250 for each day out of compliance, to be
19 recovered by the Director. Any penalty recovered shall be
20 paid into the General Revenue Fund. The Director may
21 reduce the penalty if the health maintenance organization
22 demonstrates to the Director that the imposition of the
23 penalty would constitute a financial hardship to the
24 health maintenance organization.

25 (c) A health maintenance organization that offers a
26 point-of-service product must do all of the following:

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

3 (2) Track out-of-plan, point-of-service utilization
4 separately from in-plan or non-point-of-service,
5 out-of-plan emergency care, referral care, and urgent care
6 out of the service area utilization.

7 (3) Record out-of-plan utilization in a manner that
8 will permit such utilization and cost reporting as the
9 Director may, by rule, require.

10 (4) Demonstrate to the Director's satisfaction that
11 the health maintenance organization has the fiscal,
12 administrative, and marketing capacity to control its
13 point-of-service enrollment, utilization, and costs so as
14 not to jeopardize the financial security of the health
15 maintenance organization.

16 (5) Maintain, in addition to any other deposit
17 required under this Act, the deposit required by Section
18 2-6.

19 (6) Maintain cash and cash equivalents of sufficient
20 amount to fully liquidate 10 days' average claim payments,
21 subject to review by the Director.

22 (7) Maintain and file with the Director, reinsurance
23 coverage protecting against catastrophic losses on out of
24 network point-of-service services. Deductibles may not
25 exceed \$100,000 per covered life per year, and the portion
26 of risk retained by the health maintenance organization

1 (3) Comply with the requirements of subsections (b)
2 and (c).

3 (Source: P.A. 92-135, eff. 1-1-02; 92-579, eff. 1-1-03.)

4 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

5 Sec. 5-3. Insurance Code provisions.

6 (a) Health Maintenance Organizations shall be subject to
7 the provisions of Sections 133, 134, 136, 137, 139, 140,
8 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
9 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2,
10 355.3, 355b, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356y,
11 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8,
12 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
13 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26,
14 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35,
15 356z.36, 356z.40, 356z.41, 356z.43, 356z.46, 356z.47, 356z.48,
16 356z.50, 356z.51, 364, 364.01, 367.2, 367.2-5, 367i, 368a,
17 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403,
18 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
19 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
20 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
21 Illinois Insurance Code.

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

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

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

5 (3) a corporation organized under the laws of another
6 state, 30% or more of the enrollees of which are residents
7 of this State, except a corporation subject to
8 substantially the same requirements in its state of
9 organization as is a "domestic company" under Article VIII
10 1/2 of the Illinois Insurance Code.

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

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

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

26 (3) the Director shall have the power to require the

1 following information:

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

5 (B) pro forma financial statements reflecting the
6 combined balance sheets of the acquiring company and
7 the Health Maintenance Organization sought to be
8 acquired as of the end of the preceding year and as of
9 a date 90 days prior to the acquisition, as well as pro
10 forma financial statements reflecting projected
11 combined operation for a period of 2 years;

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

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

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

24 (e) In considering any management contract or service
25 agreement subject to Section 141.1 of the Illinois Insurance
26 Code, the Director (i) shall, in addition to the criteria

1 specified in Section 141.2 of the Illinois Insurance Code,
2 take into account the effect of the management contract or
3 service agreement on the continuation of benefits to enrollees
4 and the financial condition of the health maintenance
5 organization to be managed or serviced, and (ii) need not take
6 into account the effect of the management contract or service
7 agreement on competition.

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

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

21 (ii) the amount of the refund or additional premium
22 shall not exceed 20% of the Health Maintenance
23 Organization's profitable or unprofitable experience with
24 respect to the group or other enrollment unit for the
25 period (and, for purposes of a refund or additional
26 premium, the profitable or unprofitable experience shall

1 be calculated taking into account a pro rata share of the
2 Health Maintenance Organization's administrative and
3 marketing expenses, but shall not include any refund to be
4 made or additional premium to be paid pursuant to this
5 subsection (f)). The Health Maintenance Organization and
6 the group or enrollment unit may agree that the profitable
7 or unprofitable experience may be calculated taking into
8 account the refund period and the immediately preceding 2
9 plan years.

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

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

26 (g) Rulemaking authority to implement Public Act 95-1045,

1 if any, is conditioned on the rules being adopted in
2 accordance with all provisions of the Illinois Administrative
3 Procedure Act and all rules and procedures of the Joint
4 Committee on Administrative Rules; any purported rule not so
5 adopted, for whatever reason, is unauthorized.

6 (Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19;
7 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff.
8 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625,
9 eff. 1-1-21; 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
10 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
11 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
12 eff. 10-8-21; revised 10-27-21.)

13 Section 20. The Managed Care Reform and Patient Rights Act
14 is amended by changing Section 70 as follows:

15 (215 ILCS 134/70)

16 Sec. 70. Post-stabilization medical services.

17 (a) If prior authorization for covered post-stabilization
18 services is required by the health care plan, the plan shall
19 provide access 24 hours a day, 7 days a week to persons
20 designated by the plan to make such determinations, provided
21 that any determination made under this Section must be made by
22 a health care professional. The review shall be resolved in
23 accordance with the provisions of Section 85 and the time
24 requirements of this Section.

1 (a-5) Prior authorization or approval by the plan shall
2 not be required for post-stabilization services that
3 constitute emergency services under Section 356z.3a of the
4 Illinois Insurance Code.

5 (b) The treating physician licensed to practice medicine
6 in all its branches or health care provider shall contact the
7 health care plan or delegated health care provider as
8 designated on the enrollee's health insurance card to obtain
9 authorization, denial, or arrangements for an alternate plan
10 of treatment or transfer of the enrollee.

11 (c) The treating physician licensed to practice medicine
12 in all its branches or health care provider shall document in
13 the enrollee's medical record the enrollee's presenting
14 symptoms; emergency medical condition; and time, phone number
15 dialed, and result of the communication for request for
16 authorization of post-stabilization medical services. The
17 health care plan shall provide reimbursement for covered
18 post-stabilization medical services if:

19 (1) authorization to render them is received from the
20 health care plan or its delegated health care provider, or

21 (2) after 2 documented good faith efforts, the
22 treating health care provider has attempted to contact the
23 enrollee's health care plan or its delegated health care
24 provider, as designated on the enrollee's health insurance
25 card, for prior authorization of post-stabilization
26 medical services and neither the plan nor designated

1 persons were accessible or the authorization was not
2 denied within 60 minutes of the request. "Two documented
3 good faith efforts" means the health care provider has
4 called the telephone number on the enrollee's health
5 insurance card or other available number either 2 times or
6 one time and an additional call to any referral number
7 provided. "Good faith" means honesty of purpose, freedom
8 from intention to defraud, and being faithful to one's
9 duty or obligation. For the purpose of this Act, good
10 faith shall be presumed.

11 (d) After rendering any post-stabilization medical
12 services, the treating physician licensed to practice medicine
13 in all its branches or health care provider shall continue to
14 make every reasonable effort to contact the health care plan
15 or its delegated health care provider regarding authorization,
16 denial, or arrangements for an alternate plan of treatment or
17 transfer of the enrollee until the treating health care
18 provider receives instructions from the health care plan or
19 delegated health care provider for continued care or the care
20 is transferred to another health care provider or the patient
21 is discharged.

22 (e) Payment for covered post-stabilization services may be
23 denied:

24 (1) if the treating health care provider does not meet
25 the conditions outlined in subsection (c);

26 (2) upon determination that the post-stabilization

1 services claimed were not performed;

2 (3) upon timely determination that the
3 post-stabilization services rendered were contrary to the
4 instructions of the health care plan or its delegated
5 health care provider if contact was made between those
6 parties prior to the service being rendered;

7 (4) upon determination that the patient receiving such
8 services was not an enrollee of the health care plan; or

9 (5) upon material misrepresentation by the enrollee or
10 health care provider; "material" means a fact or situation
11 that is not merely technical in nature and results or
12 could result in a substantial change in the situation.

13 (f) Nothing in this Section prohibits a health care plan
14 from delegating tasks associated with the responsibilities
15 enumerated in this Section to the health care plan's
16 contracted health care providers or another entity. Only a
17 clinical peer may make an adverse determination. However, the
18 ultimate responsibility for coverage and payment decisions may
19 not be delegated.

20 (g) Coverage and payment for post-stabilization medical
21 services for which prior authorization or deemed approval is
22 received shall not be retrospectively denied.

23 (h) Nothing in this Section shall prohibit the imposition
24 of deductibles, copayments, and co-insurance. Nothing in this
25 Section alters the prohibition on billing enrollees contained
26 in the Health Maintenance Organization Act.

1 (Source: P.A. 91-617, eff. 1-1-00.)

2 Section 25. 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, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b,
10 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w,
11 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5,
12 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
13 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25,
14 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33,
15 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, ~~356z.43~~, 364.01,
16 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
17 and paragraphs (7) and (15) of Section 367 of the Illinois
18 Insurance Code.

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

1 (Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19;
2 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff.
3 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306,
4 eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21;
5 revised 10-27-21.)

6 Section 99. Effective date. This Act takes effect July 1,
7 2022, except that the changes to Section 356z.3 of the
8 Illinois Insurance Code and Section 4.5-1 of the Health
9 Maintenance Organization Act take effect January 1, 2023.