AN ACT concerning regulation.

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

Section 5. The Illinois Pension Code is amended by changing Sections 1-110.6, 1-110.10, 1-110.15, 1-113.4, 1-113.4a, 1-113.5, 1-113.18, 2-162, 3-110, 4-108, 4-109.3, 18-169, and 22-1004 as follows:

(40 ILCS 5/1-110.6)

Sec. 1-110.6. Transactions prohibited by retirement systems; Republic of the Sudan.

(a) The Government of the United States has determined that Sudan is a nation that sponsors terrorism and genocide. The General Assembly finds that acts of terrorism have caused injury and death to Illinois and United States residents who serve in the United States military, and pose a significant threat to safety and health in Illinois. The General Assembly finds that public employees and their families, including police officers and firefighters, are more likely than others to be affected by acts of terrorism. The General Assembly finds that Sudan continues to solicit investment and commercial activities by forbidden entities, including private market funds. The General Assembly finds that investments in forbidden entities are inherently and unduly risky, not in the

interests of public pensioners and Illinois taxpayers, and against public policy. The General Assembly finds that Sudan's capacity to sponsor terrorism and genocide depends on or is supported by the activities of forbidden entities. The General Assembly further finds and re-affirms that the people of the State, acting through their representatives, do not want to be associated with forbidden entities, genocide, and terrorism.

(b) For purposes of this Section:

"Business operations" means maintaining, selling, or leasing equipment, facilities, personnel, or any other apparatus of business or commerce in the Republic of the Sudan, including the ownership or possession of real or personal property located in the Republic of the Sudan.

"Certifying company" means a company that (1) directly provides asset management services or advice to a retirement system or (2) as directly authorized or requested by a retirement system (A) identifies particular investment options for consideration or approval; (B) chooses particular investment options; or (C) allocates particular amounts to be invested. If no company meets the criteria set forth in this paragraph, then "certifying company" shall mean the retirement system officer who, as designated by the board, executes the investment decisions made by the board, or, in the alternative, the company that the board authorizes to complete the certification as the agent of that officer.

"Company" is any entity capable of affecting commerce,

including but not limited to (i) a government, government agency, natural person, legal person, sole proprietorship, partnership, firm, corporation, subsidiary, affiliate, franchisor, franchisee, joint venture, trade association, financial institution, utility, public franchise, provider of financial services, trust, or enterprise; and (ii) any association thereof.

"Division ~~Department~~" means the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~.

"Forbidden entity" means any of the following:

(1) The government of the Republic of the Sudan and any of its agencies, including but not limited to political units and subdivisions;

(2) Any company that is wholly or partially managed or controlled by the government of the Republic of the Sudan and any of its agencies, including but not limited to political units and subdivisions;

(3) Any company (i) that is established or organized under the laws of the Republic of the Sudan or (ii) whose principal place of business is in the Republic of the Sudan;

(4) Any company (i) identified by the Office of Foreign Assets Control in the United States Department of the Treasury as sponsoring terrorist activities in the Republic of the Sudan; or (ii) fined, penalized, or

sanctioned by the Office of Foreign Assets Control in the United States Department of the Treasury for any violation of any United States rules and restrictions relating to the Republic of the Sudan that occurred at any time following the effective date of this Act;

(5) Any publicly traded company that is individually identified by an independent researching firm that specializes in global security risk and that has been retained by a certifying company as provided in subsection (c) of this Section as being a company that owns or controls property or assets located in, has employees or facilities located in, provides goods or services to, obtains goods or services from, has distribution agreements with, issues credits or loans to, purchases bonds or commercial paper issued by, or invests in (A) the Republic of the Sudan; or (B) any company domiciled in the Republic of the Sudan; and

(6) Any private market fund that fails to satisfy the requirements set forth in subsections (d) and (e) of this Section.

Notwithstanding the foregoing, the term "forbidden entity" shall exclude (A) mutual funds that meet the requirements of item (iii) of paragraph (13) of Section 1-113.2 and (B) companies that transact business in the Republic of the Sudan under the law, license, or permit of the United States, including a license from the United States Department of the

Treasury, and companies, except agencies of the Republic of the Sudan, who are certified as Non-Government Organizations by the United Nations, or who engage solely in (i) the provision of goods and services intended to relieve human suffering or to promote welfare, health, religious and spiritual activities, and education or humanitarian purposes; or (ii) journalistic activities.

"Private market fund" means any private equity fund, private equity fund of funds, venture capital fund, hedge fund, hedge fund of funds, real estate fund, or other investment vehicle that is not publicly traded.

"Republic of the Sudan" means those geographic areas of the Republic of Sudan that are subject to sanction or other restrictions placed on commercial activity imposed by the United States Government due to an executive or congressional declaration of genocide.

"Retirement system" means the State Employees' Retirement System of Illinois, the Judges Retirement System of Illinois, the General Assembly Retirement System, the State Universities Retirement System, and the Teachers' Retirement System of the State of Illinois.

(c) A retirement system shall not transfer or disburse funds to, deposit into, acquire any bonds or commercial paper from, or otherwise loan to or invest in any entity unless, as provided in this Section, a certifying company certifies to the retirement system that, (1) with respect to investments in

a publicly traded company, the certifying company has relied on information provided by an independent researching firm that specializes in global security risk and (2) 100% of the retirement system's assets for which the certifying company provides services or advice are not and have not been invested or reinvested in any forbidden entity at any time after 4 months after the effective date of this Section.

The certifying company shall make the certification required under this subsection (c) to a retirement system 6 months after the effective date of this Section and annually thereafter. A retirement system shall submit the certifications to the Division ~~Department~~, and the Division ~~Department~~ shall notify the Director of Insurance ~~Secretary of Financial and Professional Regulation~~ if a retirement system fails to do so.

(d) With respect to a commitment or investment made pursuant to a written agreement executed prior to the effective date of this Section, each private market fund shall submit to the appropriate certifying company, at no additional cost to the retirement system:

(1) an affidavit sworn under oath in which an expressly authorized officer of the private market fund avers that the private market fund (A) does not own or control any property or asset located in the Republic of the Sudan and (B) does not conduct business operations in the Republic of the Sudan; or

(2) a certificate in which an expressly authorized officer of the private market fund certifies that the private market fund, based on reasonable due diligence, has determined that, other than direct or indirect investments in companies certified as Non-Government Organizations by the United Nations, the private market fund has no direct or indirect investment in any company (A) organized under the laws of the Republic of the Sudan; (B) whose principal place of business is in the Republic of the Sudan; or (C) that conducts business operations in the Republic of the Sudan. Such certificate shall be based upon the periodic reports received by the private market fund, and the private market fund shall agree that the certifying company, directly or through an agent, or the retirement system, as the case may be, may from time to time review the private market fund's certification process.

(e) With respect to a commitment or investment made pursuant to a written agreement executed after the effective date of this Section, each private market fund shall, at no additional cost to the retirement system:

(1) submit to the appropriate certifying company an affidavit or certificate consistent with the requirements pursuant to subsection (d) of this Section; or

(2) enter into an enforceable written agreement with the retirement system that provides for remedies

consistent with those set forth in subsection (g) of this Section if any of the assets of the retirement system shall be transferred, loaned, or otherwise invested in any company that directly or indirectly (A) has facilities or employees in the Republic of the Sudan or (B) conducts business operations in the Republic of the Sudan.

(f) In addition to any other penalties and remedies available under the law of Illinois and the United States, any transaction, other than a transaction with a private market fund that is governed by subsections (g) and (h) of this Section, that violates the provisions of this Act shall be against public policy and voidable, at the sole discretion of the retirement system.

(g) If a private market fund fails to provide the affidavit or certification required in subsections (d) and (e) of this Section, then the retirement system shall, within 90 days, divest, or attempt in good faith to divest, the retirement system's interest in the private market fund, provided that the Board of the retirement system confirms through resolution that the divestment does not have a material and adverse impact on the retirement system. The retirement system shall immediately notify the Division ~~Department~~, and the Division ~~Department~~ shall notify all other retirement systems, as soon as practicable, by posting the name of the private market fund on the Division's ~~Department's~~ Internet website or through e-mail communications. No other

retirement system may enter into any agreement under which the retirement system directly or indirectly invests in the private market fund unless the private market fund provides that retirement system with the affidavit or certification required in subsections (d) and (e) of this Section and complies with all other provisions of this Section.

(h) If a private market fund fails to fulfill its obligations under any agreement provided for in paragraph (2) of subsection (e) of this Section, the retirement system shall immediately take legal and other action to obtain satisfaction through all remedies and penalties available under the law and the agreement itself. The retirement system shall immediately notify the Division ~~Department~~, and the Division ~~Department~~ shall notify all other retirement systems, as soon as practicable, by posting the name of the private market fund on the Division's ~~Department's~~ Internet website or through e-mail communications, and no other retirement system may enter into any agreement under which the retirement system directly or indirectly invests in the private market fund.

(i) This Section shall have full force and effect during any period in which the Republic of the Sudan, or the officials of the government of that Republic, are subject to sanctions authorized under any statute or executive order of the United States or until such time as the State Department of the United States confirms in the federal register or through other means that the Republic of the Sudan is no longer subject to

sanctions by the government of the United States.

(j) If any provision of this Section or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Section that can be given effect without the invalid provision or application.

(Source: P.A. 95-521, eff. 8-28-07.)

(40 ILCS 5/1-110.10)

Sec. 1-110.10. Servicer certification.

(a) For the purposes of this Section:

"Illinois finance entity" means any entity chartered under the Illinois Banking Act, the Savings Bank Act, the Illinois Credit Union Act, or the Illinois Savings and Loan Act of 1985 and any person or entity licensed under the Residential Mortgage License Act of 1987, the Consumer Installment Loan Act, or the Sales Finance Agency Act.

"Retirement system or pension fund" means a retirement system or pension fund established under this Code.

(b) In order for an Illinois finance entity to be eligible for investment or deposit of retirement system or pension fund assets, the Illinois finance entity must annually certify that it complies with the requirements of the High Risk Home Loan Act and the rules adopted pursuant to that Act that are applicable to that Illinois finance entity. For Illinois finance entities with whom the retirement system or pension

fund is investing or depositing assets on the effective date of this Section, the initial certification required under this Section shall be completed within 6 months after the effective date of this Section. For Illinois finance entities with whom the retirement system or pension fund is not investing or depositing assets on the effective date of this Section, the initial certification required under this Section must be completed before the retirement system or pension fund may invest or deposit assets with the Illinois finance entity.

(c) A retirement system or pension fund shall submit the certifications to the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~, and the Division shall notify the Director of Insurance ~~Secretary of Financial and Professional Regulation~~ if a retirement system or pension fund fails to do so.

(d) If an Illinois finance entity fails to provide an initial certification within 6 months after the effective date of this Section or fails to submit an annual certification, then the retirement system or pension fund shall notify the Illinois finance entity. The Illinois finance entity shall, within 30 days after the date of notification, either (i) notify the retirement system or pension fund of its intention to certify and complete certification or (ii) notify the retirement system or pension fund of its intention to not complete certification. If an Illinois finance entity fails to provide certification, then the retirement system or pension

fund shall, within 90 days, divest, or attempt in good faith to divest, the retirement system's or pension fund's assets with that Illinois finance entity. The retirement system or pension fund shall immediately notify the Public Pension Division of the Department of Insurance ~~Department~~ of the Illinois finance entity's failure to provide certification.

(e) If any provision of this Section or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Section that can be given effect without the invalid provision or application.

(Source: P.A. 95-521, eff. 8-28-07; 95-876, eff. 8-21-08.)

(40 ILCS 5/1-110.15)

Sec. 1-110.15. Transactions prohibited by retirement systems; Iran.

(a) As used in this Section:

"Active business operations" means all business operations that are not inactive business operations.

"Business operations" means engaging in commerce in any form in Iran, including, but not limited to, acquiring, developing, maintaining, owning, selling, possessing, leasing, or operating equipment, facilities, personnel, products, services, personal property, real property, or any other apparatus of business or commerce.

"Company" means any sole proprietorship, organization,

association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of those entities or business associations, that exists for the purpose of making profit.

"Direct holdings" in a company means all securities of that company that are held directly by the retirement system or in an account or fund in which the retirement system owns all shares or interests.

"Inactive business operations" means the mere continued holding or renewal of rights to property previously operated for the purpose of generating revenues but not presently deployed for that purpose.

"Indirect holdings" in a company means all securities of that company which are held in an account or fund, such as a mutual fund, managed by one or more persons not employed by the retirement system, in which the retirement system owns shares or interests together with other investors not subject to the provisions of this Section.

"Mineral-extraction activities" include exploring, extracting, processing, transporting, or wholesale selling or trading of elemental minerals or associated metal alloys or oxides (ore), including gold, copper, chromium, chromite, diamonds, iron, iron ore, silver, tungsten, uranium, and zinc.

"Oil-related activities" include, but are not limited to,

owning rights to oil blocks; exporting, extracting, producing, refining, processing, exploring for, transporting, selling, or trading of oil; and constructing, maintaining, or operating a pipeline, refinery, or other oil-field infrastructure. The mere retail sale of gasoline and related consumer products is not considered an oil-related activity.

"Petroleum resources" means petroleum, petroleum byproducts, or natural gas.

"Private market fund" means any private equity fund, private equity fund of funds, venture capital fund, hedge fund, hedge fund of funds, real estate fund, or other investment vehicle that is not publicly traded.

"Retirement system" means the State Employees' Retirement System of Illinois, the Judges Retirement System of Illinois, the General Assembly Retirement System, the State Universities Retirement System, and the Teachers' Retirement System of the State of Illinois.

"Scrutinized business operations" means business operations that have caused a company to become a scrutinized company.

"Scrutinized company" means the company has business operations that involve contracts with or provision of supplies or services to the Government of Iran, companies in which the Government of Iran has any direct or indirect equity share, consortiums or projects commissioned by the Government of Iran, or companies involved in consortiums or projects

commissioned by the Government of Iran and:

(1) more than 10% of the company's revenues produced in or assets located in Iran involve oil-related activities or mineral-extraction activities; less than 75% of the company's revenues produced in or assets located in Iran involve contracts with or provision of oil-related or mineral-extraction products or services to the Government of Iran or a project or consortium created exclusively by that government; and the company has failed to take substantial action; or

(2) the company has, on or after August 5, 1996, made an investment of $20 million or more, or any combination of investments of at least $10 million each that in the aggregate equals or exceeds $20 million in any 12-month period, that directly or significantly contributes to the enhancement of Iran's ability to develop petroleum resources of Iran.

"Substantial action" means adopting, publicizing, and implementing a formal plan to cease scrutinized business operations within one year and to refrain from any such new business operations.

(b) Within 90 days after the effective date of this Section, a retirement system shall make its best efforts to identify all scrutinized companies in which the retirement system has direct or indirect holdings.

These efforts shall include the following, as appropriate

in the retirement system's judgment:

(1) reviewing and relying on publicly available information regarding companies having business operations in Iran, including information provided by nonprofit organizations, research firms, international organizations, and government entities;

(2) contacting asset managers contracted by the retirement system that invest in companies having business operations in Iran; and

(3) Contacting other institutional investors that have divested from or engaged with companies that have business operations in Iran.

The retirement system may retain an independent research firm to identify scrutinized companies in which the retirement system has direct or indirect holdings. By the first meeting of the retirement system following the 90-day period described in this subsection (b), the retirement system shall assemble all scrutinized companies identified into a scrutinized companies list.

The retirement system shall update the scrutinized companies list annually based on evolving information from, among other sources, those listed in this subsection (b).

(c) The retirement system shall adhere to the following procedures for companies on the scrutinized companies list:

(1) The retirement system shall determine the companies on the scrutinized companies list in which the

retirement system owns direct or indirect holdings.

(2) For each company identified in item (1) of this subsection (c) that has only inactive business operations, the retirement system shall send a written notice informing the company of this Section and encouraging it to continue to refrain from initiating active business operations in Iran until it is able to avoid scrutinized business operations. The retirement system shall continue such correspondence semiannually.

(3) For each company newly identified in item (1) of this subsection (c) that has active business operations, the retirement system shall send a written notice informing the company of its scrutinized company status and that it may become subject to divestment by the retirement system. The notice must inform the company of the opportunity to clarify its Iran-related activities and encourage the company, within 90 days, to cease its scrutinized business operations or convert such operations to inactive business operations in order to avoid qualifying for divestment by the retirement system.

(4) If, within 90 days after the retirement system's first engagement with a company pursuant to this subsection (c), that company ceases scrutinized business operations, the company shall be removed from the scrutinized companies list and the provisions of this Section shall cease to apply to it unless it resumes

scrutinized business operations. If, within 90 days after the retirement system's first engagement, the company converts its scrutinized active business operations to inactive business operations, the company is subject to all provisions relating thereto.

(d) If, after 90 days following the retirement system's first engagement with a company pursuant to subsection (c), the company continues to have scrutinized active business operations, and only while such company continues to have scrutinized active business operations, the retirement system shall sell, redeem, divest, or withdraw all publicly traded securities of the company, except as provided in paragraph (f), from the retirement system's assets under management within 12 months after the company's most recent appearance on the scrutinized companies list.

If a company that ceased scrutinized active business operations following engagement pursuant to subsection (c) resumes such operations, this subsection (d) immediately applies, and the retirement system shall send a written notice to the company. The company shall also be immediately reintroduced onto the scrutinized companies list.

(e) The retirement system may not acquire securities of companies on the scrutinized companies list that have active business operations, except as provided in subsection (f).

(f) A company that the United States Government affirmatively declares to be excluded from its present or any

future federal sanctions regime relating to Iran is not subject to divestment or the investment prohibition pursuant to subsections (d) and (e).

(g) Notwithstanding the provisions of this Section, paragraphs (d) and (e) do not apply to indirect holdings in a private market fund. However, the retirement system shall submit letters to the managers of those investment funds containing companies that have scrutinized active business operations requesting that they consider removing the companies from the fund or create a similar actively managed fund having indirect holdings devoid of the companies. If the manager creates a similar fund, the retirement system shall replace all applicable investments with investments in the similar fund in an expedited timeframe consistent with prudent investing standards.

(h) The retirement system shall file a report with the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~ that includes the scrutinized companies list within 30 days after the list is created. This report shall be made available to the public.

The retirement system shall file an annual report with the Public Pension Division, which shall be made available to the public, that includes all of the following:

(1) A summary of correspondence with companies engaged by the retirement system under items (2) and (3) of subsection (c).

(2) All investments sold, redeemed, divested, or withdrawn in compliance with subsection (d).

(3) All prohibited investments under subsection (e).

(4) A summary of correspondence with private market funds notified under subsection (g).

(i) This Section expires upon the occurrence of any of the following:

(1) The United States revokes all sanctions imposed against the Government of Iran.

(2) The Congress or President of the United States declares that the Government of Iran has ceased to acquire weapons of mass destruction and to support international terrorism.

(3) The Congress or President of the United States, through legislation or executive order, declares that mandatory divestment of the type provided for in this Section interferes with the conduct of United States foreign policy.

(j) With respect to actions taken in compliance with this Act, including all good-faith determinations regarding companies as required by this Act, the retirement system is exempt from any conflicting statutory or common law obligations, including any fiduciary duties under this Article and any obligations with respect to choice of asset managers, investment funds, or investments for the retirement system's securities portfolios.

(k) Notwithstanding any other provision of this Section to the contrary, the retirement system may cease divesting from scrutinized companies pursuant to subsection (d) or reinvest in scrutinized companies from which it divested pursuant to subsection (d) if clear and convincing evidence shows that the value of investments in scrutinized companies with active scrutinized business operations becomes equal to or less than 0.5% of the market value of all assets under management by the retirement system. Cessation of divestment, reinvestment, or any subsequent ongoing investment authorized by this Section is limited to the minimum steps necessary to avoid the contingency set forth in this subsection (k). For any cessation of divestment, reinvestment, or subsequent ongoing investment authorized by this Section, the retirement system shall provide a written report to the Public Pension Division in advance of initial reinvestment, updated semiannually thereafter as applicable, setting forth the reasons and justification, supported by clear and convincing evidence, for its decisions to cease divestment, reinvest, or remain invested in companies having scrutinized active business operations. This Section does not apply to reinvestment in companies on the grounds that they have ceased to have scrutinized active business operations.

(l) If any provision of this Section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act

which can be given effect without the invalid provision or application, and to this end the provisions of this Section are severable.

(Source: P.A. 95-616, eff. 1-1-08; 95-876, eff. 8-21-08.)

(40 ILCS 5/1-113.4)

Sec. 1-113.4. List of additional permitted investments for pension funds with net assets of $5,000,000 or more.

(a) In addition to the items in Sections 1-113.2 and 1-113.3, a pension fund established under Article 3 or 4 that has net assets of at least $5,000,000 and has appointed an investment adviser under Section 1-113.5 may, through that investment adviser, invest a portion of its assets in common and preferred stocks authorized for investments of trust funds under the laws of the State of Illinois. The stocks must meet all of the following requirements:

(1) The common stocks are listed on a national securities exchange or board of trade (as defined in the federal Securities Exchange Act of 1934 and set forth in subdivision G of Section 3 of the Illinois Securities Law of 1953) or quoted in the National Association of Securities Dealers Automated Quotation System National Market System (NASDAQ NMS).

(2) The securities are of a corporation created or existing under the laws of the United States or any state, district, or territory thereof and the corporation has

been in existence for at least 5 years.

(3) The corporation has not been in arrears on payment of dividends on its preferred stock during the preceding 5 years.

(4) The market value of stock in any one corporation does not exceed 5% of the cash and invested assets of the pension fund, and the investments in the stock of any one corporation do not exceed 5% of the total outstanding stock of that corporation.

(5) The straight preferred stocks or convertible preferred stocks are issued or guaranteed by a corporation whose common stock qualifies for investment by the board.

(6) The issuer of the stocks has been subject to the requirements of Section 12 of the federal Securities Exchange Act of 1934 and has been current with the filing requirements of Sections 13 and 14 of that Act during the preceding 3 years.

(b) A pension fund's total investment in the items authorized under this Section and Section 1-113.3 shall not exceed 35% of the market value of the pension fund's net present assets stated in its most recent annual report on file with the Public Pension Division of the ~~Illinois~~ Department of Insurance.

(c) A pension fund that invests funds under this Section shall electronically file with the Public Pension Division of the Department of Insurance any reports of its investment

activities that the Division may require, at the times and in the format required by the Division.

(Source: P.A. 100-201, eff. 8-18-17.)

(40 ILCS 5/1-113.4a)

Sec. 1-113.4a. List of additional permitted investments for Article 3 and 4 pension funds with net assets of $10,000,000 or more.

(a) In addition to the items in Sections 1-113.2 and 1-113.3, a pension fund established under Article 3 or 4 that has net assets of at least $10,000,000 and has appointed an investment adviser, as defined under Sections 1-101.4 and 1-113.5, may, through that investment adviser, invest an additional portion of its assets in common and preferred stocks and mutual funds.

(b) The stocks must meet all of the following requirements:

(1) The common stocks must be listed on a national securities exchange or board of trade (as defined in the Federal Securities Exchange Act of 1934 and set forth in paragraph G of Section 3 of the Illinois Securities Law of 1953) or quoted in the National Association of Securities Dealers Automated Quotation System National Market System.

(2) The securities must be of a corporation in existence for at least 5 years.

(3) The market value of stock in any one corporation

may not exceed 5% of the cash and invested assets of the pension fund, and the investments in the stock of any one corporation may not exceed 5% of the total outstanding stock of that corporation.

(4) The straight preferred stocks or convertible preferred stocks must be issued or guaranteed by a corporation whose common stock qualifies for investment by the board.

(c) The mutual funds must meet the following requirements:

(1) The mutual fund must be managed by an investment company registered under the Federal Investment Company Act of 1940 and registered under the Illinois Securities Law of 1953.

(2) The mutual fund must have been in operation for at least 5 years.

(3) The mutual fund must have total net assets of $250,000,000 or more.

(4) The mutual fund must be comprised of a diversified portfolio of common or preferred stocks, bonds, or money market instruments.

(d) A pension fund's total investment in the items authorized under this Section and Section 1-113.3 shall not exceed 50% effective July 1, 2011 and 55% effective July 1, 2012 of the market value of the pension fund's net present assets stated in its most recent annual report on file with the Public Pension Division of the Department of Insurance.

(e) A pension fund that invests funds under this Section shall electronically file with the Public Pension Division of the Department of Insurance any reports of its investment activities that the Division may require, at the time and in the format required by the Division.

(Source: P.A. 96-1495, eff. 1-1-11.)

(40 ILCS 5/1-113.5)

Sec. 1-113.5. Investment advisers and investment services for all Article 3 or 4 pension funds.

(a) The board of trustees of a pension fund may appoint investment advisers as defined in Section 1-101.4. The board of any pension fund investing in common or preferred stock under Section 1-113.4 shall appoint an investment adviser before making such investments.

The investment adviser shall be a fiduciary, as defined in Section 1-101.2, with respect to the pension fund and shall be one of the following:

(1) an investment adviser registered under the federal Investment Advisers Act of 1940 and the Illinois Securities Law of 1953;

(2) a bank or trust company authorized to conduct a trust business in Illinois;

(3) a life insurance company authorized to transact business in Illinois; or

(4) an investment company as defined and registered

under the federal Investment Company Act of 1940 and registered under the Illinois Securities Law of 1953.

(a-5) Notwithstanding any other provision of law, a person or entity that provides consulting services (referred to as a "consultant" in this Section) to a pension fund with respect to the selection of fiduciaries may not be awarded a contract to provide those consulting services that is more than 5 years in duration. No contract to provide such consulting services may be renewed or extended. At the end of the term of a contract, however, the contractor is eligible to compete for a new contract. No person shall attempt to avoid or contravene the restrictions of this subsection by any means. All offers from responsive offerors shall be accompanied by disclosure of the names and addresses of the following:

(1) The offeror.

(2) Any entity that is a parent of, or owns a controlling interest in, the offeror.

(3) Any entity that is a subsidiary of, or in which a controlling interest is owned by, the offeror.

Beginning on July 1, 2008, a person, other than a trustee or an employee of a pension fund or retirement system, may not act as a consultant under this Section unless that person is at least one of the following: (i) registered as an investment adviser under the federal Investment Advisers Act of 1940 (15 U.S.C. 80b-1, et seq.); (ii) registered as an investment adviser under the Illinois Securities Law of 1953; (iii) a

bank, as defined in the Investment Advisers Act of 1940; or (iv) an insurance company authorized to transact business in this State.

(b) All investment advice and services provided by an investment adviser or a consultant appointed under this Section shall be rendered pursuant to a written contract between the investment adviser and the board, and in accordance with the board's investment policy.

The contract shall include all of the following:

(1) acknowledgement in writing by the investment adviser that he or she is a fiduciary with respect to the pension fund;

(2) the board's investment policy;

(3) full disclosure of direct and indirect fees, commissions, penalties, and any other compensation that may be received by the investment adviser, including reimbursement for expenses; and

(4) a requirement that the investment adviser submit periodic written reports, on at least a quarterly basis, for the board's review at its regularly scheduled meetings. All returns on investment shall be reported as net returns after payment of all fees, commissions, and any other compensation.

(b-5) Each contract described in subsection (b) shall also include (i) full disclosure of direct and indirect fees, commissions, penalties, and other compensation, including

reimbursement for expenses, that may be paid by or on behalf of the investment adviser or consultant in connection with the provision of services to the pension fund and (ii) a requirement that the investment adviser or consultant update the disclosure promptly after a modification of those payments or an additional payment.

Within 30 days after the effective date of this amendatory Act of the 95th General Assembly, each investment adviser and consultant providing services on the effective date or subject to an existing contract for the provision of services must disclose to the board of trustees all direct and indirect fees, commissions, penalties, and other compensation paid by or on behalf of the investment adviser or consultant in connection with the provision of those services and shall update that disclosure promptly after a modification of those payments or an additional payment.

A person required to make a disclosure under subsection (d) is also required to disclose direct and indirect fees, commissions, penalties, or other compensation that shall or may be paid by or on behalf of the person in connection with the rendering of those services. The person shall update the disclosure promptly after a modification of those payments or an additional payment.

The disclosures required by this subsection shall be in writing and shall include the date and amount of each payment and the name and address of each recipient of a payment.

(c) Within 30 days after appointing an investment adviser or consultant, the board shall submit a copy of the contract to the Public Pension Division of the Department of Insurance ~~of the Department of Financial and Professional Regulation~~.

(d) Investment services provided by a person other than an investment adviser appointed under this Section, including but not limited to services provided by the kinds of persons listed in items (1) through (4) of subsection (a), shall be rendered only after full written disclosure of direct and indirect fees, commissions, penalties, and any other compensation that shall or may be received by the person rendering those services.

(e) The board of trustees of each pension fund shall retain records of investment transactions in accordance with the rules of the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~.

(Source: P.A. 95-950, eff. 8-29-08; 96-6, eff. 4-3-09.)

(40 ILCS 5/1-113.18)

Sec. 1-113.18. Ethics training. All board members of a retirement system, pension fund, or investment board created under this Code must attend ethics training of at least 8 hours per year. The training required under this Section shall include training on ethics, fiduciary duty, and investment issues and any other curriculum that the board of the retirement system, pension fund, or investment board

establishes as being important for the administration of the retirement system, pension fund, or investment board. The Supreme Court of Illinois shall be responsible for ethics training and curriculum for judges designated by the Court to serve as members of a retirement system, pension fund, or investment board. Each board shall annually certify its members' compliance with this Section and submit an annual certification to the Public Pension Division of the Department of Insurance ~~of the Department of Financial and Professional Regulation~~. Judges shall annually certify compliance with the ethics training requirement and shall submit an annual certification to the Chief Justice of the Supreme Court of Illinois. For an elected or appointed trustee under Article 3 or 4 of this Code, fulfillment of the requirements of Section 1-109.3 satisfies the requirements of this Section.

(Source: P.A. 100-904, eff. 8-17-18.)

(40 ILCS 5/2-162)

(Text of Section WITHOUT the changes made by P.A. 98-599, which has been held unconstitutional)

Sec. 2-162. Application and expiration of new benefit increases.

(a) As used in this Section, "new benefit increase" means an increase in the amount of any benefit provided under this Article, or an expansion of the conditions of eligibility for any benefit under this Article, that results from an amendment

to this Code that takes effect after the effective date of this amendatory Act of the 94th General Assembly.

(b) Notwithstanding any other provision of this Code or any subsequent amendment to this Code, every new benefit increase is subject to this Section and shall be deemed to be granted only in conformance with and contingent upon compliance with the provisions of this Section.

(c) The Public Act enacting a new benefit increase must identify and provide for payment to the System of additional funding at least sufficient to fund the resulting annual increase in cost to the System as it accrues.

Every new benefit increase is contingent upon the General Assembly providing the additional funding required under this subsection. The Commission on Government Forecasting and Accountability shall analyze whether adequate additional funding has been provided for the new benefit increase and shall report its analysis to the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~. A new benefit increase created by a Public Act that does not include the additional funding required under this subsection is null and void. If the Public Pension Division determines that the additional funding provided for a new benefit increase under this subsection is or has become inadequate, it may so certify to the Governor and the State Comptroller and, in the absence of corrective action by the General Assembly, the new benefit increase shall expire at the

end of the fiscal year in which the certification is made.

(d) Every new benefit increase shall expire 5 years after its effective date or on such earlier date as may be specified in the language enacting the new benefit increase or provided under subsection (c). This does not prevent the General Assembly from extending or re-creating a new benefit increase by law.

(e) Except as otherwise provided in the language creating the new benefit increase, a new benefit increase that expires under this Section continues to apply to persons who applied and qualified for the affected benefit while the new benefit increase was in effect and to the affected beneficiaries and alternate payees of such persons, but does not apply to any other person, including without limitation a person who continues in service after the expiration date and did not apply and qualify for the affected benefit while the new benefit increase was in effect.

(Source: P.A. 94-4, eff. 6-1-05.)

(40 ILCS 5/3-110) (from Ch. 108 1/2, par. 3-110)

Sec. 3-110. Creditable service.

(a) "Creditable service" is the time served by a police officer as a member of a regularly constituted police force of a municipality. In computing creditable service furloughs without pay exceeding 30 days shall not be counted, but all leaves of absence for illness or accident, regardless of

length, and all periods of disability retirement for which a police officer has received no disability pension payments under this Article shall be counted.

(a-5) Up to 3 years of time during which the police officer receives a disability pension under Section 3-114.1, 3-114.2, 3-114.3, or 3-114.6 shall be counted as creditable service, provided that (i) the police officer returns to active service after the disability for a period at least equal to the period for which credit is to be established and (ii) the police officer makes contributions to the fund based on the rates specified in Section 3-125.1 and the salary upon which the disability pension is based. These contributions may be paid at any time prior to the commencement of a retirement pension. The police officer may, but need not, elect to have the contributions deducted from the disability pension or to pay them in installments on a schedule approved by the board. If not deducted from the disability pension, the contributions shall include interest at the rate of 6% per year, compounded annually, from the date for which service credit is being established to the date of payment. If contributions are paid under this subsection (a-5) in excess of those needed to establish the credit, the excess shall be refunded. This subsection (a-5) applies to persons receiving a disability pension under Section 3-114.1, 3-114.2, 3-114.3, or 3-114.6 on the effective date of this amendatory Act of the 91st General Assembly, as well as persons who begin to receive such a

disability pension after that date.

(b) Creditable service includes all periods of service in the military, naval or air forces of the United States entered upon while an active police officer of a municipality, provided that upon applying for a permanent pension, and in accordance with the rules of the board, the police officer pays into the fund the amount the officer would have contributed if he or she had been a regular contributor during such period, to the extent that the municipality which the police officer served has not made such contributions in the officer's behalf. The total amount of such creditable service shall not exceed 5 years, except that any police officer who on July 1, 1973 had more than 5 years of such creditable service shall receive the total amount thereof.

(b-5) Creditable service includes all periods of service in the military, naval, or air forces of the United States entered upon before beginning service as an active police officer of a municipality, provided that, in accordance with the rules of the board, the police officer pays into the fund the amount the police officer would have contributed if he or she had been a regular contributor during such period, plus an amount determined by the Board to be equal to the municipality's normal cost of the benefit, plus interest at the actuarially assumed rate calculated from the date the employee last became a police officer under this Article. The total amount of such creditable service shall not exceed 2

years.

(c) Creditable service also includes service rendered by a police officer while on leave of absence from a police department to serve as an executive of an organization whose membership consists of members of a police department, subject to the following conditions: (i) the police officer is a participant of a fund established under this Article with at least 10 years of service as a police officer; (ii) the police officer received no credit for such service under any other retirement system, pension fund, or annuity and benefit fund included in this Code; (iii) pursuant to the rules of the board the police officer pays to the fund the amount he or she would have contributed had the officer been an active member of the police department; (iv) the organization pays a contribution equal to the municipality's normal cost for that period of service; and (v) for all leaves of absence under this subsection (c), including those beginning before the effective date of this amendatory Act of the 97th General Assembly, the police officer continues to remain in sworn status, subject to the professional standards of the public employer or those terms established in statute.

(d)(1) Creditable service also includes periods of service originally established in another police pension fund under this Article or in the Fund established under Article 7 of this Code for which (i) the contributions have been transferred under Section 3-110.7 or Section

7-139.9 and (ii) any additional contribution required under paragraph (2) of this subsection has been paid in full in accordance with the requirements of this subsection (d).

(2) If the board of the pension fund to which creditable service and related contributions are transferred under Section 7-139.9 determines that the amount transferred is less than the true cost to the pension fund of allowing that creditable service to be established, then in order to establish that creditable service the police officer must pay to the pension fund, within the payment period specified in paragraph (3) of this subsection, an additional contribution equal to the difference, as determined by the board in accordance with the rules and procedures adopted under paragraph (6) of this subsection. If the board of the pension fund to which creditable service and related contributions are transferred under Section 3-110.7 determines that the amount transferred is less than the true cost to the pension fund of allowing that creditable service to be established, then the police officer may elect (A) to establish that creditable service by paying to the pension fund, within the payment period specified in paragraph (3) of this subsection (d), an additional contribution equal to the difference, as determined by the board in accordance with the rules and procedures adopted under

paragraph (6) of this subsection (d) or (B) to have his or her creditable service reduced by an amount equal to the difference between the amount transferred under Section 3-110.7 and the true cost to the pension fund of allowing that creditable service to be established, as determined by the board in accordance with the rules and procedures adopted under paragraph (6) of this subsection (d).

(3) Except as provided in paragraph (4), the additional contribution that is required or elected under paragraph (2) of this subsection (d) must be paid to the board (i) within 5 years from the date of the transfer of contributions under Section 3-110.7 or 7-139.9 and (ii) before the police officer terminates service with the fund. The additional contribution may be paid in a lump sum or in accordance with a schedule of installment payments authorized by the board.

(4) If the police officer dies in service before payment in full has been made and before the expiration of the 5-year payment period, the surviving spouse of the officer may elect to pay the unpaid amount on the officer's behalf within 6 months after the date of death, in which case the creditable service shall be granted as though the deceased police officer had paid the remaining balance on the day before the date of death.

(5) If the additional contribution that is required or elected under paragraph (2) of this subsection (d) is not

paid in full within the required time, the creditable service shall not be granted and the police officer (or the officer's surviving spouse or estate) shall be entitled to receive a refund of (i) any partial payment of the additional contribution that has been made by the police officer and (ii) those portions of the amounts transferred under subdivision (a)(1) of Section 3-110.7 or subdivisions (a)(1) and (a)(3) of Section 7-139.9 that represent employee contributions paid by the police officer (but not the accumulated interest on those contributions) and interest paid by the police officer to the prior pension fund in order to reinstate service terminated by acceptance of a refund.

At the time of paying a refund under this item (5), the pension fund shall also repay to the pension fund from which the contributions were transferred under Section 3-110.7 or 7-139.9 the amount originally transferred under subdivision (a)(2) of that Section, plus interest at the rate of 6% per year, compounded annually, from the date of the original transfer to the date of repayment. Amounts repaid to the Article 7 fund under this provision shall be credited to the appropriate municipality.

Transferred credit that is not granted due to failure to pay the additional contribution within the required time is lost; it may not be transferred to another pension fund and may not be reinstated in the pension fund from

which it was transferred.

(6) The Public ~~Employee~~ Pension ~~Fund~~ Division of the Department of Insurance shall establish by rule the manner of making the calculation required under paragraph (2) of this subsection, taking into account the appropriate actuarial assumptions; the police officer's service, age, and salary history; the level of funding of the pension fund to which the credits are being transferred; and any other factors that the Division determines to be relevant. The rules may require that all calculations made under paragraph (2) be reported to the Division by the board performing the calculation, together with documentation of the creditable service to be transferred, the amounts of contributions and interest to be transferred, the manner in which the calculation was performed, the numbers relied upon in making the calculation, the results of the calculation, and any other information the Division may deem useful.

(e)(1) Creditable service also includes periods of service originally established in the Fund established under Article 7 of this Code for which the contributions have been transferred under Section 7-139.11.

(2) If the board of the pension fund to which creditable service and related contributions are transferred under Section 7-139.11 determines that the amount transferred is less than the true cost to the

pension fund of allowing that creditable service to be established, then the amount of creditable service the police officer may establish under this subsection (e) shall be reduced by an amount equal to the difference, as determined by the board in accordance with the rules and procedures adopted under paragraph (3) of this subsection.

(3) The Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~ shall establish by rule the manner of making the calculation required under paragraph (2) of this subsection, taking into account the appropriate actuarial assumptions; the police officer's service, age, and salary history; the level of funding of the pension fund to which the credits are being transferred; and any other factors that the Division determines to be relevant. The rules may require that all calculations made under paragraph (2) be reported to the Division by the board performing the calculation, together with documentation of the creditable service to be transferred, the amounts of contributions and interest to be transferred, the manner in which the calculation was performed, the numbers relied upon in making the calculation, the results of the calculation, and any other information the Division may deem useful.

(4) Until January 1, 2010, a police officer who transferred service from the Fund established under Article 7 of this Code under the provisions of Public Act

94-356 may establish additional credit, but only for the amount of the service credit reduction in that transfer, as calculated under paragraph (3) of this subsection (e). This credit may be established upon payment by the police officer of an amount to be determined by the board, equal to (1) the amount that would have been contributed as employee and employer contributions had all of the service been as an employee under this Article, plus interest thereon at the rate of 6% per year, compounded annually from the date of service to the date of transfer, less (2) the total amount transferred from the Article 7 Fund, plus (3) interest on the difference at the rate of 6% per year, compounded annually, from the date of the transfer to the date of payment. The additional service credit is allowed under this amendatory Act of the 95th General Assembly notwithstanding the provisions of Article 7 terminating all transferred credits on the date of transfer.

(Source: P.A. 96-297, eff. 8-11-09; 96-1260, eff. 7-23-10; 97-651, eff. 1-5-12.)

(40 ILCS 5/4-108) (from Ch. 108 1/2, par. 4-108)

Sec. 4-108. Creditable service.

(a) Creditable service is the time served as a firefighter of a municipality. In computing creditable service, furloughs and leaves of absence without pay exceeding 30 days in any one year shall not be counted, but leaves of absence for illness or

accident regardless of length, and periods of disability for which a firefighter received no disability pension payments under this Article, shall be counted.

(b) Furloughs and leaves of absence of 30 days or less in any one year may be counted as creditable service, if the firefighter makes the contribution to the fund that would have been required had he or she not been on furlough or leave of absence. To qualify for this creditable service, the firefighter must pay the required contributions to the fund not more than 90 days subsequent to the termination of the furlough or leave of absence, to the extent that the municipality has not made such contribution on his or her behalf.

(c) Creditable service includes:

(1) Service in the military, naval or air forces of the United States entered upon when the person was an active firefighter, provided that, upon applying for a permanent pension, and in accordance with the rules of the board the firefighter pays into the fund the amount that would have been contributed had he or she been a regular contributor during such period of service, if and to the extent that the municipality which the firefighter served made no such contributions in his or her behalf. The total amount of such creditable service shall not exceed 5 years, except that any firefighter who on July 1, 1973 had more than 5 years of such creditable service shall receive

the total amount thereof as of that date.

(1.5) Up to 24 months of service in the military, naval, or air forces of the United States that was served prior to employment by a municipality or fire protection district as a firefighter. To receive the credit for the military service prior to the employment as a firefighter, the firefighter must apply in writing to the fund and must make contributions to the fund equal to (i) the employee contributions that would have been required had the service been rendered as a member, plus (ii) an amount determined by the fund to be equal to the employer's normal cost of the benefits accrued for that military service, plus (iii) interest at the actuarially assumed rate provided by the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~, compounded annually from the first date of membership in the fund to the date of payment on items (i) and (ii). The changes to this paragraph (1.5) by this amendatory Act of the 95th General Assembly apply only to participating employees in service on or after its effective date.

(2) Service prior to July 1, 1976 by a firefighter initially excluded from participation by reason of age who elected to participate and paid the required contributions for such service.

(3) Up to 8 years of service by a firefighter as an

officer in a statewide firefighters' association when he is on a leave of absence from a municipality's payroll, provided that (i) the firefighter has at least 10 years of creditable service as an active firefighter, (ii) the firefighter contributes to the fund the amount that he would have contributed had he remained an active member of the fund, (iii) the employee or statewide firefighter association contributes to the fund an amount equal to the employer's required contribution as determined by the board, and (iv) for all leaves of absence under this subdivision (3), including those beginning before the effective date of this amendatory Act of the 97th General Assembly, the firefighter continues to remain in sworn status, subject to the professional standards of the public employer or those terms established in statute.

(4) Time spent as an on-call fireman for a municipality, calculated at the rate of one year of creditable service for each 5 years of time spent as an on-call fireman, provided that (i) the firefighter has at least 18 years of creditable service as an active firefighter, (ii) the firefighter spent at least 14 years as an on-call firefighter for the municipality, (iii) the firefighter applies for such creditable service within 30 days after the effective date of this amendatory Act of 1989, (iv) the firefighter contributes to the Fund an amount representing employee contributions for the number

of years of creditable service granted under this subdivision (4), based on the salary and contribution rate in effect for the firefighter at the date of entry into the Fund, to be determined by the board, and (v) not more than 3 years of creditable service may be granted under this subdivision (4).

Except as provided in Section 4-108.5, creditable service shall not include time spent as a volunteer firefighter, whether or not any compensation was received therefor. The change made in this Section by Public Act 83-0463 is intended to be a restatement and clarification of existing law, and does not imply that creditable service was previously allowed under this Article for time spent as a volunteer firefighter.

(5) Time served between July 1, 1976 and July 1, 1988 in the position of protective inspection officer or administrative assistant for fire services, for a municipality with a population under 10,000 that is located in a county with a population over 3,000,000 and that maintains a firefighters' pension fund under this Article, if the position included firefighting duties, notwithstanding that the person may not have held an appointment as a firefighter, provided that application is made to the pension fund within 30 days after the effective date of this amendatory Act of 1991, and the corresponding contributions are paid for the number of

years of service granted, based upon the salary and contribution rate in effect for the firefighter at the date of entry into the pension fund, as determined by the Board.

(6) Service before becoming a participant by a firefighter initially excluded from participation by reason of age who becomes a participant under the amendment to Section 4-107 made by this amendatory Act of 1993 and pays the required contributions for such service.

(7) Up to 3 years of time during which the firefighter receives a disability pension under Section 4-110, 4-110.1, or 4-111, provided that (i) the firefighter returns to active service after the disability for a period at least equal to the period for which credit is to be established and (ii) the firefighter makes contributions to the fund based on the rates specified in Section 4-118.1 and the salary upon which the disability pension is based. These contributions may be paid at any time prior to the commencement of a retirement pension. The firefighter may, but need not, elect to have the contributions deducted from the disability pension or to pay them in installments on a schedule approved by the board. If not deducted from the disability pension, the contributions shall include interest at the rate of 6% per year, compounded annually, from the date for which service credit is being established to the date of payment. If

contributions are paid under this subdivision (c)(7) in excess of those needed to establish the credit, the excess shall be refunded. This subdivision (c)(7) applies to persons receiving a disability pension under Section 4-110, 4-110.1, or 4-111 on the effective date of this amendatory Act of the 91st General Assembly, as well as persons who begin to receive such a disability pension after that date.

(8) Up to 6 years of service as a police officer and participant in an Article 3 police pension fund administered by the unit of local government that employs the firefighter under this Article, provided that the service has been transferred to, and the required payment received by, the Article 4 fund in accordance with subsection (a) of Section 3-110.12 of this Code.

(9) Up to 8 years of service as a police officer and participant in an Article 3 police pension fund administered by a unit of local government, provided that the service has been transferred to, and the required payment received by, the Article 4 fund in accordance with subsection (a-5) of Section 3-110.12 of this Code.

(Source: P.A. 102-63, eff. 7-9-21.)

(40 ILCS 5/4-109.3)

Sec. 4-109.3. Employee creditable service.

(a) As used in this Section:

"Final monthly salary" means the monthly salary attached to the rank held by the firefighter at the time of his or her last withdrawal from service under a particular pension fund.

"Last pension fund" means the pension fund in which the firefighter was participating at the time of his or her last withdrawal from service.

(b) The benefits provided under this Section are available only to a firefighter who:

(1) is a firefighter at the time of withdrawal from the last pension fund and for at least the final 3 years of employment prior to that withdrawal;

(2) has established service credit with at least one pension fund established under this Article other than the last pension fund;

(3) has a total of at least 20 years of service under the various pension funds established under this Article and has attained age 50; and

(4) is in service on or after the effective date of this amendatory Act of the 93rd General Assembly.

(c) A firefighter who is eligible for benefits under this Section may elect to receive a retirement pension from each pension fund under this Article in which the firefighter has at least one year of service credit but has not received a refund under Section 4-116 (unless the firefighter repays that refund under subsection (g)) or subsection (c) of Section 4-118.1, by applying in writing and paying the contribution

required under subsection (i).

(d) From each such pension fund other than the last pension fund, in lieu of any retirement pension otherwise payable under this Article, a firefighter to whom this Section applies may elect to receive a monthly pension of 1/12th of 2.5% of his or her final monthly salary under that fund for each month of service in that fund, subject to a maximum of 75% of that final monthly salary.

(e) From the last pension fund, in lieu of any retirement pension otherwise payable under this Article, a firefighter to whom this Section applies may elect to receive a monthly pension calculated as follows:

The last pension fund shall calculate the retirement pension that would be payable to the firefighter under Section 4-109 as if he or she had participated in that last pension fund during his or her entire period of service under all pension funds established under this Article (excluding any period of service for which the firefighter has received a refund under Section 4-116, unless the firefighter repays that refund under subsection (g), or for which the firefighter has received a refund under subsection (c) of Section 4-118.1). From this hypothetical pension there shall be subtracted the original amounts of the retirement pensions payable to the firefighter by all other pension funds under subsection (d). The remainder is the retirement pension payable to the firefighter by the last pension fund under this subsection

(e).

(f) Pensions elected under this Section shall be subject to increases as provided in Section 4-109.1.

(g) A current firefighter may reinstate creditable service in a pension fund established under this Article that was terminated upon receipt of a refund, by payment to that pension fund of the amount of the refund together with interest thereon at the rate of 6% per year, compounded annually, from the date of the refund to the date of payment. A repayment of a refund under this Section may be made in equal installments over a period of up to 10 years, but must be paid in full prior to retirement.

(h) As a condition of being eligible for the benefits provided in this Section, a person who is hired to a position as a firefighter on or after July 1, 2004 must, within 21 months after being hired, notify the new employer, all of his or her previous employers under this Article, and the Public Pension Division of the Department ~~Division~~ of Insurance ~~of the Department of Financial and Professional Regulation~~ of his or her intent to receive the benefits provided under this Section.

As a condition of being eligible for the benefits provided in this Section, a person who first becomes a firefighter under this Article after December 31, 2010 must (1) within 21 months after being hired or within 21 months after the effective date of this amendatory Act of the 102nd General

Assembly, whichever is later, notify the new employer, all of his or her previous employers under this Article, and the Public Pension Division of the Department of Insurance of his or her intent to receive the benefits provided under this Section; and (2) make the required contributions with applicable interest. A person who first becomes a firefighter under this Article after December 31, 2010 and who, before the effective date of this amendatory Act of the 102nd General Assembly, notified the new employer, all of his or her previous employers under this Article, and the Public Pension Division of the Department of Insurance of his or her intent to receive the benefits provided under this Section shall be deemed to have met the notice requirement under item (1) of the preceding sentence. The changes made to this Section by this amendatory Act of the 102nd General Assembly apply retroactively, notwithstanding Section 1-103.1.

(i) In order to receive a pension under this Section or an occupational disease disability pension for which he or she becomes eligible due to the application of subsection (m) of this Section, a firefighter must pay to each pension fund from which he or she has elected to receive a pension under this Section a contribution equal to 1% of monthly salary for each month of service credit that the firefighter has in that fund (other than service credit for which the firefighter has already paid the additional contribution required under subsection (c) of Section 4-118.1), together with interest

thereon at the rate of 6% per annum, compounded annually, from the firefighter's first day of employment with that fund or the first day of the fiscal year of that fund that immediately precedes the firefighter's first day of employment with that fund, whichever is earlier.

In order for a firefighter who, as of the effective date of this amendatory Act of the 93rd General Assembly, has not begun to receive a pension under this Section or an occupational disease disability pension under subsection (m) of this Section and who has contributed 1/12th of 1% of monthly salary for each month of service credit that the firefighter has in that fund (other than service credit for which the firefighter has already paid the additional contribution required under subsection (c) of Section 4-118.1), together with the required interest thereon, to receive a pension under this Section or an occupational disease disability pension for which he or she becomes eligible due to the application of subsection (m) of this Section, the firefighter must, within one year after the effective date of this amendatory Act of the 93rd General Assembly, make an additional contribution equal to 11/12ths of 1% of monthly salary for each month of service credit that the firefighter has in that fund (other than service credit for which the firefighter has already paid the additional contribution required under subsection (c) of Section 4-118.1), together with interest thereon at the rate of 6% per annum, compounded annually, from the firefighter's

first day of employment with that fund or the first day of the fiscal year of that fund that immediately precedes the firefighter's first day of employment with the fund, whichever is earlier. A firefighter who, as of the effective date of this amendatory Act of the 93rd General Assembly, has not begun to receive a pension under this Section or an occupational disease disability pension under subsection (m) of this Section and who has contributed 1/12th of 1% of monthly salary for each month of service credit that the firefighter has in that fund (other than service credit for which the firefighter has already paid the additional contribution required under subsection (c) of Section 4-118.1), together with the required interest thereon, in order to receive a pension under this Section or an occupational disease disability pension under subsection (m) of this Section, may elect, within one year after the effective date of this amendatory Act of the 93rd General Assembly to forfeit the benefits provided under this Section and receive a refund of that contribution.

(j) A retired firefighter who is receiving pension payments under Section 4-109 may reenter active service under this Article. Subject to the provisions of Section 4-117, the firefighter may receive credit for service performed after the reentry if the firefighter (1) applies to receive credit for that service, (2) suspends his or her pensions under this Section, and (3) makes the contributions required under subsection (i).

(k) A firefighter who is newly hired or promoted to a position as a firefighter shall not be denied participation in a fund under this Article based on his or her age.

(l) If a firefighter who elects to make contributions under subsection (c) of Section 4-118.1 for the pension benefits provided under this Section becomes entitled to a disability pension under Section 4-110, the last pension fund is responsible to pay that disability pension and the amount of that disability pension shall be based only on the firefighter's service with the last pension fund.

(m) Notwithstanding any provision in Section 4-110.1 to the contrary, if a firefighter who elects to make contributions under subsection (c) of Section 4-118.1 for the pension benefits provided under this Section becomes entitled to an occupational disease disability pension under Section 4-110.1, each pension fund to which the firefighter has made contributions under subsection (c) of Section 4-118.1 must pay a portion of that occupational disease disability pension equal to the proportion that the firefighter's service credit with that pension fund for which the contributions under subsection (c) of Section 4-118.1 have been made bears to the firefighter's total service credit with all of the pension funds for which the contributions under subsection (c) of Section 4-118.1 have been made. A firefighter who has made contributions under subsection (c) of Section 4-118.1 for at least 5 years of creditable service shall be deemed to have met

the 5-year creditable service requirement under Section 4-110.1, regardless of whether the firefighter has 5 years of creditable service with the last pension fund.

(n) If a firefighter who elects to make contributions under subsection (c) of Section 4-118.1 for the pension benefits provided under this Section becomes entitled to a disability pension under Section 4-111, the last pension fund is responsible to pay that disability pension, provided that the firefighter has at least 7 years of creditable service with the last pension fund. In the event a firefighter began employment with a new employer as a result of an intergovernmental agreement that resulted in the elimination of the previous employer's fire department, the firefighter shall not be required to have 7 years of creditable service with the last pension fund to qualify for a disability pension under Section 4-111. Under this circumstance, a firefighter shall be required to have 7 years of total combined creditable service time to qualify for a disability pension under Section 4-111. The disability pension received pursuant to this Section shall be paid by the previous employer and new employer in proportion to the firefighter's years of service with each employer.

(Source: P.A. 102-81, eff. 7-9-21.)

(40 ILCS 5/18-169)

Sec. 18-169. Application and expiration of new benefit

increases.

(a) As used in this Section, "new benefit increase" means an increase in the amount of any benefit provided under this Article, or an expansion of the conditions of eligibility for any benefit under this Article, that results from an amendment to this Code that takes effect after the effective date of this amendatory Act of the 94th General Assembly.

(b) Notwithstanding any other provision of this Code or any subsequent amendment to this Code, every new benefit increase is subject to this Section and shall be deemed to be granted only in conformance with and contingent upon compliance with the provisions of this Section.

(c) The Public Act enacting a new benefit increase must identify and provide for payment to the System of additional funding at least sufficient to fund the resulting annual increase in cost to the System as it accrues.

Every new benefit increase is contingent upon the General Assembly providing the additional funding required under this subsection. The Commission on Government Forecasting and Accountability shall analyze whether adequate additional funding has been provided for the new benefit increase and shall report its analysis to the Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~. A new benefit increase created by a Public Act that does not include the additional funding required under this subsection is null and void. If the Public Pension

Division determines that the additional funding provided for a new benefit increase under this subsection is or has become inadequate, it may so certify to the Governor and the State Comptroller and, in the absence of corrective action by the General Assembly, the new benefit increase shall expire at the end of the fiscal year in which the certification is made.

(d) Every new benefit increase shall expire 5 years after its effective date or on such earlier date as may be specified in the language enacting the new benefit increase or provided under subsection (c). This does not prevent the General Assembly from extending or re-creating a new benefit increase by law.

(e) Except as otherwise provided in the language creating the new benefit increase, a new benefit increase that expires under this Section continues to apply to persons who applied and qualified for the affected benefit while the new benefit increase was in effect and to the affected beneficiaries and alternate payees of such persons, but does not apply to any other person, including without limitation a person who continues in service after the expiration date and did not apply and qualify for the affected benefit while the new benefit increase was in effect.

(Source: P.A. 94-4, eff. 6-1-05.)

(40 ILCS 5/22-1004)

Sec. 22-1004. Commission on Government Forecasting and

Accountability report on Articles 3 and 4 funds. Each odd numbered year, the Commission on Government Forecasting and Accountability shall analyze data submitted by the Public Pension Division of the ~~Illinois~~ Department of Insurance ~~Financial and Professional Regulation~~ pertaining to the pension systems established under Article 3 and Article 4 of this Code. The Commission shall issue a formal report during such years, the content of which is, to the extent practicable, to be similar in nature to that required under Section 22-1003. In addition to providing aggregate analyses of both systems, the report shall analyze the fiscal status and provide forecasting projections for selected individual funds in each system. To the fullest extent practicable, the report shall analyze factors that affect each selected individual fund's unfunded liability and any actuarial gains and losses caused by salary increases, investment returns, employer contributions, benefit increases, change in assumptions, the difference in employer contributions and the normal cost plus interest, and any other applicable factors. In analyzing net investment returns, the report shall analyze the assumed investment return compared to the actual investment return over the preceding 10 fiscal years. The Public Pension Division of the Department of Insurance ~~Financial and Professional Regulation~~ shall provide to the Commission any assistance that the Commission may request with respect to its report under this Section.

(Source: P.A. 95-950, eff. 8-29-08.)

Section 10. The Illinois Insurance Code is amended by changing Sections 143.20a, 155.18, 155.19, 155.36, 155.49, 370c, 412, 500-140, and 1204 as follows:

(215 ILCS 5/143.20a) (from Ch. 73, par. 755.20a)

Sec. 143.20a. Cancellation of Fire and Marine Policies. (1) Policies covering property, except policies described in subsection (b) of Section 143.13 ~~143.13b~~, of this Code, issued for the kinds of business enumerated in Class 3 of Section 4 of this Code may be cancelled 10 days following receipt of written notice by the named insureds if the insured property is found to consist of one or more of the following:

(a) Buildings to which, following a fire loss, permanent repairs have not commenced within 60 days after satisfactory adjustment of loss, unless such delay is a direct result of a labor dispute or weather conditions.

(b) Buildings which have been unoccupied 60 consecutive days, except buildings which have a seasonal occupancy and buildings which are undergoing construction, repair or reconstruction and are properly secured against unauthorized entry.

(c) Buildings on which, because of their physical condition, there is an outstanding order to vacate, an outstanding demolition order, or which have been declared

unsafe in accordance with applicable law.

(d) Buildings on which heat, water, sewer service or public lighting have not been connected for 30 consecutive days or more.

(2) All notices of cancellation under this Section shall be sent by certified mail and regular mail to the address of record of the named insureds.

(3) All cancellations made pursuant to this Section shall be on a pro rata basis.

(Source: P.A. 86-437.)

(215 ILCS 5/155.18) (from Ch. 73, par. 767.18)

(Text of Section WITHOUT the changes made by P.A. 94-677, which has been held unconstitutional)

Sec. 155.18. (a) This Section shall apply to insurance on risks based upon negligence by a physician, hospital or other health care provider, referred to herein as medical liability insurance. This Section shall not apply to contracts of reinsurance, nor to any farm, county, district or township mutual insurance company transacting business under an Act entitled "An Act relating to local mutual district, county and township insurance companies", approved March 13, 1936, as now or hereafter amended, nor to any such company operating under a special charter.

(b) The following standards shall apply to the making and use of rates pertaining to all classes of medical liability

insurance:

(1) Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided, and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

No rate shall be held inadequate unless it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the company.

(2) Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside this State.

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers.

(3) The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of

companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(4) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors of the class.

(c) Every company writing medical liability insurance shall file with the Director of Insurance the rates and rating schedules it uses for medical liability insurance.

(1) This filing shall occur at least annually and as often as the rates are changed or amended.

(2) For the purposes of this Section any change in premium to the company's insureds as a result of a change

in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director.

(3) It shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

(d) If after a hearing the Director finds:

(1) that any rate, rating plan or rating system violates the provisions of this Section applicable to it, he may issue an order to the company which has been the subject of the hearing specifying in what respects such violation exists and stating when, within a reasonable period of time, the further use of such rate or rating system by such company in contracts of insurance made thereafter shall be prohibited;

(2) that the violation of any of the provisions of this Section applicable to it by any company which has been the subject of hearing was wilful, he may suspend or revoke, in whole or in part, the certificate of authority of such company with respect to the class of insurance which has been the subject of the hearing.

(Source: P.A. 79-1434.)

(215 ILCS 5/155.19) (from Ch. 73, par. 767.19)

(Text of Section WITHOUT the changes made by P.A. 94-677,

which has been held unconstitutional)

Sec. 155.19. All claims filed after December 31, 1976 with any insurer and all suits filed after December 31, 1976 in any court in this State, alleging liability on the part of any physician, hospital or other health care provider for medically related injuries, shall be reported to the Director of Insurance in such form and under such terms and conditions as may be prescribed by the Director. The Director shall maintain complete and accurate records of all such claims and suits including their nature, amount, disposition and other information as he may deem useful or desirable in observing and reporting on health care provider liability trends in this State. The Director shall release to appropriate disciplinary and licensing agencies any such data or information which may assist such agencies in improving the quality of health care or which may be useful to such agencies for the purpose of professional discipline.

With due regard for appropriate maintenance of the confidentiality thereof, the Director may release from time to time to the Governor, the General Assembly and the general public statistical reports based on such data and information.

The Director may promulgate such rules and regulations as may be necessary to carry out the provisions of this Section.

(Source: P.A. 79-1434.)

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 25, 45, 45.1, 45.2, 45.3, 65, 70, and 85, subsection (d) of Section 30, and the definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 101-608, eff. 1-1-20; 102-409, eff. 1-1-22.)

(215 ILCS 5/155.49 new)

Sec. 155.49. Insurance company supplier diversity report.

(a) Every company authorized to do business in this State or accredited by this State with assets of at least $50,000,000 shall submit a 2-page report on its voluntary supplier diversity program, or the company's procurement program if there is no supplier diversity program, to the Department. The report shall set forth all of the following:

(1) The name, address, phone number, and email address of the point of contact for the supplier diversity program for vendors to register with the program.

(2) Local and State certifications the company accepts or recognizes for minority-owned, women-owned, LGBT-owned, or veteran-owned business status.

(3) On the second page, a narrative explaining the results of the program and the tactics to be employed to achieve the goals of its voluntary supplier diversity

program.

(4) The voluntary goals for the calendar year for which the report is made in each category for the entire budget of the company and the commodity codes or a description of particular goods and services for the area of procurement in which the company expects most of those goals to focus on in that year.

Each company is required to submit a searchable report, in Portable Document Format (PDF), to the Department on or before April 1, 2024 and on or before April 1 every year thereafter.

(b) For each report submitted under subsection (a), the Department shall publish the results on its Internet website for 5 years after submission. The Department is not responsible for collecting the reports or for the content of the reports.

(c) The Department shall hold an annual insurance company supplier diversity workshop in July of 2024 and every July thereafter to discuss the reports with representatives of the companies and vendors.

(d) The Department shall prepare a one-page template, not including the narrative section, for the voluntary supplier diversity reports.

(e) The Department may adopt such rules as it deems necessary to implement this Section.

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a)(1) On and after January 1, 2022 (the effective date of Public Act 102-579), every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall provide coverage for the medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions consistent with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act of his or her choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of coverage, provided (i) the disorder or

condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his or her profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

(4) "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental

and behavioral disorders chapter of the current edition of the World Health Organization's International Classification of Disease or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. "Mental, emotional, nervous, or substance use disorder or condition" includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(5) Medically necessary treatment and medical necessity determinations shall be interpreted and made in a manner that is consistent with and pursuant to subsections (h) through (t).

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the reimbursing insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a

mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for

substance use disorders.

(4) A group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024) or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall provide coverage based upon medical necessity for the treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the parity requirements of Section 370c.1 of this Code; provided, however, that in each calendar year coverage shall not be less than the following:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A); and

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan.

(C) (Blank).

(5) An issuer of a group health benefit plan or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(5.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after September 9, 2015 (the effective date of Public Act 99-480) shall offer coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity

determinations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

"Clinical stabilization services" means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(6.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall not impose prior authorization requirements, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring

Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, before authorizing coverage for a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(C) shall place all prescription medications approved by the United States Food and Drug Administration prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications; and

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use

disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(7) (Blank).

(8) (Blank).

(9) With respect to all mental, emotional, nervous, or substance use disorders or conditions, coverage for inpatient treatment shall include coverage for treatment in a residential treatment center certified or licensed by the Department of Public Health or the Department of Human Services.

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 of this Code.

(d) With respect to a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace, the Department and, with respect to medical assistance, the Department of Healthcare and Family Services shall each enforce the requirements of this Section and Sections 356z.23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under, those Acts, including, but not limited to, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity

Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans. Specifically, the Department and the Department of Healthcare and Family Services shall take action:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental, emotional, nervous, or substance use disorder or condition coverage for possible parity violations;

(3) performing parity compliance market conduct examinations or, in the case of the Department of Healthcare and Family Services, parity compliance audits of individual and group plans and policies, including, but not limited to, reviews of:

(A) nonquantitative treatment limitations,

including, but not limited to, prior authorization requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the Department.

The findings and the conclusions of the parity compliance market conduct examinations and audits shall be made public.

The Director may adopt rules to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations made under a group health plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) The reason for any denial under a group health benefit plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace (or health insurance coverage offered in connection with such plan or policy) of reimbursement or payment for services with respect to mental, emotional, nervous, or substance use disorders or conditions benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

(f) As used in this Section, "group policy of accident and health insurance" and "group health benefit plan" includes (1) State-regulated employer-sponsored group health insurance plans written in Illinois or which purport to provide coverage for a resident of this State; and (2) State employee health plans.

(g) (1) As used in this subsection:

"Benefits", with respect to insurers, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1 (Clinically Managed Low-Intensity Residential), 3.3

(Clinically Managed Population-Specific High-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

"Substance use disorder treatment provider or facility" means a licensed physician, licensed psychologist, licensed psychiatrist, licensed advanced practice registered nurse, or licensed, certified, or otherwise State-approved facility or provider of substance use disorder treatment.

(2) A group health insurance policy, an individual health benefit plan, or qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after January 1, 2019 (the effective date of Public Act 100-1023) shall comply with the requirements of this Section and Section 370c.1. The services for the treatment and the ongoing

assessment of the patient's progress in treatment shall follow the requirements of 77 Ill. Adm. Code 2060.

(3) Prior authorization shall not be utilized for the benefits under this subsection. The substance use disorder treatment provider or facility shall notify the insurer of the initiation of treatment. For an insurer that is not a managed care organization, the substance use disorder treatment provider or facility notification shall occur for the initiation of treatment of the covered person within 2 business days. For managed care organizations, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. If the substance use disorder treatment provider or facility fails to notify the insurer of the initiation of treatment in accordance with these provisions, the insurer may follow its normal prior authorization processes.

(4) For an insurer that is not a managed care

organization, if an insurer determines that benefits are no longer medically necessary, the insurer shall notify the covered person, the covered person's authorized representative, if any, and the covered person's health care provider in writing of the covered person's right to request an external review pursuant to the Health Carrier External Review Act. The notification shall occur within 24 hours following the adverse determination.

Pursuant to the requirements of the Health Carrier External Review Act, the covered person or the covered person's authorized representative may request an expedited external review. An expedited external review may not occur if the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary. ~~Under this subsection, a request for expedited external review must be initiated within 24 hours following the adverse determination notification by the insurer. Failure to request an expedited external review within 24 hours shall preclude a covered person or a covered person's authorized representative from requesting an expedited external review.~~

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical necessity within 72 hours. If an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits

through the day following the determination of the independent review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(5) The substance use disorder treatment provider or facility shall provide the insurer with 7 business days' advance notice of the planned discharge of the patient from the substance use disorder treatment provider or facility and notice on the day that the patient is discharged from the substance use disorder treatment provider or facility.

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

(7) Nothing in this subsection shall be construed to require an insurer to provide coverage for any of the benefits in this subsection.

(h) As used in this Section:

"Generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources

reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities in a manner that is all of the following:

(1) in accordance with the generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

"Utilization review" means either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to insureds.

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

"Utilization review criteria" means patient placement criteria or any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

(i)(1) Every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2023 shall, pursuant to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or

substance use disorders or conditions.

(2) An insurer shall not set a specific limit on the duration of benefits or coverage of medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions or limit coverage only to alleviation of the insured's current symptoms.

(3) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through (u).

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. Nothing in this Section shall require Medicaid managed care organizations to pay for services if the individual was not eligible for Medicaid at the time the

service was rendered. Nothing in this Section shall require an insurer to pay for services if the individual was not the insurer's enrollee at the time services were rendered. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program. Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Medicaid managed care organizations are not subject to this subsection.

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use

disorders or conditions on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. All denials and appeals shall be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.

(l) For medical necessity determinations relating to level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental, emotional, and nervous disorders or conditions, an insurer shall apply the patient placement criteria set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, patient placement criteria determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental, emotional, nervous or substance use disorder or condition care. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) For medical necessity determinations relating to level of care placement, continued stay, and transfer or discharge that are within the scope of the sources specified in subsection (l), an insurer shall not apply different,

additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the assessment of the insured using the relevant patient placement criteria as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its assessment using the relevant criteria as specified in subsection (l) to the provider of the service and the patient.

Nothing in this subsection or subsection (l) prohibits an insurer from applying utilization review criteria that were developed in accordance with subsection (k) to health care services and benefits for mental, emotional, and nervous disorders or conditions that are not related to medical necessity determinations for level of care placement, continued stay, and transfer or discharge. If an insurer purchases or licenses utilization review criteria pursuant to this subsection, the insurer shall verify and document before use that the criteria were developed in accordance with subsection (k).

(n) In conducting utilization review that is outside the scope of the criteria as specified in subsection (l) or relates to the advancements in technology or in the types or levels of care that are not addressed in the most recent

versions of the sources specified in subsection (l), an insurer shall conduct utilization review in accordance with subsection (k).

(o) This Section does not in any way limit the rights of a patient under the Medical Patient Rights Act.

(p) This Section does not in any way limit early and periodic screening, diagnostic, and treatment benefits as defined under 42 U.S.C. 1396d(r).

(q) To ensure the proper use of the criteria described in subsection (l), every insurer shall do all of the following:

(1) Educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the utilization review criteria.

(2) Make the educational program available to other stakeholders, including the insurer's participating or contracted providers and potential participants, beneficiaries, or covered lives. The education program must be provided at least once a year, in-person or digitally, or recordings of the education program must be made available to the aforementioned stakeholders.

(3) Provide, at no cost, the utilization review criteria and any training material or resources to providers and insured patients upon request. For utilization review criteria not concerning level of care placement, continued stay, and transfer or discharge used

by the insurer pursuant to subsection (m), the insurer may place the criteria on a secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access to insureds or their providers. No restrictions shall be placed upon the insured's or treating provider's access right to utilization review criteria obtained under this paragraph at any point in time, including before an initial request for authorization.

(4) Track, identify, and analyze how the utilization review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made; this assessment shall cover all aspects of utilization review as defined in subsection (h).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without

supervision.

(8) Maintain documentation of interrater reliability testing and the remediation actions taken for those with pass rates lower than 90% and submit to the Department of Insurance or, in the case of Medicaid managed care organizations, the Department of Healthcare and Family Services the testing results and a summary of remedial actions as part of parity compliance reporting set forth in subsection (k) of Section 370c.1.

(r) This Section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions covered by an insurance policy, including prescription drugs.

(s) This Section applies to an insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and conducts utilization review as defined in this Section, including Medicaid managed care organizations, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil

penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

(u) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this Section.

(v) The provisions of this Section are severable. If any provision of this Section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(Source: P.A. 101-81, eff. 7-12-19; 101-386, eff. 8-16-19; 102-558, eff. 8-20-21; 102-579, eff. 1-1-22; 102-813, eff. 5-13-22.)

(215 ILCS 5/412) (from Ch. 73, par. 1024)

Sec. 412. Refunds; penalties; collection.

(1)(a) Whenever it appears to the satisfaction of the Director that because of some mistake of fact, error in calculation, or erroneous interpretation of a statute of this or any other state, any authorized company, surplus line producer, or industrial insured has paid to him, pursuant to any provision of law, taxes, fees, or other charges in excess of the amount legally chargeable against it, during the 6 year

period immediately preceding the discovery of such overpayment, he shall have power to refund to such company, surplus line producer, or industrial insured the amount of the excess or excesses by applying the amount or amounts thereof toward the payment of taxes, fees, or other charges already due, or which may thereafter become due from that company until such excess or excesses have been fully refunded, or upon a written request from the authorized company, surplus line producer, or industrial insured, the Director shall provide a cash refund within 120 days after receipt of the written request if all necessary information has been filed with the Department in order for it to perform an audit of the tax report for the transaction or period or annual return for the year in which the overpayment occurred or within 120 days after the date the Department receives all the necessary information to perform such audit. The Director shall not provide a cash refund if there are insufficient funds in the Insurance Premium Tax Refund Fund to provide a cash refund, if the amount of the overpayment is less than $100, or if the amount of the overpayment can be fully offset against the taxpayer's estimated liability for the year following the year of the cash refund request. Any cash refund shall be paid from the Insurance Premium Tax Refund Fund, a special fund hereby created in the State treasury.

(b) As determined by the Director pursuant to paragraph (a) of this subsection, the Department shall deposit an amount

of cash refunds approved by the Director for payment as a result of overpayment of tax liability collected under Sections 121-2.08, 409, 444, 444.1, and 445 of this Code into the Insurance Premium Tax Refund Fund.

(c) Beginning July 1, 1999, moneys in the Insurance Premium Tax Refund Fund shall be expended exclusively for the purpose of paying cash refunds resulting from overpayment of tax liability under Sections 121-2.08, 409, 444, 444.1, and 445 of this Code as determined by the Director pursuant to subsection 1(a) of this Section. Cash refunds made in accordance with this Section may be made from the Insurance Premium Tax Refund Fund only to the extent that amounts have been deposited and retained in the Insurance Premium Tax Refund Fund.

(d) This Section shall constitute an irrevocable and continuing appropriation from the Insurance Premium Tax Refund Fund for the purpose of paying cash refunds pursuant to the provisions of this Section.

(2)(a) When any insurance company fails to file any tax return required under Sections 408.1, 409, 444, and 444.1 of this Code or Section 12 of the Fire Investigation Act on the date prescribed, including any extensions, there shall be added as a penalty $400 or 10% of the amount of such tax, whichever is greater, for each month or part of a month of failure to file, the entire penalty not to exceed $2,000 or 50% of the tax due, whichever is greater.

(b) When any industrial insured or surplus line producer fails to file any tax return or report required under Sections 121-2.08 and 445 of this Code or Section 12 of the Fire Investigation Act on the date prescribed, including any extensions, there shall be added:

(i) as a late fee, if the return or report is received at least one day but not more than 15 ~~7~~ days after the prescribed due date, $50 ~~$400~~ or 5% ~~10%~~ of the tax due, whichever is greater, the entire fee not to exceed $1,000;

~~(ii) as a late fee, if the return or report is received at least 8 days but not more than 14 days after the prescribed due date, $400 or 10% of the tax due, whichever is greater, the entire fee not to exceed $1,500;~~

(ii) ~~(iii)~~ as a late fee, if the return or report is received at least 16 ~~15~~ days but not more than 30 ~~21~~ days after the prescribed due date, $100 ~~$400~~ or 5% ~~10%~~ of the tax due, whichever is greater, the entire fee not to exceed $2,000; or

(iii) ~~(iv)~~ as a penalty, if the return or report is received more than 30 ~~21~~ days after the prescribed due date, $100 ~~$400~~ or 5% ~~10%~~ of the tax due, whichever is greater, for each month or part of a month of failure to file, the entire penalty not to exceed $500 ~~$2,000~~ or 30% ~~50%~~ of the tax due, whichever is greater.

A tax return or report shall be deemed received as of the date mailed as evidenced by a postmark, proof of mailing on a

recognized United States Postal Service form or a form acceptable to the United States Postal Service or other commercial mail delivery service, or other evidence acceptable to the Director.

(3)(a) When any insurance company fails to pay the full amount due under the provisions of this Section, Sections 408.1, 409, 444, or 444.1 of this Code, or Section 12 of the Fire Investigation Act, there shall be added to the amount due as a penalty an amount equal to 10% of the deficiency.

(a-5) When any industrial insured or surplus line producer fails to pay the full amount due under the provisions of this Section, Sections 121-2.08 or 445 of this Code, or Section 12 of the Fire Investigation Act on the date prescribed, there shall be added:

(i) as a late fee, if the payment is received at least one day but not more than 7 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $1,000;

(ii) as a late fee, if the payment is received at least 8 days but not more than 14 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $1,500;

(iii) as a late fee, if the payment is received at least 15 days but not more than 21 days after the prescribed due date, 10% of the tax due, the entire fee not to exceed $2,000; or

(iv) as a penalty, if the return or report is received more than 21 days after the prescribed due date, 10% of the tax due.

A tax payment shall be deemed received as of the date mailed as evidenced by a postmark, proof of mailing on a recognized United States Postal Service form or a form acceptable to the United States Postal Service or other commercial mail delivery service, or other evidence acceptable to the Director.

(b) If such failure to pay is determined by the Director to be wilful, after a hearing under Sections 402 and 403, there shall be added to the tax as a penalty an amount equal to the greater of 50% of the deficiency or 10% of the amount due and unpaid for each month or part of a month that the deficiency remains unpaid commencing with the date that the amount becomes due. Such amount shall be in lieu of any determined under paragraph (a) or (a-5).

(4) Any insurance company, industrial insured, or surplus line producer that fails to pay the full amount due under this Section or Sections 121-2.08, 408.1, 409, 444, 444.1, or 445 of this Code, or Section 12 of the Fire Investigation Act is liable, in addition to the tax and any late fees and penalties, for interest on such deficiency at the rate of 12% per annum, or at such higher adjusted rates as are or may be established under subsection (b) of Section 6621 of the Internal Revenue Code, from the date that payment of any such tax was due,

determined without regard to any extensions, to the date of payment of such amount.

(5) The Director, through the Attorney General, may institute an action in the name of the People of the State of Illinois, in any court of competent jurisdiction, for the recovery of the amount of such taxes, fees, and penalties due, and prosecute the same to final judgment, and take such steps as are necessary to collect the same.

(6) In the event that the certificate of authority of a foreign or alien company is revoked for any cause or the company withdraws from this State prior to the renewal date of the certificate of authority as provided in Section 114, the company may recover the amount of any such tax paid in advance. Except as provided in this subsection, no revocation or withdrawal excuses payment of or constitutes grounds for the recovery of any taxes or penalties imposed by this Code.

(7) When an insurance company or domestic affiliated group fails to pay the full amount of any fee of $200 or more due under Section 408 of this Code, there shall be added to the amount due as a penalty the greater of $100 or an amount equal to 10% of the deficiency for each month or part of a month that the deficiency remains unpaid.

(8) The Department shall have a lien for the taxes, fees, charges, fines, penalties, interest, other charges, or any portion thereof, imposed or assessed pursuant to this Code, upon all the real and personal property of any company or

person to whom the assessment or final order has been issued or whenever a tax return is filed without payment of the tax or penalty shown therein to be due, including all such property of the company or person acquired after receipt of the assessment, issuance of the order, or filing of the return. The company or person is liable for the filing fee incurred by the Department for filing the lien and the filing fee incurred by the Department to file the release of that lien. The filing fees shall be paid to the Department in addition to payment of the tax, fee, charge, fine, penalty, interest, other charges, or any portion thereof, included in the amount of the lien. However, where the lien arises because of the issuance of a final order of the Director or tax assessment by the Department, the lien shall not attach and the notice referred to in this Section shall not be filed until all administrative proceedings or proceedings in court for review of the final order or assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted.

Upon the granting of Department review after a lien has attached, the lien shall remain in full force except to the extent to which the final assessment may be reduced by a revised final assessment following the rehearing or review. The lien created by the issuance of a final assessment shall terminate, unless a notice of lien is filed, within 3 years after the date all proceedings in court for the review of the final assessment have terminated or the time for the taking

thereof has expired without such proceedings being instituted, or (in the case of a revised final assessment issued pursuant to a rehearing or review by the Department) within 3 years after the date all proceedings in court for the review of such revised final assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted. Where the lien results from the filing of a tax return without payment of the tax or penalty shown therein to be due, the lien shall terminate, unless a notice of lien is filed, within 3 years after the date when the return is filed with the Department.

The time limitation period on the Department's right to file a notice of lien shall not run during any period of time in which the order of any court has the effect of enjoining or restraining the Department from filing such notice of lien. If the Department finds that a company or person is about to depart from the State, to conceal himself or his property, or to do any other act tending to prejudice or to render wholly or partly ineffectual proceedings to collect the amount due and owing to the Department unless such proceedings are brought without delay, or if the Department finds that the collection of the amount due from any company or person will be jeopardized by delay, the Department shall give the company or person notice of such findings and shall make demand for immediate return and payment of the amount, whereupon the amount shall become immediately due and payable. If the

company or person, within 5 days after the notice (or within such extension of time as the Department may grant), does not comply with the notice or show to the Department that the findings in the notice are erroneous, the Department may file a notice of jeopardy assessment lien in the office of the recorder of the county in which any property of the company or person may be located and shall notify the company or person of the filing. The jeopardy assessment lien shall have the same scope and effect as the statutory lien provided for in this Section. If the company or person believes that the company or person does not owe some or all of the tax for which the jeopardy assessment lien against the company or person has been filed, or that no jeopardy to the revenue in fact exists, the company or person may protest within 20 days after being notified by the Department of the filing of the jeopardy assessment lien and request a hearing, whereupon the Department shall hold a hearing in conformity with the provisions of this Code and, pursuant thereto, shall notify the company or person of its findings as to whether or not the jeopardy assessment lien will be released. If not, and if the company or person is aggrieved by this decision, the company or person may file an action for judicial review of the final determination of the Department in accordance with the Administrative Review Law. If, pursuant to such hearing (or after an independent determination of the facts by the Department without a hearing), the Department determines that

some or all of the amount due covered by the jeopardy assessment lien is not owed by the company or person, or that no jeopardy to the revenue exists, or if on judicial review the final judgment of the court is that the company or person does not owe some or all of the amount due covered by the jeopardy assessment lien against them, or that no jeopardy to the revenue exists, the Department shall release its jeopardy assessment lien to the extent of such finding of nonliability for the amount, or to the extent of such finding of no jeopardy to the revenue. The Department shall also release its jeopardy assessment lien against the company or person whenever the amount due and owing covered by the lien, plus any interest which may be due, are paid and the company or person has paid the Department in cash or by guaranteed remittance an amount representing the filing fee for the lien and the filing fee for the release of that lien. The Department shall file that release of lien with the recorder of the county where that lien was filed.

Nothing in this Section shall be construed to give the Department a preference over the rights of any bona fide purchaser, holder of a security interest, mechanics lienholder, mortgagee, or judgment lien creditor arising prior to the filing of a regular notice of lien or a notice of jeopardy assessment lien in the office of the recorder in the county in which the property subject to the lien is located. For purposes of this Section, "bona fide" shall not include

any mortgage of real or personal property or any other credit transaction that results in the mortgagee or the holder of the security acting as trustee for unsecured creditors of the company or person mentioned in the notice of lien who executed such chattel or real property mortgage or the document evidencing such credit transaction. The lien shall be inferior to the lien of general taxes, special assessments, and special taxes levied by any political subdivision of this State. In case title to land to be affected by the notice of lien or notice of jeopardy assessment lien is registered under the provisions of the Registered Titles (Torrens) Act, such notice shall be filed in the office of the Registrar of Titles of the county within which the property subject to the lien is situated and shall be entered upon the register of titles as a memorial or charge upon each folium of the register of titles affected by such notice, and the Department shall not have a preference over the rights of any bona fide purchaser, mortgagee, judgment creditor, or other lienholder arising prior to the registration of such notice. The regular lien or jeopardy assessment lien shall not be effective against any purchaser with respect to any item in a retailer's stock in trade purchased from the retailer in the usual course of the retailer's business.

(Source: P.A. 102-775, eff. 5-13-22.)

(215 ILCS 5/500-140)

(Section scheduled to be repealed on January 1, 2027)

Sec. 500-140. Injunctive relief. A person required to be licensed under this Article but failing to obtain a valid and current license under this Article constitutes a public nuisance. The Director may report the failure to obtain a license to the Attorney General, whose duty it is to apply forthwith by complaint on relation of the Director in the name of the people of the State of Illinois, for injunctive relief in the circuit court of the county where the failure to obtain a license occurred to enjoin that person from acting in any capacity that requires such a license ~~failing to obtain a license~~. Upon the filing of a verified petition in the court, the court, if satisfied by affidavit or otherwise that the person is required to have a license and does not have a valid and current license, may enter a temporary restraining order without notice or bond, enjoining the defendant from acting in any capacity that requires such license. A copy of the verified complaint shall be served upon the defendant, and the proceedings shall thereafter be conducted as in other civil cases. If it is established that the defendant has been, or is engaged in any unlawful practice, the court may enter an order or judgment perpetually enjoining the defendant from further engaging in such practice. In all proceedings brought under this Section, the court, in its discretion, may apportion the costs among the parties, including the cost of filing the complaint, service of process, witness fees and expenses,

court reporter charges, and reasonable attorney fees. In case of the violation of any injunctive order entered under the provisions of this Section, the court may summarily try and punish the offender for contempt of court. The injunctive relief available under this Section is in addition to and not in lieu of all other penalties and remedies provided in this Code.

(Source: P.A. 92-386, eff. 1-1-02.)

(215 ILCS 5/1204) (from Ch. 73, par. 1065.904)

(Text of Section WITHOUT the changes made by P.A. 94-677, which has been held unconstitutional)

Sec. 1204. (A) The Director shall promulgate rules and regulations which shall require each insurer licensed to write property or casualty insurance in the State and each syndicate doing business on the Illinois Insurance Exchange to record and report its loss and expense experience and other data as may be necessary to assess the relationship of insurance premiums and related income as compared to insurance costs and expenses. The Director may designate one or more rate service organizations or advisory organizations to gather and compile such experience and data. The Director shall require each insurer licensed to write property or casualty insurance in this State and each syndicate doing business on the Illinois Insurance Exchange to submit a report, on a form furnished by the Director, showing its direct writings in this State and

companywide.

(B) Such report required by subsection (A) of this Section may include, but not be limited to, the following specific types of insurance written by such insurer:

(1) Political subdivision liability insurance reported separately in the following categories:

(a) municipalities;

(b) school districts;

(c) other political subdivisions;

(2) Public official liability insurance;

(3) Dram shop liability insurance;

(4) Day care center liability insurance;

(5) Labor, fraternal or religious organizations liability insurance;

(6) Errors and omissions liability insurance;

(7) Officers and directors liability insurance reported separately as follows:

(a) non-profit entities;

(b) for-profit entities;

(8) Products liability insurance;

(9) Medical malpractice insurance;

(10) Attorney malpractice insurance;

(11) Architects and engineers malpractice insurance; and

(12) Motor vehicle insurance reported separately for commercial and private passenger vehicles as follows:

(a) motor vehicle physical damage insurance;

(b) motor vehicle liability insurance.

(C) Such report may include, but need not be limited to the following data, both specific to this State and companywide, in the aggregate or by type of insurance for the previous year on a calendar year basis:

(1) Direct premiums written;

(2) Direct premiums earned;

(3) Number of policies;

(4) Net investment income, using appropriate estimates where necessary;

(5) Losses paid;

(6) Losses incurred;

(7) Loss reserves:

(a) Losses unpaid on reported claims;

(b) Losses unpaid on incurred but not reported claims;

(8) Number of claims:

(a) Paid claims;

(b) Arising claims;

(9) Loss adjustment expenses:

(a) Allocated loss adjustment expenses;

(b) Unallocated loss adjustment expenses;

(10) Net underwriting gain or loss;

(11) Net operation gain or loss, including net investment income;

(12) Any other information requested by the Director.

(C-3) Additional information by an advisory organization as defined in Section 463 of this Code.

(1) An advisory organization as defined in Section 463 of this Code shall report annually the following information in such format as may be prescribed by the Secretary:

(a) paid and incurred losses for each of the past 10 years;

(b) medical payments and medical charges, if collected, for each of the past 10 years;

(c) the following indemnity payment information: cumulative payments by accident year by calendar year of development. This array will show payments made and frequency of claims in the following categories: medical only, permanent partial disability (PPD), permanent total disability (PTD), temporary total disability (TTD), and fatalities;

(d) injuries by frequency and severity;

(e) by class of employee.

(2) The report filed with the Secretary of Financial and Professional Regulation under paragraph (1) of this subsection (C-3) shall be made available, on an aggregate basis, to the General Assembly and to the general public. The identity of the petitioner, the respondent, the attorneys, and the insurers shall not be disclosed.

(3) Reports required under this subsection (C-3) shall be filed with the Secretary no later than September 1 in 2006 and no later than September 1 of each year thereafter.

(D) In addition to the information which may be requested under subsection (C), the Director may also request on a companywide, aggregate basis, Federal Income Tax recoverable, net realized capital gain or loss, net unrealized capital gain or loss, and all other expenses not requested in subsection (C) above.

(E) Violations - Suspensions - Revocations.

(1) Any company or person subject to this Article, who willfully or repeatedly fails to observe or who otherwise violates any of the provisions of this Article or any rule or regulation promulgated by the Director under authority of this Article or any final order of the Director entered under the authority of this Article shall by civil penalty forfeit to the State of Illinois a sum not to exceed $2,000. Each day during which a violation occurs constitutes a separate offense.

(2) No forfeiture liability under paragraph (1) of this subsection may attach unless a written notice of apparent liability has been issued by the Director and received by the respondent, or the Director sends written notice of apparent liability by registered or certified mail, return receipt requested, to the last known address

of the respondent. Any respondent so notified must be granted an opportunity to request a hearing within 10 days from receipt of notice, or to show in writing, why he should not be held liable. A notice issued under this Section must set forth the date, facts and nature of the act or omission with which the respondent is charged and must specifically identify the particular provision of this Article, rule, regulation or order of which a violation is charged.

(3) No forfeiture liability under paragraph (1) of this subsection may attach for any violation occurring more than 2 years prior to the date of issuance of the notice of apparent liability and in no event may the total civil penalty forfeiture imposed for the acts or omissions set forth in any one notice of apparent liability exceed $100,000.

(4) All administrative hearings conducted pursuant to this Article are subject to 50 Ill. Adm. Code 2402 and all administrative hearings are subject to the Administrative Review Law.

(5) The civil penalty forfeitures provided for in this Section are payable to the General Revenue Fund of the State of Illinois, and may be recovered in a civil suit in the name of the State of Illinois brought in the Circuit Court in Sangamon County or in the Circuit Court of the county where the respondent is domiciled or has its

principal operating office.

(6) In any case where the Director issues a notice of apparent liability looking toward the imposition of a civil penalty forfeiture under this Section that fact may not be used in any other proceeding before the Director to the prejudice of the respondent to whom the notice was issued, unless (a) the civil penalty forfeiture has been paid, or (b) a court has ordered payment of the civil penalty forfeiture and that order has become final.

(7) When any person or company has a license or certificate of authority under this Code and knowingly fails or refuses to comply with a lawful order of the Director requiring compliance with this Article, entered after notice and hearing, within the period of time specified in the order, the Director may, in addition to any other penalty or authority provided, revoke or refuse to renew the license or certificate of authority of such person or company, or may suspend the license or certificate of authority of such person or company until compliance with such order has been obtained.

(8) When any person or company has a license or certificate of authority under this Code and knowingly fails or refuses to comply with any provisions of this Article, the Director may, after notice and hearing, in addition to any other penalty provided, revoke or refuse to renew the license or certificate of authority of such

person or company, or may suspend the license or certificate of authority of such person or company, until compliance with such provision of this Article has been obtained.

(9) No suspension or revocation under this Section may become effective until 5 days from the date that the notice of suspension or revocation has been personally delivered or delivered by registered or certified mail to the company or person. A suspension or revocation under this Section is stayed upon the filing, by the company or person, of a petition for judicial review under the Administrative Review Law.

(Source: P.A. 94-277, eff. 7-20-05; 95-331, eff. 8-21-07.)

(215 ILCS 5/155.18a rep.)

Section 15. The Illinois Insurance Code is amended by repealing Section 155.18a.

Section 20. The Small Employer Health Insurance Rating Act is amended by changing Section 15 as follows:

(215 ILCS 93/15)

Sec. 15. Applicability and scope.

(a) This Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this State after July 1, 2000. For

purposes of this Section, the date a plan is continued shall be the first rating period which commences after July 1, 2000. The Act shall apply to any such health benefit plan which provides coverage to employees of a small employer, except that the Act shall not apply to individual health insurance policies.

(b) This Act shall not apply to any health benefit plan for a small employer that is delivered, issued, renewed, or continued in this State on or after January 1, 2022. However, if 42 U.S.C. 18032(c)(2) or any successor law is repealed, then this Act shall apply to each health benefit plan for a small employer that is delivered, issued, renewed, or continued in this State on or after the date that law ceases to apply to such plans.

(Source: P.A. 91-510, eff. 1-1-00; 92-16, eff. 6-28-01.)

Section 22. The Dental Service Plan Act is amended by changing Section 25 as follows:

(215 ILCS 110/25) (from Ch. 32, par. 690.25)

Sec. 25. Application of Insurance Code provisions. Dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA, XI, and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.49, 355.2, 355.3, 367.2, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and subsection (15) of

Section 367 of the Illinois Insurance Code.

(Source: P.A. 99-151, eff. 7-28-15.)

Section 25. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

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, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v, 356w, 356x, ~~356y,~~ 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.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53 ~~256z.53~~, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 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. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 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; revised 1-22-23.)

Section 27. 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, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 355.2, 355.3, 355b, 356q, 356v, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 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. 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. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 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; revised 12-13-22.)

Section 30. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions.

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Health care plan" means a plan, including, but not

limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income

Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) except with respect to subsections (a) and (b) of Section 65 and subsection (a-5) of Section 70, not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other

services for the purpose of preventing, alleviating, curing, or healing human illness or injury including behavioral health, mental health, home health, and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 101-452, eff. 1-1-20; 102-409, eff. 1-1-22.)

Section 99. Effective date. This Act takes effect July 1, 2023.

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Statutes amended in order of appearance

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

215 ILCS 134/10