HB5493

LRB10339189RPS69335b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB5493

Introduced 2/9/2024, by Rep. Thaddeus Jones

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. Provides that certain coverage requirements apply to an individual policy of accident and health insurance (currently, a policy of accident and health insurance). Provides that an individual or group policy of accident and health insurance or a managed care plan must not require authorization or referral by the plan, issuer, or any person, including a primary care provider, for any covered individual who seeks coverage for certain obstetrical or gynecological care. Provides that if a policy, contract, or certificate requires or allows a covered individual to designate a primary care provider and provides coverage for any obstetrical or gynecological care, the insurer shall provide the notice required under specified federal regulations in all circumstances required under those regulations. Makes changes in provisions concerning post-parturition care. Changes the language required in the disclosure of a limited benefit. Increases the fee for filing a plan of division of a domestic stock company and for filing an insurance business transfer plan. Makes changes in provisions concerning fraud reporting; coverage for epinephrine injectors; blanket accident and health insurance; authorization of policies, agreements, or arrangements with incentives or limits on reimbursement; and refunds and penalties. Repeals a provision concerning the application of certain provisions. Amends the Network Adequacy and Transparency Act. Changes references from "woman's principal health care provider" to "obstetrical and gynecological health care professional". Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Limited Health Service Organization Act, and the Illinois Public Aid Code to make conforming changes. Amends the Health Maintenance Organization Act. Makes changes to the required disclosures. Provides that health maintenance organizations are subject to certain coverage requirements for pharmacy testing, screening, vaccinations, and treatment; for proton beam therapy; for children with neuromuscular, neurological, or cognitive impairment; and for no-cost mental health prevention and wellness visits. Effective immediately, except that certain provisions are effective January 1, 2025.

LRB103 39189 RPS 69335 b

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.7 as follows:

(5 ILCS 375/6.7)

Sec. 6.7. Access to obstetrical and gynecological care ~~Woman's health care provider~~. The program of health benefits is subject to the provisions of Section 356r of the Illinois Insurance Code.

(Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

Section 10. The Counties Code is amended by changing Section 5-1069.5 as follows:

(55 ILCS 5/5-1069.5)

Sec. 5-1069.5. Access to obstetrical and gynecological care ~~Woman's health care provider~~. All counties, including home rule counties, are subject to the provisions of Section 356r of the Illinois Insurance Code. The requirement under this Section that health care benefits provided by counties comply with Section 356r of the Illinois Insurance Code is an exclusive power and function of the State and is a denial and

limitation of home rule county powers under Article VII, Section 6, subsection (h) of the Illinois Constitution.
(Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.5 as follows:

(65 ILCS 5/10-4-2.5)

Sec. 10-4-2.5. Access to obstetrical and gynecological care ~~Woman's health care provider~~. The corporate authorities of all municipalities are subject to the provisions of Section 356r of the Illinois Insurance Code. The requirement under this Section that health care benefits provided by municipalities comply with Section 356r of the Illinois Insurance Code is an exclusive power and function of the State and is a denial and limitation of home rule municipality powers under Article VII, Section 6, subsection (h) of the Illinois Constitution.
(Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

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

(105 ILCS 5/10-22.3d)

Sec. 10-22.3d. Access to obstetrical and gynecological care ~~Woman's health care provider~~. Insurance protection and

benefits for employees are subject to the provisions of Section 356r of the Illinois Insurance Code.

(Source: P.A. 89-514, eff. 7-17-96; 90-14, eff. 7-1-97.)

Section 25. The Illinois Insurance Code is amended by changing Sections 4, 155.23, 352, 352b, 356a, 356b, 356d, 356e, 356f, 356K, 356L, 356r, 356s, 356z.3, 356z.33, 367a, 370e, 370i, 408, 412, and 531.03 as follows:

(215 ILCS 5/4) (from Ch. 73, par. 616)

Sec. 4. Classes of insurance. Insurance and insurance business shall be classified as follows:

Class 1. Life, Accident and Health.

(a) Life. Insurance on the lives of persons and every insurance appertaining thereto or connected therewith and granting, purchasing or disposing of annuities. Policies of life or endowment insurance or annuity contracts or contracts supplemental thereto which contain provisions for additional benefits in case of death by accidental means and provisions operating to safeguard such policies or contracts against lapse, to give a special surrender value, or special benefit, or an annuity, in the event, that the insured or annuitant shall become a person with a total and permanent disability as defined by the policy or contract, or which contain benefits providing acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be

payable, as an indemnity for long term care which is certified or ordered by a physician, including but not limited to, professional nursing care, medical care expenses, custodial nursing care, non-nursing custodial care provided in a nursing home or at a residence of the insured, or which contain benefits providing acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable, at any time during the insured's lifetime, as an indemnity for a terminal illness shall be deemed to be policies of life or endowment insurance or annuity contracts within the intent of this clause.

Also to be deemed as policies of life or endowment insurance or annuity contracts within the intent of this clause shall be those policies or riders that provide for the payment of up to 75% of the face amount of benefits in advance of the time they would otherwise be payable upon a diagnosis by a physician licensed to practice medicine in all of its branches that the insured has incurred a covered condition listed in the policy or rider.

"Covered condition", as used in this clause, means: heart attack, stroke, coronary artery surgery, life-threatening ~~life threatening~~ cancer, renal failure, Alzheimer's disease, paraplegia, major organ transplantation, total and permanent disability, and any other medical condition that the Department may approve for any particular filing.

The Director may issue rules that specify prohibited

policy provisions, not otherwise specifically prohibited by law, which in the opinion of the Director are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

(b) Accident and health. Insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto, including stop-loss insurance. In this clause, "stop-loss ~~Stop loss~~ insurance" means ~~is~~ insurance against the risk of economic loss issued to or for the benefit of a single employer self-funded employee disability benefit plan or an employee welfare benefit plan as described in 29 U.S.C. 1001 ~~100~~ et seq., where (i) the policy is issued to and insures an employer, trustee, or other sponsor of the plan, or the plan itself, but not employees, members, or participants; and (ii) payments by the insurer are made to the employer, trustee, or other sponsors of the plan, or the plan itself, but not to the employees, members, participants, or health care providers. The insurance laws of this State, including this Code, do not apply to arrangements between a religious organization and the organization's members or participants when the arrangement and organization meet all of the following criteria:

(i) the organization is described in Section 501(c)(3) of the Internal Revenue Code and is exempt from taxation under Section 501(a) of the Internal Revenue Code;

(ii) members of the organization share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the state in which a member resides or is employed;

(iii) no funds that have been given for the purpose of the sharing of medical expenses among members described in paragraph (ii) of this subsection (b) are held by the organization in an off-shore trust or bank account;

(iv) the organization provides at least monthly to all of its members a written statement listing the dollar amount of qualified medical expenses that members have submitted for sharing, as well as the amount of expenses actually shared among the members;

(v) members of the organization retain membership even after they develop a medical condition;

(vi) the organization or a predecessor organization has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999;

(vii) the organization conducts an annual audit that is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and is made available to the public upon request;

(viii) the organization includes the following statement, in writing, on or accompanying all applications and guideline materials:

"Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.";

(ix) any membership card or similar document issued by the organization and any written communication sent by the organization to a hospital, physician, or other health care provider shall include a statement that the organization does not issue health insurance and that the member or participant is personally liable for payment of his or her medical bills;

(x) the organization provides to a participant, within 30 days after the participant joins, a complete set of its rules for the sharing of medical expenses, appeals of decisions made by the organization, and the filing of

complaints;

(xi) the organization does not offer any other services that are regulated under any provision of the Illinois Insurance Code or other insurance laws of this State; and

(xii) the organization does not amass funds as reserves intended for payment of medical services, rather the organization facilitates the payments provided for in this subsection (b) through payments made directly from one participant to another.

(c) Legal Expense Insurance. Insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or pay on behalf of the beneficiary, all or a portion of his fees, costs, or expenses related to or arising out of services performed by or under the supervision of an attorney licensed to practice in the jurisdiction wherein the services are performed, regardless of whether the payment is made by the beneficiaries individually or by a third person for them, but does not include the provision of or reimbursement for legal services incidental to other insurance coverages. The insurance laws of this State, including this Act do not apply to:

(i) retainer contracts made by attorneys at law with individual clients with fees based on estimates of the nature and amount of services to be provided to the specific client, and similar contracts made with a group

of clients involved in the same or closely related legal matters;

(ii) plans owned or operated by attorneys who are the providers of legal services to the plan;

(iii) plans providing legal service benefits to groups where such plans are owned or operated by authority of a state, county, local or other bar association;

(iv) any lawyer referral service authorized or operated by a state, county, local or other bar association;

(v) the furnishing of legal assistance by labor unions and other employee organizations to their members in matters relating to employment or occupation;

(vi) the furnishing of legal assistance to members or dependents, by churches, consumer organizations, cooperatives, educational institutions, credit unions, or organizations of employees, where such organizations contract directly with lawyers or law firms for the provision of legal services, and the administration and marketing of such legal services is wholly conducted by the organization or its subsidiary;

(vii) legal services provided by an employee welfare benefit plan defined by the Employee Retirement Income Security Act of 1974;

(viii) any collectively bargained plan for legal services between a labor union and an employer negotiated

pursuant to Section 302 of the Labor Management Relations Act as now or hereafter amended, under which plan legal services will be provided for employees of the employer whether or not payments for such services are funded to or through an insurance company.

Class 2. Casualty, Fidelity and Surety.

(a) Accident and health. Insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto, including stop-loss insurance. In this clause, "stop-loss ~~Stop-loss~~ insurance" has meaning given to that term in clause (b) of Class 1 ~~is insurance against the risk of economic loss issued to a single employer self-funded employee disability benefit plan or an employee welfare benefit plan as described in 29 U.S.C. 1001 et seq~~.

(b) Vehicle. Insurance against any loss or liability resulting from or incident to the ownership, maintenance or use of any vehicle (motor or otherwise), draft animal or aircraft. Any policy insuring against any loss or liability on account of the bodily injury or death of any person may contain a provision for payment of disability benefits to injured persons and death benefits to dependents, beneficiaries or personal representatives of persons who are killed, including the named insured, irrespective of legal liability of the insured, if the injury or death for which benefits are provided is caused by accident and sustained while in or upon

or while entering into or alighting from or through being struck by a vehicle (motor or otherwise), draft animal or aircraft, and such provision shall not be deemed to be accident insurance.

(c) Liability. Insurance against the liability of the insured for the death, injury or disability of an employee or other person, and insurance against the liability of the insured for damage to or destruction of another person's property.

(d) Workers' compensation. Insurance of the obligations accepted by or imposed upon employers under laws for workers' compensation.

(e) Burglary and forgery. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud or otherwise; including all householders' personal property floater risks.

(f) Glass. Insurance against loss or damage to glass including lettering, ornamentation and fittings from any cause.

(g) Fidelity and surety. Become surety or guarantor for any person, copartnership or corporation in any position or place of trust or as custodian of money or property, public or private; or, becoming a surety or guarantor for the performance of any person, copartnership or corporation of any lawful obligation, undertaking, agreement or contract of any kind, except contracts or policies of insurance; and

underwriting blanket bonds. Such obligations shall be known and treated as suretyship obligations and such business shall be known as surety business.

(h) Miscellaneous. Insurance against loss or damage to property and any liability of the insured caused by accidents to boilers, pipes, pressure containers, machinery and apparatus of any kind and any apparatus connected thereto, or used for creating, transmitting or applying power, light, heat, steam or refrigeration, making inspection of and issuing certificates of inspection upon elevators, boilers, machinery and apparatus of any kind and all mechanical apparatus and appliances appertaining thereto; insurance against loss or damage by water entering through leaks or openings in buildings, or from the breakage or leakage of a sprinkler, pumps, water pipes, plumbing and all tanks, apparatus, conduits and containers designed to bring water into buildings or for its storage or utilization therein, or caused by the falling of a tank, tank platform or supports, or against loss or damage from any cause (other than causes specifically enumerated under Class 3 of this Section) to such sprinkler, pumps, water pipes, plumbing, tanks, apparatus, conduits or containers; insurance against loss or damage which may result from the failure of debtors to pay their obligations to the insured; and insurance of the payment of money for personal services under contracts of hiring.

(i) Other casualty risks. Insurance against any other

casualty risk not otherwise specified under Classes 1 or 3, which may lawfully be the subject of insurance and may properly be classified under Class 2.

(j) Contingent losses. Contingent, consequential and indirect coverages wherein the proximate cause of the loss is attributable to any one of the causes enumerated under Class 2. Such coverages shall, for the purpose of classification, be included in the specific grouping of the kinds of insurance wherein such cause is specified.

(k) Livestock and domestic animals. Insurance against mortality, accident and health of livestock and domestic animals.

(l) Legal expense insurance. Insurance against risk resulting from the cost of legal services as defined under Class 1(c).

Class 3. Fire and Marine, etc.

(a) Fire. Insurance against loss or damage by fire, smoke and smudge, lightning or other electrical disturbances.

(b) Elements. Insurance against loss or damage by earthquake, windstorms, cyclone, tornado, tempests, hail, frost, snow, ice, sleet, flood, rain, drought or other weather or climatic conditions including excess or deficiency of moisture, rising of the waters of the ocean or its tributaries.

(c) War, riot and explosion. Insurance against loss or damage by bombardment, invasion, insurrection, riot, strikes,

civil war or commotion, military or usurped power, or explosion (other than explosion of steam boilers and the breaking of fly wheels on premises owned, controlled, managed, or maintained by the insured).

(d) Marine and transportation. Insurance against loss or damage to vessels, craft, aircraft, vehicles of every kind, (excluding vehicles operating under their own power or while in storage not incidental to transportation) as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any or all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks; and for loss or damage to persons or property in connection with or appertaining to marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such insurance,

(but not including life insurance or surety bonds); but, except as herein specified, shall not mean insurances against loss by reason of bodily injury to the person; and insurance against loss or damage to precious stones, jewels, jewelry, gold, silver and other precious metals whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise, which shall include jewelers' block insurance; and insurance against loss or damage to bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion are the only hazards to be covered; and to piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion; and to other aids to navigation and transportation, including dry docks and marine railways, against all risk.

(e) Vehicle. Insurance against loss or liability resulting from or incident to the ownership, maintenance or use of any vehicle (motor or otherwise), draft animal or aircraft, excluding the liability of the insured for the death, injury or disability of another person.

(f) Property damage, sprinkler leakage and crop. Insurance against the liability of the insured for loss or damage to another person's property or property interests from any cause

enumerated in this class; insurance against loss or damage by water entering through leaks or openings in buildings, or from the breakage or leakage of a sprinkler, pumps, water pipes, plumbing and all tanks, apparatus, conduits and containers designed to bring water into buildings or for its storage or utilization therein, or caused by the falling of a tank, tank platform or supports or against loss or damage from any cause to such sprinklers, pumps, water pipes, plumbing, tanks, apparatus, conduits or containers; insurance against loss or damage from insects, diseases or other causes to trees, crops or other products of the soil.

(g) Other fire and marine risks. Insurance against any other property risk not otherwise specified under Classes 1 or 2, which may lawfully be the subject of insurance and may properly be classified under Class 3.

(h) Contingent losses. Contingent, consequential and indirect coverages wherein the proximate cause of the loss is attributable to any of the causes enumerated under Class 3. Such coverages shall, for the purpose of classification, be included in the specific grouping of the kinds of insurance wherein such cause is specified.

(i) Legal expense insurance. Insurance against risk resulting from the cost of legal services as defined under Class 1(c).

(Source: P.A. 101-81, eff. 7-12-19.)

(215 ILCS 5/155.23) (from Ch. 73, par. 767.23)

Sec. 155.23. Fraud reporting.

(1) Upon written request of the ~~The~~ Director, an insurer ~~is authorized to promulgate reasonable rules requiring insurers~~, as defined in Section 155.24, or agent authorized by an insurer to act on the insurer's behalf shall release to the Department ~~doing business in the State of Illinois to report~~ factual information in their possession that is pertinent to suspected fraudulent insurance claims, fraudulent insurance applications, ~~or~~ premium fraud, ~~after he has made a determination that the information is necessary to detect fraud~~ or arson. Claim information may include:

(a) Dates and description of accident or loss.

(b) Any insurance policy relevant to the accident or loss.

(c) Name of the insurance company claims adjustor and claims adjustor supervisor processing or reviewing any claim or claims made under any insurance policy relevant to the accident or loss.

(d) Name of claimant's or insured's attorney.

(e) Name of claimant's or insured's physician, or any person rendering or purporting to render medical treatment.

(f) Description of alleged injuries, damage or loss.

(g) History of previous claims made by the claimant or

insured.

(h) Places of medical treatment.

(i) Policy premium payment record.

(j) Material relating to the investigation of the accident or loss, including statements of any person, proof of loss, and any other relevant evidence.

(k) any facts evidencing fraud or arson.

~~The Director shall establish reporting requirements for application and premium fraud information reporting by rule.~~

(2) The Director of Insurance may designate one or more data processing organizations or governmental agencies to assist him in gathering such information and making compilations thereof~~, and may by rule establish the form and procedure for gathering and compiling such information. The rules may name any organization or agency designated by the Director to provide this service,~~ and may in such case provide for a fee to be paid by the reporting insurers directly to the designated organization or agency to cover any of the costs associated with providing this service. After determination by the Director of substantial evidence of false or fraudulent claims, fraudulent applications, or premium fraud, the information shall be forwarded by the Director or the Director's designee to the proper law enforcement agency or prosecutor. Insurers shall have access to, and may use, the information compiled under the provisions of this Section. Insurers shall release information to, and shall cooperate

with, any law enforcement agency requesting such information.

In the absence of malice, no insurer, or person who furnishes information on its behalf, is liable for damages in a civil action or subject to criminal prosecution for any oral or written statement made or any other action taken that is necessary to supply information required pursuant to this Section.

(Source: P.A. 92-233, eff. 1-1-02.)

(215 ILCS 5/352) (from Ch. 73, par. 964)

Sec. 352. Scope of Article.

(a) Except as provided in subsections (b), (c), (d), ~~and~~ (e)<u>, and (g)</u>, this Article shall apply to all companies transacting in this State the kinds of business enumerated in clause (b) of Class 1 and clause (a) of Class 2 of Section 4 <u>and to all policies, contracts, and certificates of insurance issued in connection therewith</u>. Nothing in this Article shall apply to, or in any way affect policies or contracts described in clause (a) of Class 1 of Section 4; however, this Article shall apply to policies and contracts which contain benefits providing reimbursement for the expenses of long term health care which are certified or ordered by a physician including but not limited to professional nursing care, custodial nursing care, and non-nursing custodial care provided in a nursing home or at a residence of the insured.

(b) (Blank).

(c) A policy issued and delivered in this State that provides coverage under that policy for certificate holders who are neither residents of nor employed in this State does not need to provide to those nonresident certificate holders who are not employed in this State the coverages or services mandated by this Article.

(d) Stop-loss insurance, as defined in clause (b) of Class 1 or clause (a) of Class 2 of Section 4, is exempt from all Sections of this Article, except this Section and Sections 353a, 354, 357.30, and 370. ~~For purposes of this exemption, stop-loss insurance is further defined as follows:~~

~~(1) The policy must be issued to and insure an employer, trustee, or other sponsor of the plan, or the plan itself, but not employees, members, or participants.~~

~~(2) Payments by the insurer must be made to the employer, trustee, or other sponsors of the plan, or the plan itself, but not to the employees, members, participants, or health care providers.~~

(e) A policy issued or delivered in this State to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) and providing coverage, under clause (b) of Class 1 or clause (a) of Class 2 as described in Section 4, to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act is exempt from all restrictions, limitations, standards, rules, or regulations

respecting benefits imposed by or under authority of this Code, except those specified by subsection (1) of Section 143, Section 370c, and Section 370c.1. Nothing in this subsection, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(f) An in-office membership care agreement provided under the In-Office Membership Care Act is not insurance for the purposes of this Code.

(g) The provisions of Sections 356a through 359a, both inclusive, shall not apply to or affect:

(1) any policy or contract of reinsurance; or

(2) life insurance, endowment or annuity contracts, or contracts supplemental thereto, that contain only such provisions relating to accident and sickness insurance that (A) provide additional benefits in case of death or dismemberment or loss of sight by accident, or (B) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes a person with a total and permanent disability, as defined by the contract or supplemental contract.

(Source: P.A. 101-190, eff. 8-2-19.)

(215 ILCS 5/352b)

Sec. 352b. Excepted benefits exempted ~~Policy of individual~~

~~or group accident and health insurance~~.

(a) Unless specified otherwise and when used in context of accident and health insurance policy benefits, coverage, terms, or conditions required to be provided under this Article, references to any "policy of individual or group accident and health insurance", or both, as used in this Article, do ~~does~~ not include any coverage or policy that provides an excepted benefit, as that term is defined in Section 2791(c) of the federal Public Health Service Act (42 U.S.C. 300gg-91). Nothing in this subsection ~~amendatory Act of the 101st General Assembly~~ applies to a policy of ~~liability, workers' compensation, automobile medical payment, or~~ limited scope dental or vision benefits insurance issued under this Code. Nothing in this subsection shall be construed to subject excepted benefits outside the scope of Section 352 to any requirements of this Article.

(b) Unless specified otherwise for a type of excepted benefit, nothing in this Article shall require a policy of excepted benefits to provide benefits, coverage, terms, or conditions in such a manner as to disqualify it from being classified under federal law as the type of excepted benefit for which its policy forms are filed under Sections 143 and 355 of this Code.

(Source: P.A. 101-456, eff. 8-23-19.)

(215 ILCS 5/356a) (from Ch. 73, par. 968a)

Sec. 356a. Form of policy.

(1) No individual policy of accident and health insurance shall be delivered or issued for delivery to any person in this State ~~state~~ unless:

(a) the entire money and other considerations therefor are expressed therein; and

(b) the time at which the insurance takes effect and terminates is expressed therein; and

(c) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any 2 ~~two~~ or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder; and

(d) the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief

description if any, and captions and subcaptions); and

(e) the exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Sections 357.1 through 357.30 of this act, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(f) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(g) it contains no provision purporting to make any portion of the charter, rules, constitution, or by-laws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Director.

(2) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised

the Director that any such policy is not subject to approval or disapproval by such official, the Director may by ruling require that such policy meet the standards set forth in subsection (1) of this section and in Sections 357.1 through 357.30.

(Source: P.A. 76-860.)

(215 ILCS 5/356b) (from Ch. 73, par. 968b)

Sec. 356b. (a) This Section applies to the hospital and medical expense provisions of an individual accident or health insurance policy.

(b) If a policy provides that coverage of a dependent person terminates upon attainment of the limiting age for dependent persons specified in the policy, the attainment of such limiting age does not operate to terminate the hospital and medical coverage of a person who, because of a disabling condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment and is dependent on his or her parents or other care providers for lifetime care and supervision.

(c) For purposes of subsection (b), "dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities), the Department of

Public Health, or the Department of Healthcare and Family Services (formerly Department of Public Aid).

(d) The insurer may inquire of the policyholder 2 months prior to attainment by a dependent of the limiting age set forth in the policy, or at any reasonable time thereafter, whether such dependent is in fact a person who has a disability and is dependent and, in the absence of proof submitted within 60 days of such inquiry that such dependent is a person who has a disability and is dependent may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any person who has a disability and is dependent shall continue through the term of such policy or any extension or renewal thereof.

(e) This amendatory Act of 1969 is applicable to policies issued or renewed more than 60 days after the effective date of this amendatory Act of 1969.

(Source: P.A. 99-143, eff. 7-27-15.)

(215 ILCS 5/356d) (from Ch. 73, par. 968d)

Sec. 356d. Conversion privileges for insured former spouses. (1) No <u>individual</u> policy of accident and health insurance providing coverage of hospital and/or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a

spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid judgment of dissolution of marriage between the parties.

(2) Every policy which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision to the effect that upon the entry of a valid judgment of dissolution of marriage between the insured parties the spouse whose marriage was dissolved shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 60 days following the entry of such judgment, and upon the payment of the appropriate premium, an individual policy of accident and health insurance. Such policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, such terminated coverages. Any and all probationary and/or waiting periods set forth in such policy shall be considered as being met to the extent coverage was in force under the prior policy.

(3) The requirements of this Section shall apply to all policies delivered or issued for delivery on or after the 60th day following the effective date of this Section.

(Source: P.A. 84-545.)

(215 ILCS 5/356e) (from Ch. 73, par. 968e)

Sec. 356e. Victims of certain offenses.

(1) No <u>individual</u> policy of accident and health insurance,

which provides benefits for hospital or medical expenses based upon the actual expenses incurred, delivered or issued for delivery to any person in this State shall contain any specific exception to coverage which would preclude the payment under that policy of actual expenses incurred in the examination and testing of a victim of an offense defined in Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the Criminal Code of 1961 or the Criminal Code of 2012, or an attempt to commit such offense to establish that sexual contact did occur or did not occur, and to establish the presence or absence of sexually transmitted disease or infection, and examination and treatment of injuries and trauma sustained by a victim of such offense arising out of the offense. Every policy of accident and health insurance which specifically provides benefits for routine physical examinations shall provide full coverage for expenses incurred in the examination and testing of a victim of an offense defined in Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the Criminal Code of 1961 or the Criminal Code of 2012, or an attempt to commit such offense as set forth in this Section. This Section shall not apply to a policy which covers hospital and medical expenses for specified illnesses or injuries only.

(2) For purposes of enabling the recovery of State funds, any insurance carrier subject to this Section shall upon reasonable demand by the Department of Public Health disclose

the names and identities of its insureds entitled to benefits under this provision to the Department of Public Health whenever the Department of Public Health has determined that it has paid, or is about to pay, hospital or medical expenses for which an insurance carrier is liable under this Section. All information received by the Department of Public Health under this provision shall be held on a confidential basis and shall not be subject to subpoena and shall not be made public by the Department of Public Health or used for any purpose other than that authorized by this Section.

(3) Whenever the Department of Public Health finds that it has paid all or part of any hospital or medical expenses which an insurance carrier is obligated to pay under this Section, the Department of Public Health shall be entitled to receive reimbursement for its payments from such insurance carrier provided that the Department of Public Health has notified the insurance carrier of its claims before the carrier has paid such benefits to its insureds or in behalf of its insureds.

(Source: P.A. 96-1551, eff. 7-1-11; 97-1150, eff. 1-25-13.)

(215 ILCS 5/356f) (from Ch. 73, par. 968f)

Sec. 356f. No <u>individual</u> policy of accident or health insurance or any renewal thereof shall be denied or cancelled by the insurer, nor shall any such policy contain any exception or exclusion of benefits, solely because the mother of the insured has taken diethylstilbestrol, commonly referred

to as DES.

(Source: P.A. 81-656.)

(215 ILCS 5/356K) (from Ch. 73, par. 968K)

Sec. 356K. Coverage for Organ Transplantation Procedures. No ~~accident and health~~ insurer providing individual accident and health insurance coverage under this Act for hospital or medical expenses shall deny reimbursement for an otherwise covered expense incurred for any organ transplantation procedure solely on the basis that such procedure is deemed experimental or investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. If an accident and health insurer has made written request, or had one made on its behalf by a national organization, for determination by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services as to whether a specific organ transplantation procedure is clinically acceptable and said organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a

determination that the procedure is deemed to be experimental or investigational.

(Source: P.A. 87-218.)

(215 ILCS 5/356L) (from Ch. 73, par. 968L)

Sec. 356L. No individual policy of accident or health insurance shall include any provision which shall have the effect of denying coverage to or on behalf of an insured under such policy on the basis of a failure by the insured to file a notice of claim within the time period required by the policy, provided such failure is caused solely by the physical inability or mental incapacity of the insured to file such notice of claim because of a period of emergency hospitalization.

(Source: P.A. 86-784.)

(215 ILCS 5/356r)

Sec. 356r. Access to obstetrical and gynecological care ~~Woman's principal health care provider~~.

(a) An individual or group policy of accident and health insurance or a managed care plan amended, delivered, issued, or renewed in this State must not require authorization or referral by the plan, issuer, or any person, including a primary care provider, for any covered individual who seeks coverage for obstetrical or gynecological care provided by any licensed or certified participating health care professional

who specializes in obstetrics or gynecology. ~~after November 14, 1996 that requires an insured or enrollee to designate an individual to coordinate care or to control access to health care services shall also permit a female insured or enrollee to designate a participating woman's principal health care provider, and the insurer or managed care plan shall provide the following written notice to all female insureds or enrollees no later than 120 days after the effective date of this amendatory Act of 1998; to all new enrollees at the time of enrollment; and thereafter to all existing enrollees at least annually, as a part of a regular publication or informational mailing:~~

~~"NOTICE TO ALL FEMALE PLAN MEMBERS:~~

~~YOUR RIGHT TO SELECT A WOMAN'S PRINCIPAL~~

~~HEALTH CARE PROVIDER.~~

~~Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a primary care physician. A woman's principal health care provider is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. A woman's principal health care provider may be seen for care without referrals from your primary care physician. If you have not already selected a woman's principal health care provider, you may do so now or at any other time. You are not required to have or to select a woman's principal~~

~~health care provider.~~

~~Your woman's principal health care provider must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your employer's employee benefits coordinator, or for your own copy of the current list, you may call [insert plan's toll free number]. The list will be sent to you within 10 days after your call. To designate a woman's principal health care provider from the list, call [insert plan's toll free number] and tell our staff the name of the physician you have selected.".~~

~~If the insurer or managed care plan exercises the option set forth in subsection (a-5), the notice shall also state:~~

~~"Your plan requires that your primary care physician and your woman's principal health care provider have a referral arrangement with one another. If the woman's principal health care provider that you select does not have a referral arrangement with your primary care physician, you will have to select a new primary care physician who has a referral arrangement with your woman's principal health care provider or you may select a woman's principal health care provider who has a referral arrangement with your primary care physician. The list of woman's principal health care providers will also have the names of the primary care physicians and their referral arrangements.".~~

~~No later than 120 days after the effective date of this amendatory Act of 1998, the insurer or managed care plan shall provide each employer who has a policy of insurance or a managed care plan with the insurer or managed care plan with a list of physicians licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who have contracted with the plan. At the time of enrollment and thereafter within 10 days after a request by an insured or enrollee, the insurer or managed care plan also shall provide this list directly to the insured or enrollee. The list shall include each physician's address, telephone number, and specialty. No insurer or plan formal or informal policy may restrict a female insured's or enrollee's right to designate a woman's principal health care provider, except as set forth in subsection (a-5). If the female enrollee is an enrollee of a managed care plan under contract with the Department of Healthcare and Family Services, the physician chosen by the enrollee as her woman's principal health care provider must be a Medicaid enrolled provider. This requirement does not require a female insured or enrollee to make a selection of a woman's principal health care provider. The female insured or enrollee may designate a physician licensed to practice medicine in all its branches specializing in family practice as her woman's principal health care provider.~~

(a-5) If a policy, contract, or certificate requires or

allows a covered individual to designate a primary care provider and provides coverage for any obstetrical or gynecological care, the insurer shall provide the notice required under 45 CFR 147.138(a)(4) and 149.310(a)(4) in all circumstances required under that provision. ~~The insured or enrollee may be required by the insurer or managed care plan to select a woman's principal health care provider who has a referral arrangement with the insured's or enrollee's individual who coordinates care or controls access to health care services if such referral arrangement exists or to select a new individual to coordinate care or to control access to health care services who has a referral arrangement with the woman's principal health care provider chosen by the insured or enrollee, if such referral arrangement exists. If an insurer or a managed care plan requires an insured or enrollee to select a new physician under this subsection (a-5), the insurer or managed care plan must provide the insured or enrollee with both options to select a new physician provided in this subsection (a-5).~~

~~Notwithstanding a plan's restrictions of the frequency or timing of making designations of primary care providers, a female enrollee or insured who is subject to the selection requirements of this subsection, may, at any time, effect a change in primary care physicians in order to make a selection of a woman's principal health care provider.~~

(a-6) The requirements of this Section shall be construed

in a manner consistent with the requirements for access to and notice of obstetrical and gynecological care in 45 CFR 147.138 and 45 CFR 149.310. ~~If an insurer or managed care plan exercises the option in subsection (a-5), the list to be provided under subsection (a) shall identify the referral arrangements that exist between the individual who coordinates care or controls access to health care services and the woman's principal health care provider in order to assist the female insured or enrollee to make a selection within the insurer's or managed care plan's requirement.~~

(b) Nothing in this Section prevents a health insurance issuer from requiring a participating obstetrical or gynecological health care professional to agree, with respect to individuals covered under a policy of accident and health insurance, to otherwise adhere to the health insurance issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the issuer. ~~If a female insured or enrollee has designated a woman's principal health care provider, then the insured or enrollee must be given direct access to the woman's principal health care provider for services covered by the policy or plan without the need for a referral or prior approval. Nothing shall prohibit the insurer or managed care plan from requiring prior authorization or approval from either a primary care provider or the woman's principal health~~

~~care provider for referrals for additional care or services.~~

(c) (Blank). ~~For the purposes of this Section the following terms are defined:~~

~~(1) "Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology or specializing in family practice.~~

~~(2) "Managed care entity" means any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health service organization, preferred provider organization, third party administrator, an employer or employee organization, or any person or entity that establishes, operates, or maintains a network of participating providers.~~

~~(3) "Managed care plan" means a plan operated by a managed care entity that provides for the financing of health care services to persons enrolled in the plan through:~~

~~(A) organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution; or~~

~~(B) financial incentives for persons enrolled in the plan to use the participating providers and procedures covered by the plan.~~

~~(4) "Participating provider" means a physician who has~~

~~contracted with an insurer or managed care plan to provide services to insureds or enrollees as defined by the contract.~~

(d) Nothing in this Section shall be construed to preclude a health insurance issuer from requiring that a participating obstetrical or gynecological health care professional notify the covered individual's primary care physician or the issuer of treatment decisions or update centralized medical records. ~~The original provisions of this Section became law on July 17, 1996 and took effect November 14, 1996, which is 120 days after becoming law.~~

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/356s)

Sec. 356s. Post-parturition care. An individual or group policy of accident and health insurance that provides maternity coverage and is amended, delivered, issued, or renewed after the effective date of this amendatory Act of 1996 shall provide coverage for the following:

(1) a minimum of 48 hours of inpatient care following a vaginal delivery for the mother and the newborn, except as otherwise provided in this Section; or

(2) a minimum of 96 hours of inpatient care following a delivery by caesarian section for the mother and newborn, except as otherwise provided in this Section.

Coverage may be limited to a ~~A~~ shorter length of ~~hospital~~

inpatient care ~~stay~~ for services related to maternity and newborn care ~~may be provided~~ if the attending physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn and the coverage and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge. (Source: P.A. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations

governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. Participating providers have agreed to ONLY bill members the cost-sharing amounts. ~~You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code~~

~~for covered services received at a participating health care facility from a nonparticipating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the non participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co insurance and deductible amounts.~~ You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free ~~toll free~~ telephone number on your identification card.".

(Source: P.A. 102-901, eff. 1-1-23.)

(215 ILCS 5/356z.33)

(Text of Section before amendment by P.A. 103-454)

Sec. 356z.33. Coverage for epinephrine injectors. A group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2020 (the effective date of Public Act 101-281) shall provide coverage for medically necessary epinephrine injectors for persons 18 years of age or under. As used in this Section, "epinephrine injector" has the meaning given to that term in Section 5 of the Epinephrine

Injector Act.

(Source: P.A. 101-281, eff. 1-1-20; 102-558, eff. 8-20-21.)

(Text of Section after amendment by P.A. 103-454)

Sec. 356z.33. Coverage for epinephrine injectors.

(a) A group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2020 (the effective date of Public Act 101-281) shall provide coverage for medically necessary epinephrine injectors for persons 18 years of age or under. As used in this Section, "epinephrine injector" has the meaning given to that term in Section 5 of the Epinephrine Injector Act.

(b) An insurer that provides coverage for medically necessary epinephrine injectors shall limit the total amount that an insured is required to pay for a twin-pack of medically necessary epinephrine injectors at an amount not to exceed $60, regardless of the type of epinephrine injector<u>; except that this provision does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223)</u>.

(c) Nothing in this Section prevents an insurer from reducing an insured's cost sharing by an amount greater than the amount specified in subsection (b).

(d) The Department may adopt rules as necessary to

implement and administer this Section.

(Source: P.A. 102-558, eff. 8-20-21; 103-454, eff. 1-1-25.)

(215 ILCS 5/367a) (from Ch. 73, par. 979a)

Sec. 367a. Blanket accident and health insurance.

(1) Blanket accident and health insurance is that form of accident and health insurance covering special groups of persons as enumerated in one of the following paragraphs (a) to (g), inclusive:

(a) Under a policy or contract issued to any carrier for hire, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such carrier.

(b) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(c) Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers. However, student health insurance coverage, as defined in 45 CFR 147.145, shall remain subject to the standards and requirements for individual health insurance coverage except where inconsistent with that regulation. Student health insurance coverage shall not be subject to the

Short-Term, Limited-Duration Health Insurance Coverage Act. An insurer providing student health insurance coverage or a policy or contract covering students for limited-scope dental or vision under 45 CFR 148.220 shall require an individual application or enrollment form and shall furnish each insured individual a certificate, which shall have been approved by the Director under Section 355.

(d) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(e) Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditors; Provided, however, that in the case of a loan which is subject to the Small Loans Act, no insurance premium or other cost shall be directly or indirectly charged or assessed against, or collected or received from the borrower.

(f) Under a policy or contract issued to a sports team or to a camp, which team or camp sponsor shall be deemed the policyholder, covering members or campers.

(g) Under a policy or contract issued to any other substantially similar group which, in the discretion of the Director, may be subject to the issuance of a blanket accident and health policy or contract.

(2) Any insurance company authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance. No such blanket policy may be issued or delivered in this State unless a copy of the form thereof shall have been filed in accordance with Section 355, and it contains in substance such of those provisions contained in Sections 357.1 through 357.30 as may be applicable to blanket accident and health insurance and the following provisions:

(a) A provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that to the group or class thereof originally insured shall be added from time to time all new persons or individuals eligible for coverage.

(3) An individual application shall not be required from a person covered under a blanket accident or health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(3.5) Subsection (3) does not apply to major medical insurance, or to any excepted benefits or short-term, limited-duration health insurance coverage for which an

insured individual pays premiums or contributions. In those cases, the insurer shall require an individual application or enrollment form and shall furnish each insured individual a certificate, which shall have been approved by the Director under Section 355 of this Code.

(4) All benefits under any blanket accident and health policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his or her estate, except that if the person insured be a minor or person under legal disability, such benefits may be made payable to his or her parent, guardian, or other person actually supporting him or her. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(5) Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of or injury to, any such member of such group.

(Source: P.A. 83-1362.)

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

Sec. 370e. Companies which issue group accident and health policies or blanket accident and health plans to employer groups in this State shall provide the employer with notice of termination of a group or blanket accident and health plan because of the employer's failure to pay the premium when due. The insurance company shall file ~~send~~ a copy of such notice with ~~to~~ the Department in an electronic format either through the System for Electronic Rate and Form Filing (SERFF) or as otherwise prescribed by the Director.

(Source: P.A. 83-1006.)

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

Sec. 370i. Policies, agreements or arrangements with incentives or limits on reimbursement authorized.

(a) Policies, agreements or arrangements issued under this Article may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured.

(b) An insurer or administrator may:

(1) enter into agreements with certain providers of its choice relating to health care services which may be rendered to insureds or beneficiaries of the insurer or administrator, including agreements relating to the amounts to be charged the insureds or beneficiaries for services rendered;

(2) issue or administer programs, policies or

subscriber contracts in this State that include incentives for the insured or beneficiary to utilize the services of a provider which has entered into an agreement with the insurer or administrator pursuant to paragraph (1) above.

(c) (Blank). ~~After the effective date of this amendatory Act of the 92nd General Assembly, any insurer that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional~~

~~billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".~~

(Source: P.A. 92-579, eff. 1-1-03.)

(215 ILCS 5/408) (from Ch. 73, par. 1020)

(Text of Section before amendment by P.A. 103-75)

Sec. 408. Fees and charges.

(1) The Director shall charge, collect and give proper acquittances for the payment of the following fees and charges:

(a) For filing all documents submitted for the incorporation or organization or certification of a domestic company, except for a fraternal benefit society, $2,000.

(b) For filing all documents submitted for the incorporation or organization of a fraternal benefit society, $500.

(c) For filing amendments to articles of incorporation and amendments to declaration of organization, except for a fraternal benefit society, a mutual benefit association, a burial society or a farm mutual, $200.

(d) For filing amendments to articles of incorporation of a fraternal benefit society, a mutual benefit

association or a burial society, $100.

(e) For filing amendments to articles of incorporation of a farm mutual, $50.

(f) For filing bylaws or amendments thereto, $50.

(g) For filing agreement of merger or consolidation:

(i) for a domestic company, except for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $2,000.

(ii) for a foreign or alien company, except for a fraternal benefit society, $600.

(iii) for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(h) For filing agreements of reinsurance by a domestic company, $200.

(i) For filing all documents submitted by a foreign or alien company to be admitted to transact business or accredited as a reinsurer in this State, except for a fraternal benefit society, $5,000.

(j) For filing all documents submitted by a foreign or alien fraternal benefit society to be admitted to transact business in this State, $500.

(k) For filing declaration of withdrawal of a foreign or alien company, $50.

(l) For filing annual statement by a domestic company, except a fraternal benefit society, a mutual benefit

association, a burial society, or a farm mutual, $200.

(m) For filing annual statement by a domestic fraternal benefit society, $100.

(n) For filing annual statement by a farm mutual, a mutual benefit association, or a burial society, $50.

(o) For issuing a certificate of authority or renewal thereof except to a foreign fraternal benefit society, $400.

(p) For issuing a certificate of authority or renewal thereof to a foreign fraternal benefit society, $200.

(q) For issuing an amended certificate of authority, $50.

(r) For each certified copy of certificate of authority, $20.

(s) For each certificate of deposit, or valuation, or compliance or surety certificate, $20.

(t) For copies of papers or records per page, $1.

(u) For each certification to copies of papers or records, $10.

(v) For multiple copies of documents or certificates listed in subparagraphs (r), (s), and (u) of paragraph (1) of this Section, $10 for the first copy of a certificate of any type and $5 for each additional copy of the same certificate requested at the same time, unless, pursuant to paragraph (2) of this Section, the Director finds these additional fees excessive.

(w) For issuing a permit to sell shares or increase paid-up capital:

(i) in connection with a public stock offering, $300;

(ii) in any other case, $100.

(x) For issuing any other certificate required or permissible under the law, $50.

(y) For filing a plan of exchange of the stock of a domestic stock insurance company, a plan of demutualization of a domestic mutual company, or a plan of reorganization under Article XII, $2,000.

(z) For filing a statement of acquisition of a domestic company as defined in Section 131.4 of this Code, $2,000.

(aa) For filing an agreement to purchase the business of an organization authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act or of a health maintenance organization or a limited health service organization, $2,000.

(bb) For filing a statement of acquisition of a foreign or alien insurance company as defined in Section 131.12a of this Code, $1,000.

(cc) For filing a registration statement as required in Sections 131.13 and 131.14, the notification as required by Sections 131.16, 131.20a, or 141.4, or an agreement or transaction required by Sections 124.2(2),

141, 141a, or 141.1, $200.

(dd) For filing an application for licensing of:

(i) a religious or charitable risk pooling trust or a workers' compensation pool, $1,000;

(ii) a workers' compensation service company, $500;

(iii) a self-insured automobile fleet, $200; or

(iv) a renewal of or amendment of any license issued pursuant to (i), (ii), or (iii) above, $100.

(ee) For filing articles of incorporation for a syndicate to engage in the business of insurance through the Illinois Insurance Exchange, $2,000.

(ff) For filing amended articles of incorporation for a syndicate engaged in the business of insurance through the Illinois Insurance Exchange, $100.

(gg) For filing articles of incorporation for a limited syndicate to join with other subscribers or limited syndicates to do business through the Illinois Insurance Exchange, $1,000.

(hh) For filing amended articles of incorporation for a limited syndicate to do business through the Illinois Insurance Exchange, $100.

(ii) For a permit to solicit subscriptions to a syndicate or limited syndicate, $100.

(jj) For the filing of each form as required in Section 143 of this Code, $50 per form. Informational and

advertising filings shall be $25 per filing. The fee for advisory and rating organizations shall be $200 per form.

(i) For the purposes of the form filing fee, filings made on insert page basis will be considered one form at the time of its original submission. Changes made to a form subsequent to its approval shall be considered a new filing.

(ii) Only one fee shall be charged for a form, regardless of the number of other forms or policies with which it will be used.

(iii) Fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $1,500. For advisory or rating organizations, fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $2,500.

(iv) The Director may by rule exempt forms from such fees.

(kk) For filing an application for licensing of a reinsurance intermediary, $500.

(ll) For filing an application for renewal of a license of a reinsurance intermediary, $200.

(mm) For filing a plan of division of a domestic stock company under Article IIB, $100,000 ~~$10,000~~.

(nn) For filing all documents submitted by a foreign or alien company to be a certified reinsurer in this

State, except for a fraternal benefit society, $1,000.

(oo) For filing a renewal by a foreign or alien company to be a certified reinsurer in this State, except for a fraternal benefit society, $400.

(pp) For filing all documents submitted by a reinsurer domiciled in a reciprocal jurisdiction, $1,000.

(qq) For filing a renewal by a reinsurer domiciled in a reciprocal jurisdiction, $400.

(rr) For registering a captive management company or renewal thereof, $50.

(2) When printed copies or numerous copies of the same paper or records are furnished or certified, the Director may reduce such fees for copies if he finds them excessive. He may, when he considers it in the public interest, furnish without charge to state insurance departments and persons other than companies, copies or certified copies of reports of examinations and of other papers and records.

(3) The expenses incurred in any performance examination authorized by law shall be paid by the company or person being examined. The charge shall be reasonably related to the cost of the examination including but not limited to compensation of examiners, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses. All lodging and travel expenses shall be in accord with the applicable travel regulations as published by the Department of Central Management Services and approved by

the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Section 132 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon authorization of the Director. With the exception of the direct reimbursements authorized by the Director, all performance examination charges collected by the Department shall be paid to the Insurance Producer Administration Fund, however, the electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company being examined for payment to the Technology Management Revolving Fund.

(4) At the time of any service of process on the Director as attorney for such service, the Director shall charge and collect the sum of $40, which may be recovered as taxable costs by the party to the suit or action causing such service to be made if he prevails in such suit or action.

(5) (a) The costs incurred by the Department of Insurance in conducting any hearing authorized by law shall be assessed against the parties to the hearing in such proportion as the Director of Insurance may determine upon consideration of all relevant circumstances including: (1) the nature of the hearing; (2) whether the hearing was instigated by, or for the

benefit of a particular party or parties; (3) whether there is a successful party on the merits of the proceeding; and (4) the relative levels of participation by the parties.

(b) For purposes of this subsection (5) costs incurred shall mean the hearing officer fees, court reporter fees, and travel expenses of Department of Insurance officers and employees; provided however, that costs incurred shall not include hearing officer fees or court reporter fees unless the Department has retained the services of independent contractors or outside experts to perform such functions.

(c) The Director shall make the assessment of costs incurred as part of the final order or decision arising out of the proceeding; provided, however, that such order or decision shall include findings and conclusions in support of the assessment of costs. This subsection (5) shall not be construed as permitting the payment of travel expenses unless calculated in accordance with the applicable travel regulations of the Department of Central Management Services, as approved by the Governor's Travel Control Board. The Director as part of such order or decision shall require all assessments for hearing officer fees and court reporter fees, if any, to be paid directly to the hearing officer or court reporter by the party(s) assessed for such costs. The assessments for travel expenses of Department officers and employees shall be reimbursable to the Director of Insurance for deposit to the fund out of which those expenses had been

paid.

(d) The provisions of this subsection (5) shall apply in the case of any hearing conducted by the Director of Insurance not otherwise specifically provided for by law.

(6) The Director shall charge and collect an annual financial regulation fee from every domestic company for examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be the greater fixed amount based upon the combination of nationwide direct premium income and nationwide reinsurance assumed premium income or upon admitted assets calculated under this subsection as follows:

(a) Combination of nationwide direct premium income and nationwide reinsurance assumed premium.

(i) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(ii) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(iii) $3,750, if the premium is less than

$5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(iv) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(v) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(vi) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(vii) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(viii) $37,500, if the premium is $100,000,000 or more.

(b) Admitted assets.

(i) $150, if admitted assets are less than $1,000,000;

(ii) $750, if admitted assets are $1,000,000 or more, but less than $5,000,000;

(iii) $3,750, if admitted assets are $5,000,000 or more, but less than $25,000,000;

(iv) $7,500, if admitted assets are $25,000,000 or more, but less than $50,000,000;

(v) $18,000, if admitted assets are $50,000,000 or more, but less than $100,000,000;

(vi) $22,500, if admitted assets are $100,000,000 or more, but less than $500,000,000;

(vii) $30,000, if admitted assets are $500,000,000

or more, but less than $1,000,000,000;

(viii) $37,500, if admitted assets are $1,000,000,000 or more.

(c) The sum of financial regulation fees charged to the domestic companies of the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(7) The Director shall charge and collect an annual financial regulation fee from every foreign or alien company, except fraternal benefit societies, for the examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be a fixed amount based upon Illinois direct premium income and nationwide reinsurance assumed premium income in accordance with the following schedule:

(a) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(b) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(c) $3,750, if the premium is less than $5,000,000 and

the reinsurance assumed premium is $10,000,000 or more;

(d) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(e) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(f) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(g) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(h) $37,500, if the premium is $100,000,000 or more.

The sum of financial regulation fees under this subsection (7) charged to the foreign or alien companies within the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(8) Beginning January 1, 1992, the financial regulation fees imposed under subsections (6) and (7) of this Section shall be paid by each company or domestic affiliated group annually. After January 1, 1994, the fee shall be billed by Department invoice based upon the company's premium income or admitted assets as shown in its annual statement for the preceding calendar year. The invoice is due upon receipt and must be paid no later than June 30 of each calendar year. All financial regulation fees collected by the Department shall be paid to the Insurance Financial Regulation Fund. The Department may not collect financial examiner per diem charges

from companies subject to subsections (6) and (7) of this Section undergoing financial examination after June 30, 1992.

(9) In addition to the financial regulation fee required by this Section, a company undergoing any financial examination authorized by law shall pay the following costs and expenses incurred by the Department: electronic data processing costs, the expenses authorized under Section 131.21 and subsection (d) of Section 132.4 of this Code, and lodging and travel expenses.

Electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company undergoing examination for payment to the Technology Management Revolving Fund. Except for direct reimbursements authorized by the Director or direct payments made under Section 131.21 or subsection (d) of Section 132.4 of this Code, all financial regulation fees and all financial examination charges collected by the Department shall be paid to the Insurance Financial Regulation Fund.

All lodging and travel expenses shall be in accordance with applicable travel regulations published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Sections 132.1 through 132.7 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement

of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon the authorization of the Director.

In the case of an organization or person not subject to the financial regulation fee, the expenses incurred in any financial examination authorized by law shall be paid by the organization or person being examined. The charge shall be reasonably related to the cost of the examination including, but not limited to, compensation of examiners and other costs described in this subsection.

(10) Any company, person, or entity failing to make any payment of $150 or more as required under this Section shall be subject to the penalty and interest provisions provided for in subsections (4) and (7) of Section 412.

(11) Unless otherwise specified, all of the fees collected under this Section shall be paid into the Insurance Financial Regulation Fund.

(12) For purposes of this Section:

(a) "Domestic company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of this State, and in addition includes a not-for-profit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, a health maintenance organization, and a limited health service organization.

(b) "Foreign company" means a company as defined in

Section 2 of this Code which is incorporated or organized under the laws of any state of the United States other than this State and in addition includes a health maintenance organization and a limited health service organization which is incorporated or organized under the laws of any state of the United States other than this State.

(c) "Alien company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any country other than the United States.

(d) "Fraternal benefit society" means a corporation, society, order, lodge or voluntary association as defined in Section 282.1 of this Code.

(e) "Mutual benefit association" means a company, association or corporation authorized by the Director to do business in this State under the provisions of Article XVIII of this Code.

(f) "Burial society" means a person, firm, corporation, society or association of individuals authorized by the Director to do business in this State under the provisions of Article XIX of this Code.

(g) "Farm mutual" means a district, county and township mutual insurance company authorized by the Director to do business in this State under the provisions of the Farm Mutual Insurance Company Act of 1986.

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

(Text of Section after amendment by P.A. 103-75)

Sec. 408. Fees and charges.

(1) The Director shall charge, collect and give proper acquittances for the payment of the following fees and charges:

(a) For filing all documents submitted for the incorporation or organization or certification of a domestic company, except for a fraternal benefit society, $2,000.

(b) For filing all documents submitted for the incorporation or organization of a fraternal benefit society, $500.

(c) For filing amendments to articles of incorporation and amendments to declaration of organization, except for a fraternal benefit society, a mutual benefit association, a burial society or a farm mutual, $200.

(d) For filing amendments to articles of incorporation of a fraternal benefit society, a mutual benefit association or a burial society, $100.

(e) For filing amendments to articles of incorporation of a farm mutual, $50.

(f) For filing bylaws or amendments thereto, $50.

(g) For filing agreement of merger or consolidation:

(i) for a domestic company, except for a fraternal benefit society, a mutual benefit association, a

burial society, or a farm mutual, $2,000.

(ii) for a foreign or alien company, except for a fraternal benefit society, $600.

(iii) for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(h) For filing agreements of reinsurance by a domestic company, $200.

(i) For filing all documents submitted by a foreign or alien company to be admitted to transact business or accredited as a reinsurer in this State, except for a fraternal benefit society, $5,000.

(j) For filing all documents submitted by a foreign or alien fraternal benefit society to be admitted to transact business in this State, $500.

(k) For filing declaration of withdrawal of a foreign or alien company, $50.

(l) For filing annual statement by a domestic company, except a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(m) For filing annual statement by a domestic fraternal benefit society, $100.

(n) For filing annual statement by a farm mutual, a mutual benefit association, or a burial society, $50.

(o) For issuing a certificate of authority or renewal thereof except to a foreign fraternal benefit society,

$400.

(p) For issuing a certificate of authority or renewal thereof to a foreign fraternal benefit society, $200.

(q) For issuing an amended certificate of authority, $50.

(r) For each certified copy of certificate of authority, $20.

(s) For each certificate of deposit, or valuation, or compliance or surety certificate, $20.

(t) For copies of papers or records per page, $1.

(u) For each certification to copies of papers or records, $10.

(v) For multiple copies of documents or certificates listed in subparagraphs (r), (s), and (u) of paragraph (1) of this Section, $10 for the first copy of a certificate of any type and $5 for each additional copy of the same certificate requested at the same time, unless, pursuant to paragraph (2) of this Section, the Director finds these additional fees excessive.

(w) For issuing a permit to sell shares or increase paid-up capital:

(i) in connection with a public stock offering, $300;

(ii) in any other case, $100.

(x) For issuing any other certificate required or permissible under the law, $50.

(y) For filing a plan of exchange of the stock of a domestic stock insurance company, a plan of demutualization of a domestic mutual company, or a plan of reorganization under Article XII, $2,000.

(z) For filing a statement of acquisition of a domestic company as defined in Section 131.4 of this Code, $2,000.

(aa) For filing an agreement to purchase the business of an organization authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act or of a health maintenance organization or a limited health service organization, $2,000.

(bb) For filing a statement of acquisition of a foreign or alien insurance company as defined in Section 131.12a of this Code, $1,000.

(cc) For filing a registration statement as required in Sections 131.13 and 131.14, the notification as required by Sections 131.16, 131.20a, or 141.4, or an agreement or transaction required by Sections 124.2(2), 141, 141a, or 141.1, $200.

(dd) For filing an application for licensing of:

(i) a religious or charitable risk pooling trust or a workers' compensation pool, $1,000;

(ii) a workers' compensation service company, $500;

(iii) a self-insured automobile fleet, $200; or

(iv) a renewal of or amendment of any license issued pursuant to (i), (ii), or (iii) above, $100.

(ee) For filing articles of incorporation for a syndicate to engage in the business of insurance through the Illinois Insurance Exchange, $2,000.

(ff) For filing amended articles of incorporation for a syndicate engaged in the business of insurance through the Illinois Insurance Exchange, $100.

(gg) For filing articles of incorporation for a limited syndicate to join with other subscribers or limited syndicates to do business through the Illinois Insurance Exchange, $1,000.

(hh) For filing amended articles of incorporation for a limited syndicate to do business through the Illinois Insurance Exchange, $100.

(ii) For a permit to solicit subscriptions to a syndicate or limited syndicate, $100.

(jj) For the filing of each form as required in Section 143 of this Code, $50 per form. Informational and advertising filings shall be $25 per filing. The fee for advisory and rating organizations shall be $200 per form.

(i) For the purposes of the form filing fee, filings made on insert page basis will be considered one form at the time of its original submission. Changes made to a form subsequent to its approval shall be considered a new filing.

(ii) Only one fee shall be charged for a form, regardless of the number of other forms or policies with which it will be used.

(iii) Fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $1,500. For advisory or rating organizations, fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $2,500.

(iv) The Director may by rule exempt forms from such fees.

(kk) For filing an application for licensing of a reinsurance intermediary, $500.

(ll) For filing an application for renewal of a license of a reinsurance intermediary, $200.

(mm) For filing a plan of division of a domestic stock company under Article IIB, $100,000 ~~$10,000~~.

(nn) For filing all documents submitted by a foreign or alien company to be a certified reinsurer in this State, except for a fraternal benefit society, $1,000.

(oo) For filing a renewal by a foreign or alien company to be a certified reinsurer in this State, except for a fraternal benefit society, $400.

(pp) For filing all documents submitted by a reinsurer domiciled in a reciprocal jurisdiction, $1,000.

(qq) For filing a renewal by a reinsurer domiciled in

a reciprocal jurisdiction, $400.

(rr) For registering a captive management company or renewal thereof, $50.

(ss) For filing an insurance business transfer plan under Article XLVII, $100,000 ~~$25,000~~.

(2) When printed copies or numerous copies of the same paper or records are furnished or certified, the Director may reduce such fees for copies if he finds them excessive. He may, when he considers it in the public interest, furnish without charge to state insurance departments and persons other than companies, copies or certified copies of reports of examinations and of other papers and records.

(3) The expenses incurred in any performance examination authorized by law shall be paid by the company or person being examined. The charge shall be reasonably related to the cost of the examination including but not limited to compensation of examiners, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses. All lodging and travel expenses shall be in accord with the applicable travel regulations as published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Section 132 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of

subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon authorization of the Director. With the exception of the direct reimbursements authorized by the Director, all performance examination charges collected by the Department shall be paid to the Insurance Producer Administration Fund, however, the electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company being examined for payment to the Technology Management Revolving Fund.

(4) At the time of any service of process on the Director as attorney for such service, the Director shall charge and collect the sum of $40, which may be recovered as taxable costs by the party to the suit or action causing such service to be made if he prevails in such suit or action.

(5) (a) The costs incurred by the Department of Insurance in conducting any hearing authorized by law shall be assessed against the parties to the hearing in such proportion as the Director of Insurance may determine upon consideration of all relevant circumstances including: (1) the nature of the hearing; (2) whether the hearing was instigated by, or for the benefit of a particular party or parties; (3) whether there is a successful party on the merits of the proceeding; and (4) the relative levels of participation by the parties.

(b) For purposes of this subsection (5) costs incurred shall mean the hearing officer fees, court reporter fees, and

travel expenses of Department of Insurance officers and employees; provided however, that costs incurred shall not include hearing officer fees or court reporter fees unless the Department has retained the services of independent contractors or outside experts to perform such functions.

(c) The Director shall make the assessment of costs incurred as part of the final order or decision arising out of the proceeding; provided, however, that such order or decision shall include findings and conclusions in support of the assessment of costs. This subsection (5) shall not be construed as permitting the payment of travel expenses unless calculated in accordance with the applicable travel regulations of the Department of Central Management Services, as approved by the Governor's Travel Control Board. The Director as part of such order or decision shall require all assessments for hearing officer fees and court reporter fees, if any, to be paid directly to the hearing officer or court reporter by the party(s) assessed for such costs. The assessments for travel expenses of Department officers and employees shall be reimbursable to the Director of Insurance for deposit to the fund out of which those expenses had been paid.

(d) The provisions of this subsection (5) shall apply in the case of any hearing conducted by the Director of Insurance not otherwise specifically provided for by law.

(6) The Director shall charge and collect an annual

financial regulation fee from every domestic company for examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be the greater fixed amount based upon the combination of nationwide direct premium income and nationwide reinsurance assumed premium income or upon admitted assets calculated under this subsection as follows:

(a) Combination of nationwide direct premium income and nationwide reinsurance assumed premium.

(i) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(ii) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(iii) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(iv) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(v) $18,000, if the premium is $10,000,000 or

more, but less than $25,000,000;

(vi) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(vii) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(viii) $37,500, if the premium is $100,000,000 or more.

(b) Admitted assets.

(i) $150, if admitted assets are less than $1,000,000;

(ii) $750, if admitted assets are $1,000,000 or more, but less than $5,000,000;

(iii) $3,750, if admitted assets are $5,000,000 or more, but less than $25,000,000;

(iv) $7,500, if admitted assets are $25,000,000 or more, but less than $50,000,000;

(v) $18,000, if admitted assets are $50,000,000 or more, but less than $100,000,000;

(vi) $22,500, if admitted assets are $100,000,000 or more, but less than $500,000,000;

(vii) $30,000, if admitted assets are $500,000,000 or more, but less than $1,000,000,000;

(viii) $37,500, if admitted assets are $1,000,000,000 or more.

(c) The sum of financial regulation fees charged to the domestic companies of the same affiliated group shall

not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(7) The Director shall charge and collect an annual financial regulation fee from every foreign or alien company, except fraternal benefit societies, for the examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be a fixed amount based upon Illinois direct premium income and nationwide reinsurance assumed premium income in accordance with the following schedule:

(a) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(b) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(c) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(d) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(e) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(f) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(g) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(h) $37,500, if the premium is $100,000,000 or more.

The sum of financial regulation fees under this subsection (7) charged to the foreign or alien companies within the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(8) Beginning January 1, 1992, the financial regulation fees imposed under subsections (6) and (7) of this Section shall be paid by each company or domestic affiliated group annually. After January 1, 1994, the fee shall be billed by Department invoice based upon the company's premium income or admitted assets as shown in its annual statement for the preceding calendar year. The invoice is due upon receipt and must be paid no later than June 30 of each calendar year. All financial regulation fees collected by the Department shall be paid to the Insurance Financial Regulation Fund. The Department may not collect financial examiner per diem charges from companies subject to subsections (6) and (7) of this Section undergoing financial examination after June 30, 1992.

(9) In addition to the financial regulation fee required by this Section, a company undergoing any financial examination authorized by law shall pay the following costs

and expenses incurred by the Department: electronic data processing costs, the expenses authorized under Section 131.21 and subsection (d) of Section 132.4 of this Code, and lodging and travel expenses.

Electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company undergoing examination for payment to the Technology Management Revolving Fund. Except for direct reimbursements authorized by the Director or direct payments made under Section 131.21 or subsection (d) of Section 132.4 of this Code, all financial regulation fees and all financial examination charges collected by the Department shall be paid to the Insurance Financial Regulation Fund.

All lodging and travel expenses shall be in accordance with applicable travel regulations published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Sections 132.1 through 132.7 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 CFR ~~C.F.R.~~ 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon the authorization of the Director.

In the case of an organization or person not subject to the financial regulation fee, the expenses incurred in any

financial examination authorized by law shall be paid by the organization or person being examined. The charge shall be reasonably related to the cost of the examination including, but not limited to, compensation of examiners and other costs described in this subsection.

(10) Any company, person, or entity failing to make any payment of $150 or more as required under this Section shall be subject to the penalty and interest provisions provided for in subsections (4) and (7) of Section 412.

(11) Unless otherwise specified, all of the fees collected under this Section shall be paid into the Insurance Financial Regulation Fund.

(12) For purposes of this Section:

(a) "Domestic company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of this State, and in addition includes a not-for-profit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, a health maintenance organization, and a limited health service organization.

(b) "Foreign company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any state of the United States other than this State and in addition includes a health maintenance organization and a limited health service organization which is incorporated or organized under the laws of any

state of the United States other than this State.

(c) "Alien company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any country other than the United States.

(d) "Fraternal benefit society" means a corporation, society, order, lodge or voluntary association as defined in Section 282.1 of this Code.

(e) "Mutual benefit association" means a company, association or corporation authorized by the Director to do business in this State under the provisions of Article XVIII of this Code.

(f) "Burial society" means a person, firm, corporation, society or association of individuals authorized by the Director to do business in this State under the provisions of Article XIX of this Code.

(g) "Farm mutual" means a district, county and township mutual insurance company authorized by the Director to do business in this State under the provisions of the Farm Mutual Insurance Company Act of 1986.

(Source: P.A. 102-775, eff. 5-13-22; 103-75, eff. 1-1-25.)

(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 ~~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. In this paragraph, "tax due" means the full amount due for that year under Section 408.1, 409, 444, or 444.1 of this Code or Section 12 of the Fire Investigation Act.

(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 days after the prescribed due date, $50 or 5% 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 16 days but not more than 30 days after the prescribed due date, $100 or 5% of the tax due, whichever is greater, the entire fee not to exceed $2,000; or

(iii) as a penalty, if the return or report is received more than 30 days after the prescribed due date, $100 or 5% 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 or 30% of the tax due, whichever

is greater.

In this paragraph, "tax due" means the full amount due for that year under Section 121-2.08 or 445 of this Code or Section 12 of the Fire Investigation Act. 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.

In this paragraph, "tax due" means the full amount due for that year under this Section, Section 121-2.08 or 445 of this Code, or Section 12 of the Fire Investigation Act. 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 willful ~~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; 103-426, eff. 8-4-23.)

(215 ILCS 5/531.03) (from Ch. 73, par. 1065.80-3)

Sec. 531.03. Coverage and limitations.

(1) This Article shall provide coverage for the policies and contracts specified in subsection (2) of this Section:

(a) to persons who, regardless of where they reside (except for non-resident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under a health insurance policy or certificate, of the persons covered under paragraph (b) of this subsection, and

(b) to persons who are owners of or certificate holders or enrollees under the policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:

(i) are residents; or

(ii) are not residents, but only under all of the following conditions:

(A) the member insurer that issued the policies or contracts is domiciled in this State;

(B) the states in which the persons reside have associations similar to the Association created by this Article;

(C) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in that state at the time specified in that state's guaranty association law.

(c) For unallocated annuity contracts specified in subsection (2), paragraphs (a) and (b) of this subsection (1) shall not apply and this Article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to:

(i) persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State; and

(ii) persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(d) For structured settlement annuities specified in subsection (2), paragraphs (a) and (b) of this subsection (1) shall not apply and this Article shall (except as provided in paragraphs (e) and (f) of this subsection)

provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(i) is a resident, regardless of where the contract owner resides; or

(ii) is not a resident, but only under both of the following conditions:

(A) with regard to residency:

(I) the contract owner of the structured settlement annuity is a resident; or

(II) the contract owner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this State and the state in which the contract owner resides has an association similar to the Association created by this Article; and

(B) neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(e) This Article shall not provide coverage to:

(i) a person who is a payee or beneficiary of a contract owner resident of this State if the payee or beneficiary is afforded any coverage by the association of another state; or

(ii) a person covered under paragraph (c) of this subsection (1), if any coverage is provided by the association of another state to that person.

(f) This Article is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Article is provided coverage under the laws of any other state, then the person shall not be provided coverage under this Article. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this Article shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) This Article shall provide coverage to the persons specified in subsection (1) of this Section for policies or contracts of direct, (i) nongroup life insurance, health insurance (that, for the purposes of this Article, includes health maintenance organization subscriber contracts and certificates), annuities and supplemental contracts to any of these, (ii) for certificates under direct group policies or contracts, (iii) for unallocated annuity contracts and (iv) for contracts to furnish health care services and subscription certificates for medical or health care services issued by

persons licensed to transact insurance business in this State under this Code. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in paragraph (c) of this subsection, this Article shall not provide coverage for:

(i) that portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(ii) any such policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(iii) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor is determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest

determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for that same 4-year period or for such lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier; and

(B) on and after the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iv) any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(v) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(vi) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including without

limitation:

(A) a claim based on marketing materials;

(B) a claim based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) a misrepresentation of or regarding policy or contract benefits;

(D) an extra-contractual claim; or

(E) a claim for penalties or consequential or incidental damages;

(vii) any stop-loss insurance, as defined in clause (b) of Class 1 or clause (a) of Class 2 of Section 4~~, and further defined in subsection (d) of Section 352~~;

(viii) any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D), Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto;

(ix) any portion of a policy or contract to the extent that the assessments required by Section 531.09 of this Code with respect to the policy or contract are preempted or otherwise not permitted by federal or State law;

(x) any portion of a policy or contract issued to a

plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services only contract;

(xi) any portion of a policy or contract to the extent that it provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(xii) any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this State;

(xiii) any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan

participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xiv) any portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Code, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this Section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

(xv) that portion or part of a variable life insurance or variable annuity contract not guaranteed by a member insurer.

(c) The exclusion from coverage referenced in subdivision (iii) of paragraph (b) of this subsection shall not apply to

any portion of a policy or contract, including a rider, that provides long-term care or other health insurance benefits.

(3) The benefits for which the Association may become liable shall in no event exceed the lesser of:

(a) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(b)(i) with respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) for health insurance benefits:

(I) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability income insurance and $300,000 for long-term care insurance; and

(III) $500,000 for health benefit plans;

(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b), or 457 of the U.S. Internal Revenue

Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) with respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any; or

(iv) with respect to either (1) one contract owner provided coverage under subparagraph (ii) of paragraph (c) of subsection (1) of this Section or (2) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subparagraph (ii) of paragraph (b) of this subsection, $5,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this Article and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this State. In no event shall the Association be obligated to cover more than

$5,000,000 in benefits with respect to all these unallocated contracts.

In no event shall the Association be obligated to cover more than (1) an aggregate of $300,000 in benefits with respect to any one life under subparagraphs (i), (ii), and (iii) of this paragraph (b) except with respect to benefits for health benefit plans under item (B) of subparagraph (i) of this paragraph (b), in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual or (2) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this Article may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

For purposes of this Article, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage under Section 531.08 of this Code, the Association shall not be required to guarantee, assume, reinsure, reissue, or perform or cause to be guaranteed, assumed, reinsured, reissued, or performed the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(Source: P.A. 100-687, eff. 8-3-18; 100-863, eff. 8-14-18.)

(215 ILCS 5/362a rep.)

Section 26. The Illinois Insurance Code is amended by repealing Section 362a.

Section 30. The Network Adequacy and Transparency Act is amended by changing Sections 5 and 10 as follows:

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the

beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of daily living, instrumental activities of daily living, or other medical or nursing tasks for the quality and welfare of that patient.

"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers

compensation insurance, and pharmacy benefit managers.

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of accident and health insurance that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the insurer.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; (3) a course of treatment for a health condition that a treating provider attests that

discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; or (4) the third trimester of pregnancy through the post-partum period.

"Preferred provider" means any provider who has entered, either directly or indirectly, into an agreement with an employer or risk-bearing entity relating to health care services that may be rendered to beneficiaries under a network plan.

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions that provide health care services.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

~~"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.~~

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

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

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

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

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and <u>obstetrical and gynecological health care professionals</u> ~~women's principal health care providers~~.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description

shall include all of the following:

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

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

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

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

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

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

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently

enrolled population;

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a

health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan

cost-sharing ~~cost sharing~~ provisions.

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

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

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; and

(CC) HIV.

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

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the

maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

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

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

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1

of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the

beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to

treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

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

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

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios and time and distance standards established by the

Department may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

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

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

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's

compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)

Section 35. The Health Maintenance Organization Act is amended by changing Sections 4.5-1, 5-3, and 5-3.1 as follows:

(215 ILCS 125/4.5-1)

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

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

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

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

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

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

(5) may not consider emergency services, authorized referral services, or non-routine services obtained out of

the service area to be point-of-service services;

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

(7) after January 1, 2003 (the effective date of Public Act 92-579), must include the following disclosure on its point-of-service contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), non-participating providers furnishing non-emergency services may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. If you elect to use a non-participating provider, plan benefit payments will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. Participating providers have agreed to ONLY bill members the cost-sharing amounts. ~~You should be aware that when you elect to utilize the services of a~~

~~non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a non participating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts.~~ You may obtain further information about the participating

status of professional providers and information on out-of-pocket expenses by calling the toll-free ~~toll free~~ telephone number on your identification card.".

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

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

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

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

(4) A health maintenance organization failing, without just cause, to comply with the provisions of this

subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the health maintenance organization demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the health maintenance organization.

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

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

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

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

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

(5) Maintain, in addition to any other deposit

required under this Act, the deposit required by Section 2-6.

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

(7) Maintain and file with the Director, reinsurance coverage protecting against catastrophic losses on out-of-network point-of-service services. Deductibles may not exceed $100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed 20%. Reinsurance must be placed with licensed authorized reinsurers qualified to do business in this State.

(d) A health maintenance organization may not issue a point-of-service contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance organization will do all of the following:

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

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

(A) process and pay claims for all out-of-plan

covered services;

(B) meet the requirements for point-of-service contracts set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and regulatory reports on a timely basis so that the Department of Insurance can evaluate the health maintenance organization's experience with the point-of-service contract and monitor compliance with point-of-service contract provisions.

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

(Source: P.A. 102-901, eff. 1-1-23; 103-154, eff. 6-30-23.)

(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, 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, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

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

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

(c) In considering the merger, consolidation, or other

acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

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

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

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

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

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

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

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

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

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

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a

Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

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

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

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee

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

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

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

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,

eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

(215 ILCS 125/5-3.1)

Sec. 5-3.1. Access to obstetrical and gynecological care ~~Woman's health care provider~~. Health maintenance organizations are subject to the provisions of Section 356r of the Illinois Insurance Code.

(Source: P.A. 89-514, eff. 7-17-96.)

Section 40. The Limited Health Service Organization Act is amended by changing Section 4002.1 as follows:

(215 ILCS 130/4002.1)

Sec. 4002.1. Access to obstetrical and gynecological care ~~Woman's health care provider~~. Limited health service organizations are subject to the provisions of Section 356r of the Illinois Insurance Code.

(Source: P.A. 89-514, eff. 7-17-96.)

Section 45. The Illinois Public Aid Code is amended by changing Section 5-16.9 as follows:

(305 ILCS 5/5-16.9)

Sec. 5-16.9. Access to obstetrical and gynecological care ~~Woman's health care provider~~. The medical assistance program is subject to the provisions of Section 356r of the Illinois Insurance Code. The Illinois Department shall adopt rules to implement the requirements of Section 356r of the Illinois Insurance Code in the medical assistance program including managed care components.

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

(Source: P.A. 97-689, eff. 6-14-12.)

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

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Sections 356r, 356s, 356z.3, and 367a of the Illinois Insurance Code and Section 4.5-1 of the Health Maintenance Organization Act take effect January 1, 2025.

INDEX

Statutes amended in order of appearance

215 ILCS 5/412	from Ch. 73, par. 1024
215 ILCS 5/531.03	from Ch. 73, par. 1065.80-3
215 ILCS 5/362a rep.	
215 ILCS 124/5	
215 ILCS 124/10	
215 ILCS 125/4.5-1	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 125/5-3.1	
215 ILCS 130/4002.1	
305 ILCS 5/5-16.9	